

**Deanship of Graduate Studies**

**AL-Quds University**

**Assessment of Antenatal Care Services  
Provided at MoH and UNRWA Clinics  
in Gaza Province**

Submitted by

**Bassam Mohammad Omer Shaheen**

**Master Thesis**

**Fall 2004/2005**



وزارة الصحة

كلية الصحة العامة  
School of Public Health



جامعة القدس

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Submitted by

**Bassam Mohammad Omer Shaheen**

A thesis Submitted in a Partial Fulfillment of the Requirement for  
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Supervised By

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By

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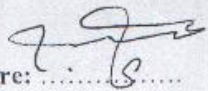
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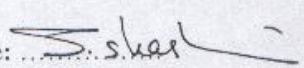
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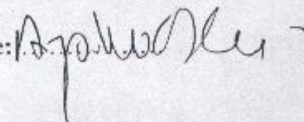
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**Declaration**

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

Signed..........

Bassam Mohammad Shaheen

Date: 15/1/2005

## *Dedication*

*To the spirit of my father*

*To all persons who work to change*

*To my family: my mother, my wife, my kids, my brothers  
and my sisters for their endless patience, support and  
encouragement*

*To all people who support me and encourage me*

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Finally I would like to thank who I am forget to do, great thank to all.

## *Abstract*

*Assessment of the perspective of health care providers and pregnant women toward the antenatal care services provided at government and UNRWA clinics is an important significant factor in improving the health services. The overall aim of this study was to assess and contribute to the improvement of antenatal care services provided at the Ministry of Health and UNRWA clinics in Gaza Province that could help in improving the current situation for the benefit of health care providers and women.*

*A cross sectional study was conducted at six centers in three governorates namely: Gaza North, Gaza and KhanYounis governorate. In each governorate, the largest two centers of government and UNRWA were conducted; the study is followed a previous studies in Gaza Province for the same purpose. Two questionnaires were used to collect data; the first was a self administered questionnaire for health care providers and exit interview questionnaire was used for the pregnant women. The number of participating health workers was 52 health workers, the number of participating women was 241 pregnant women. The response rate was 94.7% that considered a high rate. The study explored six dimensions of assessment including accessibility to antenatal services, qualification and training of health care provider, competence of health care providers, consultation, interpersonal relation needs and availability of medication and equipment.*

*The results show high portion of the health care providers are midwives, nurse or nurse-midwife, one third of the health care providers have a bachelor or specialist certificate, high portion of health care providers have post graduation specialists and antenatal training. The high portion of women has up to 4 labors, and up to 6 pregnancies. Regarding the antenatal care visits schedule, 80% of the health care providers reported that the number of antenatal care visits is good and 92% of health care providers reported good duration between antenatal visits. The attendant women reported their opinion on antenatal care visits schedule that around 88% of them were satisfied with the number of antenatal visits, 91%of attended women reported their opinion on the number of antenatal visits as good, and around 83% of women accept and reported good spacing between the visits.*

*The study concluded that the perspective of health care providers in UNRWA clinics was highly than those in government clinics and the difference reach a statistical significant level regarding a previous appointment system, the women spent waiting time more than one hour, advice for referral, need for qualification,*



*availability of equipment and medication but the difference did not reach a statistical significant level.*

*The women attending UNRWA health services experienced a previous appointment system and advice for referral and availability of medication than those attending government health services and they experienced shortage of staff, privacy during providing services, verbal conflict and advice for referral than those attending government health services, the difference reach a statistical significant level.*

*The women attending UNRWA health services experienced long waiting time than those attending government clinics, but they were more satisfied, the difference between the two groups reach a statistical significant level.*

*The health care providers reported their perspective about providing information for women about breast feeding and family planning, the percentage (91.4%) is very high in UNRWA clinics, the difference reach a statistical significant level. The perspective of attending women regarding received information about labor process that high portion did not received, but the difference did not reach a statistical significant level.*

*The women attending government clinics reported that they did not received information about breast feeding and family planning more than those who attended UNRWA clinics, the difference reach a statistical significant level.*

#### ملخص الدراسة

تقييم الخدمات المقدمة للسيدات الحوامل في عيادات وزارة الصحة ووكالة الغوث

لقد أصبحت الصحة الإنجابية في الوقت الحاضر تمثل أحد أهم الجوانب الصحية في العالم, وهي من الأهمية بمكان في بلدنا وخاصة أنها تعتبر من العناصر الأساسية في الخطة الفلسطينية للتطوير لدى وزارة الصحة الفلسطينية. وحيث أن خدمات رعاية الحوامل من أهم أسس الصحة الإنجابية. وحيث من الأهمية الاستمرار في منح صحة عالية للأمهات الحوامل ولأطفالهن فقد أجريت هذه الدراسة في عيادات أهم وأكبر مؤسستين تقدمان خدمات الرعاية الأولية في قطاع غزة وهما وزارة الصحة ووكالة الغوث.

#### هدف الدراسة:-

تهدف هذه الدراسة للتعرف علي الخدمات المقدمة للسيدات الحوامل وتقييم هذه الخدمات المقدمة لمن في عيادات وزارة الصحة ووكالة الغوث بقطاع غزة وذلك من خلال وجهة نظر مقدمي الخدمات والسيدات الحوامل, من أجل تحقيق الجودة في الأداء وتطوير الأداء الصحي.

#### الفئة المستهدفة:-

لقد اشتملت عينة الدراسة على فئتين هما مقدمي خدمة رعاية السيدات الحوامل العاملين في عيادات وزارة الصحة ووكالة الغوث, والسيدات الحوامل المتلقيات لهذه الخدمة في نفس العيادات التابعة لوزارة الصحة ووكالة الغوث خلال فترة إجراء الدراسة واللواتي تعشن في قطاع غزة, وقد كانت نسبة الاستجابة 94.7% من مجموع عينة الدراسة التي شملت 255 سيدة, وشملت كل مقدمي خدمة رعاية السيدات الحوامل العاملين في العيادات.

#### جمع البيانات:-

تم جمع البيانات من خلال استبانتين, الأولى خاصة بمقدمي الخدمة تبعاً مباشرة من مقدم الخدمة نفسه, والثانية خاصة بالسيدات الحوامل وتبعاً من الباحث أو المساعدين عن طريق المقابلة في العيادة بعد الانتهاء من تلقي الخدمة, وقد احتوت الاستبانتين علي مجموعة من المعطيات الشخصية ونقاط محددة علي شكل أربعة مجموعات تمثل المقاييس الستة التي اعتمدت في الدراسة, وقد أضيف إليها سؤاليين ذات إجابة مفتوحة لإعطاء الفرصة لمشاركة أكبر. وقد جمعت البيانات من الباحث وستة من الباحثات الميدانيات بعد أن تلقين التدريب اللازم للقيام بالعمل.

#### تحليل البيانات:-

تم استخدام البرنامج الإحصائي "SPSS" وتم اختبار النتائج باستخدام اختبار "Chi-square".

## نتائج الدراسة:-

لقد أظهرت الدراسة رضا عالي للسيدات ومقدمي الخدمة عن الخدمة المقدمة في العيادات, حيث أن 80% من مقدمي الخدمة يعتبر عدد الزيارات المنفذة في العيادة جيد وأن 92% منهم يعتبر الفترات الزمنية بين الزيارات جيد, وكانت 91% من السيدات يعتبرن العدد جيد و 86% منهن راضيات عن العدد و 82% منهن يعتبر الفترات الزمنية بين الزيارات جيد.

ومن حيث سهولة الحصول على الخدمة, فإن 85% من مقدمي الخدمة و86% من السيدات يؤكد استعمال نظام الحجز المسبق مع زيادة النسبة لصالح وكالة الغوث وكان الفرق ذو دلالة إحصائية.

وكانت وجهة نظر 80% من مقدمي الخدمة أن السيدات ينتظرن لغاية ساعة ونصف للحصول على الخدمة مع زيادة النسبة لصالح وزارة الصحة وكان الفرق ذو دلالة إحصائية.

وعبرت 65% من السيدات أنهن يقضين حتى ساعة ونصف للحصول على الخدمة. واعتبرت 49% من السيدات أن الوقت طويل وكانت 47% من السيدات غير راضيات من وقت الانتظار وكان الفرق ذو دلالة إحصائية مع زيادة نسبة الفرق في عيادات وكالة الغوث. وعبرت 41% من السيدات عن وجهة نظرهن أن عدد مقدمي الخدمة لا يكفي لتقديم الخدمة مع زيادة الفرق في عيادات وكالة الغوث ووجود الدلالة الإحصائية.

كانت وجهة نظر 31% من مقدمي الخدمة تعبر عن حاجتهم للتدريب, وعبر 88% منهم أنهم يقضون لغاية 15 دقيقة مع السيدات لتقديم الخدمة, وأن 60% منهم لا يستطيع تقديم الخدمة اللازمة. وقد عبرت 70% من السيدات أنهن يقضين لغاية 15 دقيقة مع مقدمي الخدمة لتلقي الخدمة, وأن 55% من السيدات يعتبرنه وقت جيد وكان الفرق زيادة في عيادات وزارة الصحة ذو دلالة إحصائية, وقد كان 73% من السيدات راضيات عن هذا الوقت و25% منهن يطلبن زيادة الوقت.

عبر مقدمي الخدمة والسيدات عن تقديم النصيحة في مكان خاص لذلك, وعن تقديم النصيحة بالتوجه لمركز صحي آخر, وقد عبر مقدمي الخدمة عن تقديمهم معلومات حول عملية الرضاعة وتنظيم الأسرة بنسبة عالية, وقد أبدت حوالي 73% من السيدات عدم تلقيهن معلومات حول عملية الرضاعة وتنظيم الأسرة وعملية الولادة.

وأظهرت الدراسة رضا عالي للسيدات ومقدمي الخدمة عن العلاقة أثناء تقديم الخدمة من حيث الترحيب واحترام الشكوى وتوفير الخصوصية عند الفحص. وكذلك أظهرت الدراسة رضا السيدات ومقدمي الخدمة حول توفر العلاجات والأدوات وإجراء الفحوصات وإن كانت لدى السيدات بصورة أقل من ناحية الأدوات والعلاجات.

#### التوصيات:-

خلصت الدراسة إلى عدة توصيات لزيادة تحسين الخدمات المقدمة والوصول برضا السيدات الحوامل لأعلى درجة, ولهذا توصي الدراسة:

- توفير البرامج التعليمية والتدريبية لمقدمي الخدمة حول النواحي الصحية والعلاجية أثناء الحمل, وحول عملية الولادة والرضاعة ووسائل تنظيم الأسرة.
- العمل على تقليل وقت الانتظار للحصول على الخدمة وذلك بالزيادة والتوسع في استعمال نظام حجز المسبق, توفير أماكن أوسع وتقليل الازدحام وزيادة عدد مقدمي الخدمة الصحية.
- توفير البرامج التعليمية والتدريبية لمقدمي الخدمة لزيادة مهاراتهم في الاتصال والحوار والتثقيف الصحي وتوفير السرية والخصوصية للسيدة الحامل.

### Abbreviations

ANC	Antenatal care
DISH	Delivery of Improved Services for Health

<b>Epi-Info</b>	Epidemiological Information
<b>GDP</b>	Gross Domestic Product
<b>GNI</b>	Gross National Income
<b>HHS</b>	Health Human Services
<b>HIV/AIDS</b>	Human Immune Virus/ Acquired Immune-Deficiency Syndrome
<b>MCH</b>	Maternal and Child Health
<b>MNH</b>	Maternal and Neonatal Health Program
<b>MoH</b>	Ministry Of Health
<b>NGOs</b>	Non-Governmental Organizations
<b>NHS</b>	National Health Services
<b>NICE</b>	National Institute for Clinical Excellence
<b>PHC</b>	Primary Health Care
<b>PNA</b>	Palestinian National Authority
<b>SPSS</b>	Statistical Package for Social Science
<b>STD's</b>	Sexual Transmitted Diseases
<b>WHO</b>	World Health Organization
<b>UN</b>	United Nation
<b>UNICEF</b>	United Nation Children's Fund
<b>UNFPA</b>	United Nation Population Fund
<b>UNRWA</b>	United Nation Relief and Work Agency

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# Definitions

## **Accessibility of antenatal care services:**

Refers to antenatal care services are unrestricted and ensured that antenatal care services can be achieved easily and provided in the primary health centers that reaches appropriately to the pregnant women.

## **Availability of medication and equipment:**

It identifies the presence or absence of needed medications and equipments in the primary health centers that the pregnant women need during checking visits in the pregnancy period.

## **Care provider:**

The care providers are defined in this study as the professional members whom providing the care to the pregnant women during the prenatal care period, physicians, nurses or midwives.

## **Consultation:**

It is a conference or a contact between the health care provider and the pregnant women to consider a particular care as; listening to their problem, give clear instruction, provide the appropriate medical information and assist in making decisions rather than telling what to do.

**Interpersonal relation needs:**

The skills that the health care providers need as interaction between the health care provider and the client, effective listening, pay attention to client and communication skills.

**Qualification, training and Competence of health care providers:**

It refers to the qualification, training courses, skills and actual performance of the health care providers in regards to examinations, investigations, consultations and other technical procedures which demonstrate that they having the capacity to function effectively.

# **Chapter 1**

## **Introduction**



## Chapter 1

# Introduction

Maternal health services are directed toward improving women's health. This new focus, driven by recent research, emphasizes the close tie between women's health status and the overall well being of the entire family. This link is most apparent in studies that have demonstrated higher risks of infant and child mortality following maternal death and the tangible benefits of birth spacing for both the mother and the child.

The antenatal care refers to the care that is given to an expectant mother from the time that conception is confirmed until the beginning of labor, in addition to monitoring the progress of the pregnancy that attempt to provide, appropriate support for the mother and her family whatever the outcome of the pregnancy. Although the importance of antenatal care is widely recognized, it is necessary to be known about the impact of provided care services on the health outcomes. It is very important to demonstrate that adequate antenatal care is quality intervention that improves pregnancy outcomes, including reducing infant mortality rates (Bennett, and Brown, 1999).

Internationally the recent trends about the antenatal care are to achieve improved maternal morbidity and increase consumer satisfaction. The question why is antenatal care important? The answer for this question is that the regular health checks for a pregnant woman and her unborn baby reduce the risks of complications in pregnancy and labor. Even if the women have already had a previous child or more, the women still need antenatal care to monitor things and to do the tests of antenatal care to make sure that the baby is growing well, these services are provided by the health care providers at the clinic of antenatal care.

Nationally the antenatal care is considered as very important aspect in the primary health care sector, about 95.6% of pregnant women receive antenatal care, about 95.2% of women completed three visits and over during their recent pregnancy. The number of pregnant women has been reported in governmental sector in Palestine in the year 2000 are 26,903 pregnant women (MoH, 2001).

Other organizations providing antenatal care as UNRWA which plays distinguished role in the program of antenatal care and other health's services cooperation with Ministry of Health (MoH, 2001).

### **1.1 Justification of the study**

Women have health needs for all the major diseases and have needs associated with membership of particular vulnerable groups, as do men. In addition women have special needs associated with their reproductive and social functions. Women are the most frequent consumers of health services, both for their own needs as parents and careers. The antenatal care is an important aspect of the primary health care sector in all over the world that it provides services for the clients, so the looking is to provide these services by good managed way and to achieve the quality of antenatal care. The overall goal of providing antenatal care is to improve and maintain the health and well-being of mothers, babies, and families. This involves ongoing assessment and monitoring of the health status of the women and their unborn babies. Many studies have shown that women who receive antenatal care early and regularly have a better outcome than those who do not.

In Palestine The percentage of women in child bearing age from total population is (21.9%), and the maternal mortality ratio is (18.6) per 100,000 live births, the total

fertility rate in Palestine is one of the highest rates in the world; it is about 3.87, in Gaza Strip it is 4.6 (MoH 2002).

About 94.8% of births take place in health institutions and 5.2% at home in Palestine; the vast majority of deliveries took place in hospitals with a percentage of about 82.3%. The governmental hospitals take the largest share of the total deliveries with a percentage of 52.1% (MoH 2002).

Although the purpose is to provide a regular antenatal care with an equity and good outcome, it must be recognized that many determinants influence the health of pregnant women and their unborn babies. Some of these determinants require the cooperation and coordination of many different health care providers and services. The study explores the main domains of the quality of antenatal services among the setting attending this services, the study also explores the difference in quality through the views of the health care providers and women at the MoH and UNRWA clinics in Gaza Strip.

## **1.2 Purpose of the study**

The purpose of this study is to assess and contribute to the improvement of antenatal care services provided at the Ministry of Health and UNWRA clinics. The study intend to examine antenatal services both client's and health providers perspective and to make recommendations for improving the services.

### **1.3 Objectives**

1. To assess antenatal services in terms of accessibility, staffing (qualification, training, competence), availability of equipment and supplement.
2. To diagnose the common problems in antenatal services at MoH and UNRWA clinics.
3. To examine the level of clients satisfaction.
4. To assess the perspective of health care providers and women with respect to interpersonal relationships and service provider consultation.
5. To suggest recommendations; to the policy makers and the health professionals for adopting creative ways to improve the providing of antenatal care services.

### **1.4 Research question**

1. What are the features of the antenatal care services that currently provided at the antenatal care clinics?
2. What is the perspective of the health care providers and women with respect to the qualifications and training of service providers?
3. What is the opinion of the clients with respect to competence of health care providers?
4. What is the view of the health care providers and clients with respect to service provider consultation skills; as listening, explanations, give clear instruction and the opportunity to ask questions?
5. What is the perspective of the health care providers and women with respect to health care providers and women's interpersonal relation needs; as warm

welcome, shows respect, sympathetic, communicates well in a language the client understands, pays attention to the client, assures clients of confidentiality.

6. What is the perspective of the health care providers and women with respect to accessibility of services; a willingness to serve clients at any time, number of providers available, Punctuality, waiting time.
7. What is the perspective of the health care providers and women with respect to availability of drug and proper equipment available?
8. What are the recommendations strategies that could improve the providing and implementation of antenatal care services?

### **1.5 Feasibility and cost**

The study was conducted at primary health care centers (PHC) as a part of the researcher's study at the School of Public Health, Al-Quds University. Discussion with the responsible people in the School of Public Health whom offered the necessary research support made the implementation of the study is more feasible. Also the managers in the Ministry of Health, Director of health in UNRWA and the managers of the primary health care clinics in MoH and UNRWA whom offered and provide support such as access to study population and ethical approval to conduct the study made the implementation of the study is more feasible.

The study is self-funded and supervised by school of public health.

## **1.6 Context of the study**

The study is about the assessment of antenatal care services at MoH and UNRWA clinics through views of the health care providers who provide the services either nurses, midwives and doctors, and women who receive the services. The study was conducted at Gaza Strip- Palestine and could be influenced by geographic, demographic, educational, socio-economic, and political situation of this area. Therefore, it is so necessary to provide some relevant information about this piece of land, population, culture, health status, and the infrastructure as the following.

## **1.7 Back ground of the study**

The information that describes the health care services and the population who received that care considers very important for proper planning and development of the health care services. The health care situation is influenced by geographic, demographic, educational, socio-economic, and political situation. This study is conducted in Gaza Strip in Palestine, the following information are presented the Palestine population and their health status.

### **1.7.1 Geographical and Demographic situation**

Palestine National Authority territory comprises two areas separated geographically: the West Bank and Gaza Strip. West Bank lies within an area of 5,800 square kilometers west of the river Jordan. Many areas of the West Bank have diversified communities. The differences are observable in life style and living conditions not only among classes or socio-economic levels and religious affiliations, but also among urban, rural and refugee camp communities with their

respective subdivisions. Up to sixty percent of the population lives in approximately 400 villages and rural refugee camps. Gaza Strip is a narrow area of land lying on the coast of the Mediterranean Sea between Egypt and Israel. It is about 360 square kilometers, it is very crowded area, there are small villages, and eight refugee camps that contain two thirds of the population (MoH, 2001).

The Palestinian people were estimated in the med year 2001 as about 7,968,543 all over the world including those in Diaspora, the population size in Palestine constitutes(41.4%) of all the Palestinian, it was estimated about 3,298,951 out of which 1,666,805 that constitute (50.5%) are males and 1,632,164 that constitute (49.5%) are females. The Palestine number in the occupied land in 1948 is 1,113,000 with proportion (14%) of total Palestinian. The age of Palestinian people less than 15 years constitute (46.7%) of all the Palestinian population, while the age 60 years and over constitute (4.6%) of the total Palestinian population. From the population size in Palestine 2,102,360 (63.7%) are living in West Bank, and 1,196,591 (36.3%) in Gaza Strip (MoH, 2002).

The percentage of males in Gaza Strip is (50.4%) and females constitute (49.6%) of the total population in Palestine, in Gaza Strip (49.9%) of total population are under the age of 15 years (MoH, 2002).

The report of UNRWA in 2001 the total number of refugees is 1,483,394 where 865,242 are residencies in Gaza Strip at percentage of (58.3%), while 618,152 residencies in West Bank at percentage of (41.7%). It is worth to remind the readers that refugees represent (72.3%) of all population in Gaza Strip, while in West Bank they represent (29.4%) of all population (UNRWA report, 2001).

Regarding the population density in Gaza Strip, it is about 3,278 inhabitants per one square kilometer comparing to 362 inhabitants per one square kilometer in West

Bank. The actual density rates are higher than the estimated rates by figures because of the presence of the Israeli settlements (MoH, 2001).

Education is considered an important matter in the Palestinian population that it is seen as strength guarantee in the life, in order to gain social standing and economic well-being, and to increase income. The rate of literacy for Palestinian education in Gaza Strip is about 85% (United Nation, 1998).

### **1.7.2 Socioeconomic Status**

The Palestinian socioeconomic status is affecting by many factors, the political factors is the most important factor. The GNI declined by 12 and 15 percent in the year 2000 and 2001 respectively. The GDP declined by 7 and 12 percent in the years 2000 and 2001 respectively, the GNI declined more rapidly than the GDP. Income per capita is half of in September 2000 it is 1,070 US\$, the Gross Domestic Product per capita 831US\$, unemployment rate in Gaza Strip reached about 67%. 45 - 50 percent of Palestinian population living below the poverty line (US\$2 per person per day). About 84.6 % of the populations in Gaza Strip are under the poverty line (World Bank report 2002).

### **1.7.3 Palestinian health care system**

Over the past years, the Palestinian health care system has been developing through the development of Palestinian society, during the period (June 1967 to the early 1970s) and since the early days of Israeli Military Occupation in the West Bank and Gaza Strip, the Israeli Military Occupation's goal was to increase the dependency on the Israeli health care system, and attempted to takeover the exiting Palestinian health care structures. A little development had taken place as most of



the efforts of the Palestinian structures, but the Israeli Military Authorities were directed towards maintaining their existence and providing needed health care services under numerous restrictions. Many forms of restrictions were ranging from delays in licenses to the activities requiring permission from the military occupation authorities as health education. During the period 1970\_ 1980 a new trends began to build as many independent health care structures as possible and despite the many restrictions imposed by the Israeli authorities, a health care organizations were able to obtain permits to operate in the Occupied Territories which were mainly focused on curative health service with little emphasis on preventive health activities and primary health care services. Some significant achievements were obtained during that period; the restrictions imposed by the Israeli Military Authorities were a briar for further development of those sectors. Another trend began to develop in the Occupied Territories which was based on a more holistic concept of health, the trend focused on, that health and illness were not merely biological phenomena and that the health of the individual and the population were an integral part of the social, economic, and the political situation which the population lived. In the first Intifada from 1988 to establishment of Palestinian National Authority, and as a resulted from Israeli army violence the Palestinian health structure was put in a state of emergency. This situation was the reason to establish a large number of new clinics in the West Bank and Gaza Strip in order to meet the increasing need of medical services (MoH 2001).

The Palestinian health care system is a mixture of public, non-governmental, UNRWA, and private either profit or not-for-profit service delivery, and governmental health insurance system. Remarkable improvements have been made in the last five years since the PNA assumed responsibility for the health sector, with

enhanced linkages between the Ministry of Health (MoH) and related ministries such as the Ministry of Education, Social Affairs, Finance, Planning and International Cooperation, Supplies, Industry, Agriculture and Environment, which have improved the public health functions of the system ((MoH, 1997).

### **1.7.3.1 Health Services Delivery**

There are three prominent providers for health services, the Ministry of Health (MoH), the United Nation relief and Works Agency (UNRWA), and Non-Governmental Organizations (NGOs). The largest and major health sectors, that providing and covering these services are the Ministry of health and UNRWA.

### **1.7.3.2 The role of Ministry of Health**

The Ministry of health is responsible for providing the primary health care, secondary health care and some tertiary care. The primary health care is the portion that needs the Palestinian society, which it looks for the primary health care interventions, there is more emphasizing on health promotion, health education and health prevention.

### **1.7.3.3 The role of UNRWA**

UNRWA is responsible for Primary Health Care services provision for refugees, the number of people who can make use of UNRWA services in Gaza Strip is much higher than in the West Bank. Also the refugees can access to all health services provided by Ministry of health (MoH, 2002).

#### **1.7.3.4 Maternity health services**

Antenatal care is provided as an integral part of the maternal health program. According to defined standards and procedures the ultimate objective is to get pregnancy without risks or complications either for mothers or babies. In MoH and UNRWA antenatal care services are provided by a team of nurses, midwives, physicians and obstetricians. During the first antenatal visit, a full history is taken including medical, personal, social, previous history of pregnancy, and current history of pregnancy. The schedule of antenatal care which is used in all PHC centers in MoH and UNRWA, recommends monthly visits during the first 24 weeks of pregnancy, from 25-32 weeks the recommended visits are every two weeks and then one visit weekly till labor.

Assessment for risk factors and complications is an ongoing process through the pregnancy period at PHC. In MoH the women who are at high risk pregnancy are referred from the local health centers to the high centers as the high risk pregnancy centers. In UNRWA the women are registered as early as possible after proving the pregnancy, for early assessment to risk factors and complications through the pregnancy period.

## **1.7.4 Demographic Trends**

### **1.7.4.1 Population Size**

Total mid year population size 2002 in Gaza Strip is 1,261,909, the percentage for total population is 13.7%. This population is distributed to the governorates of Gaza as the following:

Gaza north governorate: the total population is 236,298 people (18.7% of total population of Gaza Strip). The Gaza governorate population is 446,416 people (35.4% of total population of Gaza Strip). In Mid-Zone governorate population is 182,882 people (14.5% of total population of Gaza Strip). In Khan Younis governorate population is 245,588 people (19.4% of total population of Gaza Strip). In Rafah governorate population is 150,725 people (12% of total population of Gaza Strip) (MoH 2003).

### **1.7.4.2 Age and sex distribution**

The sex ratio of males per females in Palestine at the end of year 2002 is 102.2 per 100 females. The estimated number of males at the end of year 2002 is 1,750,000 while the estimated number of females at the end of year 2002 is 1,710,000. In Gaza Strip at the end of year 2002, the number of males compared to females is 636,000 and 625,000 respectively, so the sex ratio is 101.9 per 100 females. Females under 15 years in Palestine at the end of year 2002 are 22.7% of total population, in Gaza Strip Females under 15 years the percentage is 24.4% of total population. The number of females aged 15-49 years in Palestine is estimated 763,746 with percentage 22% and 44.5% of total population and total number of

females respectively, in Gaza Strip number of females aged 15-49 years is 273,125 with percentage 43.9% of total number of females (MoH 2003).

#### **1.7.4.3 Distribution by refugee**

According to United Nation Relief and Work Agency report, the total number of refugees in Palestine is 1,532,589. The number of refugees resident in Gaza Strip is 893,141 at percentage of 58%. In Gaza Strip the percentage of refugees is larger than in West Bank, it is about 70.8% of population residents in Gaza Strip (MoH 2003).

#### **1.7.4.4 Population Density and Growth**

Population density is very high in Gaza Strip; it is about 3,505 inhabitants per square kilometer. Natural increase rate in Palestine is estimated at the year 2002 about 3.7%, it was declined from 3.8% at year 1997 to 3.7% at year 1998-1999, and 3.6% at year 2000-2001 (MoH 2003).

#### **1.7.4.5 Dependency Ratio**

Dependency ratio is calculated as the number of persons below 15 years and above 65 years per 100 persons aged 15-65 years. It is about 101.6% in Palestine and it is about 108% for Gaza Strip (MoH 2003).

#### **1.7.4.6 Fertility**

The total fertility rate (average number of children born to women (15-49) had been decreased progressively over the period 1997-2003. In Gaza Strip total fertility rate is 4.8. This decline has taken place in all age groups. The fertility peak was between the ages 20-29 years, in Gaza Strip the total fertility rate and age was higher than West Bank, it is 4.8 in Gaza Strip and 3.3 in West Bank (MoH 2003).

#### **1.7.4.7 Crude birth rate**

Crude birth rate (the number of live births per 1000 population per year) is still high despite progressive decline over the years compared to other countries. Crude birth rate declined from 46.5/1000 in the year 1995 to 27.2/1000 in the year 2002 respectively. In Gaza Strip the rate decreased from 45.4/1000 in 1997 to 33.1/1000 in 2002 (MoH 2003).

#### **1.7.4.8 Crude death rate**

The crude death rate in Palestine declined from 4.8 deaths per 1000 population in 1997 to 3.1 per 1000 in 2002. In Gaza Strip, crude death rate is 4.7 in 1997 and dropped to 3.5 in 2002. In the West Bank, the crude death rate is 4.9 in 1997 and dropped to 2.9 in 2002, these results indicated that there was an improvement in the living standards (MoH 2003).

# **Chapter 2**

## **Literature Review**

## Chapter 2

# Literature Review

### 2.1 Definition of Antenatal care

The antenatal care refers to "the care that is given to an expectant mother from the time that conception is confirmed until the beginning of labor" (Bennett and Brown, 1999).

WHO defined the antenatal care as "the care refers to pregnancy-related care provided by a health worker either in a medical facility or at home. In theory, antenatal care should address both the psychosocial and medical needs of the woman in the context of the health care delivery system and the surrounding culture" (WHO, 1996).

The Maternal and Neonatal Health (MNH) Program defined the antenatal care, "the care a woman receives throughout her pregnancy" (MNH, 2001).

Ozvaris, S. and Akin, A. define "Antenatal care is the monitoring of mother and fetus by trained health personnel throughout the whole pregnancy with necessary examinations and recommendations by regular intervals" (Ozvaris, S and Akin, A 2002).

### 2.2 Aims of antenatal care

The aims of antenatal care services are to provide appropriate support for the woman and the family regardless the outcome of the pregnancy, to encourage the family adjust psychologically and socially by healthy way to childbearing. Also the aim of antenatal care services is to build up the relationship trusty between the woman and her family and the care providers, to monitor the progress of the pregnancy and in the end of the pregnancy the woman and her be healthy and the



fetal is developed well, and to recognize any deviation about the normal services which is required to the woman (Bennet V, and Brown L 1999).

The aim of antenatal care is to provide advice, reassurance, education, and support for the woman and her family, deals with the minor problems of pregnancy, provides an ongoing screening programs, (clinical and laboratory based) to confirm that the woman continues not be at risk, and to prevent, detect, and manage those problems and factors that adversely affect the health of the mother or her baby (James, D. K. 1995).

Neilson, J said; the aim of antenatal care is to provide many benefits including clinical improvement, education, counseling and psycho-social support to the pregnant women (Neilson, J 1996).

### **2.3 History and routine of antenatal care**

The history of traditional pattern antenatal care in United Kingdom originates early since the year 1929, the pattern is consist of one visit every four weeks until twenty eight weeks, then one visit every two week for the thirty six weeks, in the last the visit is weekly until delivery. There were a question about the benefit of this pattern of care and there has been much researches which done recently that to explore a new pattern of antenatal care for both the timing of visits and place of consultation. The aim of this new pattern is improving the maternal morbidity and increase the satisfaction of consumer (Bennett and Brown, 1999).

The new pattern of antenatal care considers the quality of care is come over quantity of visits. This pattern of antenatal care "focused antenatal care" shows that; to improve pregnancy outcomes, it is not necessary to increase the visit's number and the high-risk pregnant women is not necessary to develop complications, but the low

risk pregnant women may develop these complications. Therefore, if high-risk pregnant women do not develop complications, there may unnecessary usage of care in antenatal care planned to use a risk pattern. In the other side low-risk, pregnant women may not be prepared to receive care but they develop complications. The look for the pregnant women is the same that all pregnant women must receive the same antenatal care because all pregnant women are at risk for complication, and there is not proven about the routine measures and risk factors that used in the traditional pattern of antenatal care to be effective in improving the pregnancy outcome (MNH, 2001).

The result of a study to compare the acceptance and effectiveness of a reduced antenatal visits pattern of six to seven visits with the traditional thirteen visits on low risk pregnant women shows; that there were no differences on the clinical outcome was denoted by using the two patterns of antenatal care (Sikorski et al. 1996).

Sahin Aksoy said that until the middle of 20th century the techniques were not applied to antenatal care. Antenatal screening and diagnostic techniques are almost the measuring of the quality of antenatal care. In the United Kingdom, about 90% of the pregnant women have undergone one of these techniques at some time during pregnancy (Aksoy S. 2001).

The schedule of antenatal care visits was starting from the year of 1920; it was inconvenience for the pregnant women and it become as a habit. These visits are too many that to be seen by many professionals in many setting (Neilson, J 1996).

Villar J. and others said that decreasing the number of antenatal care visits could be implemented, regardless the content of the visits and without increase in adverse effect on pregnancy outcome. Women may be less satisfied with decreasing the visits but a benefit can be achieved that reduce the costs for the mothers and

providers. The clinical effectiveness seemed similar, women showed slightly more satisfied with midwife or general practitioner more than with obstetrician or gynecologist (Villar J. et al, 2003).

#### **2.4 Models of antenatal care**

The aims of antenatal care services are to provide appropriate support for the woman and the family regardless the outcome of the pregnancy, this support is provided through the visits of antenatal care, there are more than one models of antenatal care used.

There are many antenatal care models, which used currently around the world, these models have not been evaluated by scientific base and no scientific evaluation is done to evaluate their effectiveness. Although there is a widespread for these models and the goals are to improve maternal care services, but there is lack of the identification of effective interventions and the optimal allocation of resources (WHO 2002).

The European models of antenatal care, which developed in 1900, are the base for the most of antenatal care programs that used in the developing countries, there were developing in the number, time, and content of visits. Despite of this development there has been low scientific evaluation on the effectiveness of these components (WHO 1998).

Carroli G. et al (2001) says that the current antenatal care models were originated from the European models which developed in the twenty century, there was no changes in the activities of these models, even the new procedures , tests and intervention were added to the programs without evaluation based on scientific base. The number of visits was added to these programs; in some countries these visits

reached sixteen visits, this show that the number, time of visit and the content of antenatal care visits appear to be more to the normal evidence base health care (Garroli G. et al 2001).

Tucker et al developed and tested a model of care, which considered the low-risk pregnancy complication women should received the antenatal care in primary care setting by general practitioners and midwives only (Tucker et al 1996).

Mayor S, said to get a healthy pregnant woman without complications, she should have fewer with more informative antenatal visits. NICE recommends 10 checks up during the first pregnancy and seven during subsequent pregnancies, rather than the traditional schedule, NHS in England and Wales, suggests that check up should start earlier in pregnancy, that women should see a doctor at around eight weeks instead at around 12 weeks. Mayor S. said also that this guideline focuses on the quality of rather than quantity, and will avoid long waiting time and it may help to improve continuity of care and lead to a beneficial pregnancy outcome (Mayor S, 2003).

Mayor S, said also that "Jane Thomas, director of the National Collaborating Centre for Women's and Children's Health, the group that developed the guidance for NICE, said: "It is important that there is a clearly defined purpose to every antenatal appointment offered to women. The pattern of antenatal care has evolved over the last 80 years, but it has been based on ritual and has not always had a scientific basis" (Mayor S, 2003).

## **2.5 Magnitude, Epidemiology and Link Factors of antenatal care**

It is very important and essential to promote healthy behaviors and increase the knowledge about pregnancy and complications of pregnancy among women,

families and communities that to provide the health and well-being of pregnant women. To improve the health of pregnant women, in-related to immediate complications as ill or death and related causes as socio-economic situation or malnutrition, effective antenatal care should be provided and increased the mother's chances of giving birth to a healthy baby. In the other side preventing the development of complications during pregnancy and delivery and treated the complications before they become life-threatening emergencies, all these complications can be managing by appropriately trained and equipped health care providers. All these beneficial interventions are to help the mothers and their babies.

In the developing countries, there are irregular clinical visits with long waiting times, poor feedback to the women, and poor implementation of routinely recommended antenatal care programs used in these countries (WHO 2002).

Unicef report shows that about 65% of women in the developing world are attended at least only one antenatal visit during pregnancy by skilled professional health providers, The high rate is in Latin America and the Caribbean (83%) and lowest in South Asia (51%), the report shows that in general, antenatal care has improved steadily, it increased from 53% in 1990 to 64% in 2000 with rising 20%. An increasing was greatest in Asia and slowest in Sub-Saharan Africa (UNICEF 2001).

The needs for health services are important needs, that it enables the women to go with their pregnancy and labor safely and to born their babies healthy. This importance for health services is including the care during pregnancy, by providing antenatal care services that should be initiated in the early of pregnancy.

The women can get antenatal care services by many ways, either through health center which gives an idea about the utilization of antenatal care services by women or by home visits which provide an idea about the quality of care. One of the most important aspects of antenatal care is providing information and counseling to the pregnant women about complication of pregnancy and procedures to prevent and cure these complications. In the study of Milligan, R et al (2002) the comparison between women whose receive antenatal care, shows that the not American originated women are beginning in the first trimester less than the White women (73.3% and 87.9% respectively in 1998). This difference is increased progressively through the years as shown in the followed year greater, it was about (67.1% and 90.9% respectively in 1999). The study shows also that the women from poor urban communities receive antenatal care later and their antenatal care visits less than women of higher socio-economic levels. There are women with little or no use of antenatal care, these women as homeless and substance abusing women, they do not believe about the importance of antenatal care. Women who abusing drug are starting their antenatal care later and they have less utilization of antenatal care services (Milligan, R. et al 2002).

More than 90% of women reported attending an ANC at least once in both Malawi and Kenya, the total number of reported visits was equally, while the percent of women who attending two or more times were 87% and 92%, respectively, more than 40% of the women in both countries reported attending five or more times. In both Malawi and Kenya, more than 85% of pregnant women were available to benefit from the treatment regimen for many diseases as malaria, syphilis, and anemia. In contrast, fewer than 45% were available for continued risk management and supplementation of drug (Schultz J. et al 1996).

In Saudi Arabia maternal and child health is a priority in public health programs. Regular antenatal care can decreased the effects of pregnancy and complications of child delivery. The existence of facilities for maternal health care does not necessarily mean that they will be used, even by women who have been advised to do; many factors play a role in the accessibility of antenatal care services, as socioeconomic standards and behavioral attitudes toward these facilities affect antenatal check-up and the residency area of women. The number of mothers attending antenatal care at the local primary health care centers is to be in the rural area more than the urban area (El-Gilany, A.H. and Aref, Y. 2000).

The percent of women attended antenatal care services in Jordan was 95.6% in year 1997 and in Egypt was 53% in year 2000 (UNICEF 2001).

In Palestine the antenatal care is considered as very important aspect in the primary health care sector, about 95.6% of pregnant women receive antenatal care, about 95.2% of women completed three visits and over during their recent pregnancy. The number of pregnant women has been reported in governmental sector in Palestine in the year 2000 are 26,903 women (MoH, 2001).

Limitation of accessibility to antenatal care services may be due to many factors, these factors including the distance to the near clinics, lack of transportation, cost of transportation, availability of facilities and offering free antenatal care. Other factors can limit access to services as socioeconomic status, level of education either the mother or her husband, income of the family, relation between family members and satisfaction for services. There was increase in access to services with increasing the level of education, the access increase also with good relation between the family members that lead to optimal decision making and more access can obtained

when women be satisfied with the services they received. Women with high level of social class attended services more than the poor or low level of social class women. Previous pregnancy history and the complications that women suffered before in their previous pregnancies are considered a positive factor for seeking and going on more access to services (Glei, D. et al 2002).

## **2.6 Importance of antenatal care services on mother's health and pregnancy outcome**

Pregnancy is a special event, and the family and community should treat a pregnant woman with particular care. The outcome of a pregnancy depends on the care given; antenatal, during the delivery and after the delivery. The danger signs which may arise during pregnancy must be known to provide help and treatment for the mother and her fetus as early as possible, from the most appropriate place. Antenatal care provides an important opportunity for discussion between a pregnant woman and a health provider about healthy behavior during pregnancy.

Pregnant women are assessed on a monthly basis to reduce infant and maternal mortality rates. Encouraging women to participate in this service beginning as early as possible in the first trimester, many women do not participate until the second or third trimester. Gather the Information about the pregnant woman helped to identify possible risk factors as, age, height and weight, number of pregnancies, date of last pregnancy, number of spontaneous abortions and Cesarean sections, and number of children living. The physical examination is performed to assess the condition of the fetus and the mother. High risk pregnancies are also identified at this time. These include women with risky age as under the age of twenty or over the age of thirty-five; women who have had multi pregnancy as more than four pregnancies; newly



delivered mothers, and women who have HIV/AIDS or other STDs. Women who complains from problem with their pregnancies, as well as, needs subsequently counseled by the midwife at the antenatal care. The women receive consultations about the preparations necessary for breast feeding, and women are encouraged to join the Family Planning program six weeks postpartum. During the antenatal care session, women are advised to follow up in the hospitals for STDs and HIV infection, as well as for delivery (Health Outreach program, 1995).

The psychosocial and the medical needs of the woman, within the context of the health care delivery system and the culture of women should be considered during the antenatal care period. The antenatal care visits during the antenatal period are important and necessary by many ways; to establish confidence between the woman and her health care provider, to provide health promotional services, and to identify and manage any maternal complications or risk factors. The essential services are provide at antenatal visits that are recommended for all pregnant women, such as immunization of tetanus toxoid and the prevention of anemia through nutrition education and provision of treatment as "iron/folic acid" tablets (WHO 1994).

Dr. Malpani is looking at the antenatal care that the women must be good for her baby before it is born, this emphasize the importance of antenatal care during pregnancy, Dr. Malpani is considered the preconception care is the very important that it is easy, inexpensive, and can prevent many diseases and can provide the chance for the doctor and the women to be relax with the care (Malpani, 1999).

"Antenatal care -care during pregnancy- provides an important opportunity for discussion between a pregnant woman and a health care provider about healthy behavior during pregnancy (such as adequate nutrition), about recognizing complications that may arise during pregnancy, and about a delivery plan that will

meet the needs of the individual woman. Antenatal care is important also for preventive care, including tetanus toxoid immunization and provision of iron/folic acid tablets to prevent and treat anemia. Finally antenatal care is important for early diagnosis and prompts treatment for complications of pregnancy and other illness that can arise during pregnancy, such as sexually transmitted diseases (STDs), malaria, and helminthes infections"(WHO 1996).

Taguchi N and others said maternal mortality is influenced by low socio-economic background and the low availability of antenatal care (Taguchi N et al 2003).

Antenatal care services can improve the outcome of many issues in pregnancy, and many complications outcome may be prevented or improved by antenatal care, by using further investigations. These issues include maternal and fetal mortality, severe neonatal morbidity, and long-term handicap. There is an emphasis about the importance of identifying, specifically, what is the achievement during designing the antenatal care. To achieve specific pregnancy outcomes; determination the specific antenatal interventions must be achieved (HHS, 2000).

The benefits of antenatal care are to provide healthy conditions for mothers throughout their pregnancy and their babies' delivery during the pregnancy, delivery and after the delivery. Also early detection of complications, and providing the suitable treatment for these diseases and pregnancy complications, providing special care for the high risk pregnancies mothers, intrauterine monitoring of the fetus, vaccinating the mother against tetanus, determining the place of the delivery, and type of assistance, educating the mother on nutrition, hygiene, delivery, postpartum care, infant care, and family planning methods (Ozvaris, S and Akin, A 2002).

The early antenatal care is important for young mothers that; low accessibility for antenatal services early during pregnancy, and low availability of antenatal services themselves, lead to little access to counseling and testing services, screening for curable diseases as STIs, and lead to limited knowledge about the healthy behavior (UNFPA 2002).

## **2.7 Importance of women's and care provider's perspective on assessment of antenatal care services**

The clinical relationship between patient and care provider still represents the base of the current health care services, even though with the increasing involvement of technology in routine antenatal care in both developed and developing countries, the offered care should be acceptable for the recipients. There are an importance of allowing for patients' views alongside medical and economic considerations regarding care assessment during pregnancy and childbirth (Langer A. et al 2002).

The satisfaction with team midwifery care for low- and high-risk women shows that the team of the midwifery care was associated with increased satisfaction with antenatal care. In addition, it shows that the continuity of midwifery care is realistically achievable and is associated with increased satisfaction, (Biro MA, et al 2003).

Women's views and health professionals' perspective should be known that there are determinants in greater acceptance and continuity use of services. Policymakers and program managers need careful evaluation before and during using new care models into institutional protocols, during the process of change the manager should certainly contribute to improving providers' commitment to their clinical work. Also

in health care evaluation the patients' views, increasing the attention are given (Langer A. et al 2002).

The patient's and care provider's perspectives are a mirror for the quality of the care received and provided, (Donabedian A. 1988).

O'Connell T, and others said that a majority of GPs wanted more involvement in antenatal care, the female GPs. were significantly more likely wanted to be involvement to antenatal care more than male GPs. The models involving midwife care were much less popular with the GPs. The perspective of GPs. was varies about antenatal services and home births. Issues rose in relation to home births included the need for increased skill deficits (O'Connell T, 1998).

Another study said that it was not easily identified if the women were satisfied with traditional or reduced antenatal visit schedules. It is need more assess, and provide care according to their preferences; by providing social support and improving the psychosocial quality of antenatal care may be a good strategy for making reduced visit schedules more acceptable to pregnant women (Clement S et al, 1996).

## **2.8 Accessibility of services and care providers**

Antenatal care is important for identifying and responding to risk factors in pregnancy, as the kind of care is provide exactly, the services accessible to the clients. In the developing world, the mothers receive adequate and appropriate antenatal care. The use of antenatal care is associated with a variety of factors such as socio-economic, cultural and reproductive factors. Accessibility of healthcare facilities also influences their use by pregnant women. Access to antenatal care is

important. Women who live near to a health facility have more antenatal visits and those who have access to a Community Health Worker are more likely to have an early first visit (Dr KKAgarwal, 2001).

Gathering the information by the staff from women as age, height and weight, number of pregnancies, date of last pregnancy, number of abortions and Cesarean sections, and number of children living, also the performed physical examination and assessing the presentation and position of the fetus, and the fetal heart rate are a sign for accessibility of services. The checks and tests that are done by the nurse midwife as tests of anemia, the legs for swelling, and the general cleanliness of the woman, also advised her to go to the hospital to be checked for infectious diseases, and delivery is considered the indicator for Accessibility of antenatal care services and health care providers (Health Outreach program, 1995).

The study about the utilization of antenatal care services in Rajasthan show that the accessibility to services and the health care providers were low either in the home or outside the home, this can be seen through low accessibility to services as tetanus toxide (Mondal, S.K. 1997).

The women received antenatal care services either by visiting the health center or any private health professional, even or in her home after identify the women in her area. Therefore, the women received the services by any way, which mean the accessibility for services and health care providers (Mishra, U.S. et al 1998).

The study which was done about the patient perception and satisfaction among vitnamese born mothers shows that accessibility for health care services and health care providers in pregnancy is affected by many factors, and the level of satisfaction

with health services is low because of poor availability and accessibility of health services, poor communication, and consultation (Young, L. and Phung, H. 2000).

There is suffering from access to health services for women and children because of considering gender, and disadvantage of women's positioning society that mean equity absence, so the services must be access for all with actually adequate access to health services without inequity (Nudmbe, P. 1999).

The number of women who receive antenatal care in India is still relatively low, that about half of all pregnant women receive some antenatal care, this problems is exit ed on the sides of demand and supply. The knowledge of the pregnant women shows that the women are often unaware of the need for antenatal care services, and the importance of receiving this care from early pregnancy. In addition, many women are not aware that maternity care is available from female health workers. The prophylaxis services as supplements services (iron and folic acid tablets) are very low because of supply and demand problems. The low accessibility of ANC appears through poor supplies, refused or discontinued using the tablets by the women, the poor quality and effectiveness of the tablets. Moreover, low coverage levels of services although the high maternal mortality. The numbers of deliveries that take place in institutions or are attended by trained health care providers remain low (Dr KKAgarwal, 2001).

The DISH project found that lack of providers at a health facility had a negative impact on clients' perception of quality. Since available providers were overwhelmed this often leads to untrained providers delivering reproductive health services which in most cases were poorly handled (DISH, 1999).

Dobson R, said there are two indicators for maternal mortality in developing countries, access to maternity health services is the most important one, this can be achieved by the extent of access for rural women to treatment for complications and the adequacy of transport in emergencies. This access to maternal health services has a consistent and significant effect to reduce maternal mortality (Dobson R, 2003).

Navaneetham, K. and Dharmalingam, A. said that the range of reproductive, socio-economic, cultural, program factors and the state and type of health service, also differences in the implementation of maternal health care program and differences in availability and accessibility between the states have a role in utilization of maternal health care services. They said that there was significant difference between rural and urban areas on antenatal care, that the health care providers played multipurpose work in the rural areas to provide maternal health care services (Navaneetham, K. and Dharmalingam, A. 2002).

## **2.9 Training and competence of health care providers**

The health care providers showed themselves to be technically competent when undertaking for the medical counseling and examination procedures. The clients are particularly concerned about the qualifications and training of care providers.

Ashcroft B, and others said that there are shortage in midwifery staffing levels and ineffective deployment of midwives, this considered an essential failings in the system of care and are the basic of many work accidents. So the midwives are fundamental components in the system of care, and the system cannot operate safely and services cannot be effectively in case of shortage the number of midwives, or

ineffective deployment of midwives, and there are no opportunities for training and updating (Ashcroft B, et al 2003).

The Quality of Reproductive Healthcare Study (DISH, 1999) shows that clients often expected that the health care centers to have well qualified medical doctors and laboratory technicians. Specifically, clients wanted the providers to be trained for the proper examination, identify the problem and prescribe treatment. Many clients felt that there is shortage with qualified staff and refused to be treated by the staff that was “training-on-the-job.” Therefore, clients recommended that the health care centers must have an adequate number of staff to satisfy demands, although one trained provider can performing well (DISH, 1999).

Trained health care providers have an important role to play in reducing the burden of smoking among women especially in primary care settings. Experts concluded that brief cessation counseling provided by a trained provider and using self-help materials increases rates of cessation among pregnant smokers (Ebrahim SH. 2000).

A study about the women's opinions shows that the Cuban women have strong opinions about the type of care that they prefer to receive, these opinions is that they prefer the modern and technically care, and this care they trust. They show a strong preference for being attended by health care providers with high skills. Even they show that the distance to place -where the provider is present- is not important if they can get this care. They feel that they can receive the attention they need. The preferences of women according to their strong views are for skilled care provider but there is no preference about the gender of the provider. They are looking for the care provider who can look after them, and having chances to go in depth with every



patient, and who is well trained enough information to deal with their problems (Nigenda, G. et. al. 2003).

## **2.10 Consultation on antenatal care**

Consultation is a conference between two or more people to consider a particular question; this refers to consultation with consumers in relation to developing health information. Consumers are asked for the view of consultant that may or may not be adopted by the consumers.

Bagshawe A and Taylor A said that The task of consultant is how to deal with the stress of the situation as to define what has led to it, to find ways to open a clear communication, and help the client to explore the correct action' that he aims to clarify the needs of person. The frequency, duration, and focus of counseling vary and will depend on the circumstances of the client (Bagshawe A, and Taylor A, 2003).

The study of "consultation patterns and provision of contraception in general practice before teenage" suggests that improving access to health education and contraceptive services is seen as the principal way to reduce teenage pregnancy, the teenagers refused to seek advice because of difficulty in gaining access and fears about confidentiality. The study shows; that most of the pregnant teenagers do access to general practice in the year before pregnancy, the pregnant teenagers have higher consultation rates than the same age peers, and most of the difference is due to consultation (Churchill, D. et al 2000).

A small number of women consulted a professional for advice or assistance demonstrates the sensitive nature of the problems and confirms, that the women are

refused to talk about or asking for help in special problems, even if this consultation might alleviate their problems. The health professionals must be able to give appropriate advice to those women who do consult them for all problems either antenatal or postnatal (Clarkson, J. et al 2001).

## **2.11 Communication and Interpersonal relation**

The interpersonal relationship between a client and the health care provider is one of the most important issues for client's assessment of antenatal care. The clients prefer a care provider who gives a warm welcome, acts friendly, shows respect and treats clients as a human being, is sympathetic, acts fair and does not discriminate, communicates well in a language the client understands, pays attention to the client, expresses or demonstrates a commitment to their work, assures clients of confidentiality. The relationship between health care provider and client is a thin one. The care provider has an opportunity to be extremely effective on a client simply by the way he or she interacts with that person. Many people view health care providers as a parent. Therefore, clients expect health care providers to behave and act in a manner deserving such respect.

To be good communicator you must be good listener, it is the best start and finding the right time to say the right words, by showing good understanding, and rephrasing what is the need of clients lead to positive effect, and having a good chance for communication, and understood their concerns. Also reflecting the feeling and to be sympathy is one of the most active forms of listening, that lead to increases the confidence, and there is interpersonal relation between the care provider and client (Manallack, S 2003).

The full benefits of knowledge can be gained if the health care provider can communicate this knowledge effectively and patients are able to use it in their decisions about treatment and lifestyles. If the health care providers want to communicate risk effectively to their patients, the health care providers are one source of information and may not be longer the most trusted. Health care providers can communicate risk information more effectively if they develop relationships with their patients and if they take into account knowledge and perceptions of health risks in the general public (Alaszewski, A. and Jones, T.H. 2003).

Client centered care requires providers to respect a clients' view, encourage clients to discuss their needs, and to provide the appropriate medical information to the client and assist them in making decisions rather than telling them what to do (Kim et. al. 2000).

Murira N, et al (2003) conducted a study to explore communication between pregnant women and health care providers at an antenatal clinic in Zimbabwe. They identified many forms of communication as impersonal, nonprivate, rigid, uninformed and authoritative communications. These forms were as a result to interaction between the pregnant women and the health care providers. The communication styles at the antenatal clinic reflected the attitudes (Murira N, et al 2003).

The health care providers should have effective interpersonal skills that the communication process must go by two ways to involve the health care providers and women, using open questions, active listen, facilitate confidence and trust, good observation and smell (Bennett, and Brown, 1999).

## **2.12 Interventions and policies to improve the antenatal care services**

The policy interventions which help to improve access to care may differ according to many causes such as people, health concerns, resources, nature of the area, culture and health policy. Any intervention policy should be start by assessment, so the first policy is to assess the local needs by preparing proposals, to assess the training and managerial capacities, to provide training in delivery of primary health and antenatal care, preparing sustainable program by community participation, manage the health care needs of the community, technical assistance to support existing units, to build required competencies by monitoring and supporting the program and to assess program outcomes. Increase health awareness through social marketing and communications campaign which will help to create community awareness and determine demands for primary health care and provide health education.

Tayal U, said to increase the access of ANC services, organizations should to employ the health care providers from different ethnic group, and to allocate the resources to maternity units which lead to good plan and implement change without fear from shortage of staff (Tayal U, 2003).

Dish program in Uganda recommended that efforts to improve reproductive, maternal and child health services should focus on both the public and the private sector. To pay more attention to the private sector because of its big role in providing reproductive, maternal and child health care services, and to provide support to the private sector by systematic assessment and consultations that conducted by government and donor communities which helps to establish entry points for. To improve the quality of services and increase service utilization at

public facilities, many factors should be avoided as long waiting time, low drug availability, bad service, accessibility of services and increase staff qualification. Health education and increasing knowledge about quality of services and constitutes good quality services which is the needs of clients should be provided to be widely spread (DISH, 1999).

# Chapter 3

## **METHODOLOGY**

## Chapter 3

# METHODOLOGY

### 3.1 Study design

The design of this study is a cross sectional design. This type of studies are usually used for descriptive and assessment purposes. A cross sectional design is used to examine groups of subjects in various stages of process at the same point of time. This design is identifying the problem with the current situation, through getting information at various points of the process (Burns and Grove, 1997).

The complicity of the cross sectional design is varies, that It may contains more than two variables in a situation, the examined phenomenon's overall picture can be identified by the relationship among variables. It is carried at the same point of time, the result of this study will be useful to provide an evaluation and appraisal about the assessment of antenatal care services for managers and decision makers, and verifying the perspective of the health care providers and the women.

### 3.2 Study population

The study population consists of all registered midwives, nurses and physicians at the time of the study, who provide the services and were working at the clinics which provide antenatal services in either MoH or UNRWA clinics. The second part of the population are the pregnant women who receive these services during the pregnancy period, met the study criteria and attended the antenatal care at the clinics of the primary health care centers in Gaza Strip during the implementation of the study.

### **3.3 Period of the study**

The study was conducted in August 2003, after the researcher had approval from the director general of the Ministry of Health and the manager of health programs in UNRWA. Pilot study was conducted in February 17<sup>th</sup> 2004 and continued to February 22<sup>th</sup> 2004. Data collection started at March 2<sup>th</sup> 2004 to May 20<sup>th</sup> 2004.

### **3.4 Study setting**

The study was carried out at the primary health care centers in two sectors; the first sector is UNRWA, which provide these services in 17 clinics and the other sector is MoH which provides these services in 32 clinics. The study was conducted at the antenatal care clinic services providers.

MoH and UNRWA clinics were purposively selected in this study because these two sectors are the largest and the major health providers covering for these services. It is worth noting that the various dimensions of antenatal care services that the study intends to examine were available in both places. However the different organizational culture and managerial system provided chance to compare and contrast between factors that might contribute to the antenatal care quality.

### **3.5 Sample size**

The UNRWA clinics that provide antenatal care services are 17 clinics and there are 32 clinics for MoH (MoH, 2003). These clinics are distributed as the following in the governorates of Gaza.

The clinics of UNRWA are distributing as the following; in Gaza north there are three clinics, in Gaza city there are four clinics, while in the middle zone there are five clinics, there are two clinics in KhanYounis and three clinics in Rafah. In the



other side, the Ministry of health clinics are distributed as the following {four, thirteen, three, ten and two} in Gaza North, Gaza City, Mid-Zone, KhanYounis and Rafah respectively. Table 1 shows the distribution of PHC clinics and the number of pregnant women that attended antenatal care in each governorate in Gaza Strip.

**Table 1: Distribution of PHC clinics and the number of pregnant women that attended antenatal care in governorates of Gaza Strip.**

Governorates	N. of clinics		N. of pregnant women	
	M O H	UN	M O H	UN
Gaza North	4	3	1603	5135
Gaza City	13	4	7028	8296
Mid-Zone	3	5	548	5584
KhanYounis	10	2	2889	4615
Rafah	2	3	1070	4204

The researcher used the statistical calculator of the Epi-Info to determine a scientifically based sample; Given that the numbers of pregnant women were 40972 women and at 95% confidence level, 80% power and worst acceptable 75%. The Epi-Info showed that the sample is about 244 subjects. The researcher increased the sample size to be 255 subjects.

The distributions of the sample as shown in the following table, at the Gaza North governorate the represented sample were 15 and 48 subjects for MoH and UNRWA clinics respectively, in Gaza governorate the represented sample were 48 and 77 subjects for MoH and UNRWA clinics respectively, in KhanYounis governorate the represented sample were 22 and 45 subjects for MoH and UNRWA

clinics respectively. Table 2 shows the distributions of the subjects of samples in the chosen governorates.

**Table 2: Distributions of the subjects of sample in the chosen governorates.**

<b>Governorates</b>	<b>Number of subjects per clinics</b>	
	<b>MoH</b>	<b>UN</b>
<b>Gaza North</b>	<b>15</b>	<b>48</b>
<b>Gaza City</b>	<b>48</b>	<b>77</b>
<b>KhanYounis</b>	<b>22</b>	<b>45</b>

### **3.6 Sampling method**

To ensure that the sample is represented to all the target population, the researcher used a simple stratified sampling technique for the governorates. A proportion sample is used to choose the largest three clinics of MoH and UNRWA clinics in three governorates of the five governorates of Gaza Strip, these governorates are Gaza north, Gaza city and KhanYounis, they provides services for about 88% and 65% for pregnant women in MoH and UNRWA clinics respectively. All the health care providers were the sample, their number was 52. Women were selected randomly in each clinic, after they received the care, then women asked to participate in filling the questionnaire.

### **3.7 Response rate**

The number of the respondents was 241 subjects of 255 subjects of represented sample, it distributed as 80 subjects for government clinics, 161 subjects for UNRWA clinics. The number of unrespondents was 14 subjects, 5 subjects among government clinics and 9 subjects among UNRWA clinics. The response rate of the

pregnant women was 94.5%. The response rate in governmental clinics was 94.1% and the response rate in UNRWA clinics was 94.7%. All the health care providers were the sample; the response rate was 100%.

### **3.8 Instrument of the study**

A self-administered questionnaire is used for the care providers, as it has many benefits. It saved time, standardizing administration of the questionnaire for all respondents, less costly, require less energy in administration, self-administered questionnaire provides the subject with opportunity to complete the questionnaire adequately and minimize as much as possible missing information.

An exit interview questionnaire is used for the pregnant women after they finished their visit and receiving the services at the clinic. Through these interviews another questionnaire is administered by the researcher or the assistants. This questionnaire is not filling as the first questionnaire; this questionnaire is used by the researcher or the assistants. The researcher or the assistants meet the women after they received the care, and then asked them the questions about the services and filled the answers to the questionnaire.

This questionnaire is used for its benefits as; saving time, less costly, require less energy in administration, completing the questionnaire adequately and minimizing as much as possible missing information.

### **3.9 Questionnaire design**

A self administered questionnaire and exit interview questionnaire was used in this study. The self-administered questionnaire is used for the care providers, while the exit interview administered questionnaire is used for the women that filled by the

researcher or the assistants. The questions are asked by the researcher or the assistants while they filled the questionnaire through the answers and the responses of the interviewed women, it develops solid base data; the researcher had a little involvement that the assistants were filling the questionnaire after the women receive the care directly. This approach saved time, the recall bias is excluded.

### **3.10 Ethical consideration**

An official letter of approval to conduct the research was obtained from the Helsinki Committee, that the researcher maintained throughout the research an adherence and commitment to the ethical principals developed by Helsinki Declaration (Annex 1). Permission letters from both General Director of Ministry of Health and the UNWRA Chief Field Health Programme in Gaza were obtained to conduct the study at PHC clinics (Annexes 2 & 3).

Explanatory letter for all participants was given when they demonstrated a willingness to participate. Explanations were given to participants before filling the questionnaire that to maintain participant's rights, confidentiality and anonymity was ensured. The subject agrees voluntarily to share and the researcher did not asked for identifying information.

### **3.11 Piloting**

The instrument was piloted before starting data collecting, it was considered as a pre-test using a sample of 15 pregnant women and 7 of health care providers. The pilot was done at middle governorate, the pilot study was conducted in the largest clinic in both MoH and UNRWA clinics, all health care providers in the two clinics participated, the pregnant women were selected randomly in each clinic, after they

received the care, then women asked to participate in filling the questionnaire. The sample was about 6.5% of total sample. All of the participants were received clear explanation about the study, purposes and flexibility to refuse participation.

This piloting study is useful in estimating the construction of the questionnaire, adequacy of responses, validity and suitability of questionnaires as well as areas that need modifications. Result from the piloting pointed that the questionnaire would provide the needed data to meet the purpose of the study. The pilot subjects were excluded from the study sample.

### **3.12 Data collection**

The data was collected by the researcher and 6 assistants. The assistants are professionals, they are nurses. There was training and preparing well on how to approach and interview the women in the same way as the researcher for the assistants. The researcher goes with the assistants for the first time, and then he filled the questionnaire as a practice to the assistants as follows: the pregnant women gave their consent; explanation was given for them, then the filling of the questionnaire through the interview after receiving the antenatal care and to express their perception. The self-administered questionnaires were given to the care providers, after providing explanation and asked them to complete those questionnaires. The researcher and the assistants collected the questionnaires after the completion and the researcher looked over the completed questionnaires to ensure the completion of information.

### **3.13 Data entry**

Data entry was done by using data entry model using the Computer Software Statistical Package for Social Science (SPSS). The coded questionnaire was entered onto the computer by the researcher with the help of the supervisor.

Recoding of the data was done for all uncategorized variables, data cleaning was done by checking out all the entered questionnaires and a random selected of numbers of the questionnaires and reviewing the frequencies tables for all variables.

### **3.14 Data analysis**

Data analysis process was started when the researcher received guidance from the supervisor, cross tabulation were conducted for the study variables. After tested the validity and reliability of the instruments the data analysis started, data analysis for sociodemographic and other personal variables was done firstly then followed by analysis for factors and sub-scale dimensions associated with antenatal care services. Chi-square used to examine the potential relationship between the different variables.

### **3.15 Validity and Reliability**

Content validity was conducted before data collection by the help of experts to ensure relevance, clarity, and completeness of the questionnaires. The researcher sent the designed questionnaires with covering letter and paper of key for experts purposes, and objectives and other relevant information. The researcher sent to 13 experts from different backgrounds including researchers, managers, experts in MCH field, nurses and experts in social science to estimate relevance, clarity, and

completeness of each item in the questionnaires. Minor modifications were considered with the help of the supervisor and some were omitted.

### **3.16 Eligibility criteria**

#### **3.16.1 Inclusion criteria**

The eligible women to be included in the study were all pregnant women registered, attended and received antenatal care services at governmental and UNRWA clinics during the implementation of the study.

#### **3.16.2 Exclusion criteria**

All pregnant women whom came with emergency cases of pregnancy, pregnant woman who is not resident in Gaza Strip and want to receive care, woman who is come to receive the antenatal care services out the time of providing the care.

### **3.17 Limitation of the study**

- Limitation of educational and financial resources.
- Limitation of time.
- Pregnant women with a previous medical problem that may influence their perspective on care.
- The political and socio-economic situation made it difficulties to conduct the study in different location.

# **Chapter 4**

## **Results and Analysis**



## Chapter 4

# Results and Analysis

This chapter presents the result of statistical analysis of the data and the characteristic and distribution of the respondents. In addition, the chapter presents some statistical tests to explore the relationship between the different variables as organizational and personal characteristics, such as age, residency place, marital status, job of participants, years of education, years of experience, monthly income, attended continuous education programs and many other factors with antenatal care services.

### **4.1 Distribution of health care providers by sociodemographic characteristics**

Table 3 shows the distribution of health care providers by sociodemographic variables were as the following, the represented sample of health care providers were 52 subjects distributed as 13 subjects with percent 25% of total sample for government clinics, and 39 subjects with percent 75% of total sample for UNRWA clinics.

The distributions of respondent subjects by age groups were represented in three groups. Firstly (34 years and less), their number was 15 subjects and represented 28.8% of total respondent, 4 subjects (30.8%) and 11 subjects (28.8%) represent the government and UNRWA clinics respectively. The second from (35 to 40 years) and their number was 23 subjects represented (44.2%) of total respondent, 7 subjects (53.8%) and 16 subjects (41%) represent the government and UNRWA clinics respectively. The third group from (41 years and more), their number was 14 subjects represented (27%) of total respondent, 2 subjects (15.4%) and 12 subjects (30.8%) represent the government and UNRWA clinics respectively.

The majority of the study population were married and represented (90.4%), it were (76.9%) and (94.8%) in the government and UNRWA clinics respectively. Single category represented (5.8%) of respondents; it represented (15.4%) and (2.6%) in the government and UNRWA clinics respectively. The third category either divorced or widows represented 3.8% of respondents, it represented (7.7%) and (2.6%) in the government and UNRWA clinics respectively.

The distributions of subjects by job were as; the majority of the sample was midwife, they were more in UNRWA than those in government, they represented (46.2%) of the total respondents, their represents (23.1%) of government subjects and (53.8%) of UNRWA subjects. Nurse and midwife was the second category that their number was 12 subjects represented (23.1%) of the total respondents; also, it represented (23.1%) of both government and UNRWA subjects. Registered nurse and physician represented (15.4%) and their numbers were 8 subjects for both. In government clinics, they represented (30.8%) for registered nurse and (23.1%) for physician, while in UNRWA clinics they (10.3%) for registered nurse and (23.1%) for physician. Registered nurses were more in governmental clinics.

Places of residency are the same in all governorates of Gaza provenance; that it contains the cities, villages and camps. Distributions of the majority of subjects were live in city; their number was 26 subjects represented (51%) of total respondents, (46.2%) and (52.6%) represented the distributions of the subjects in both government and UNRWA clinics respectively. 20 Subjects were live in camp represented (39.2%) of total respondents, the distribution of subjects for government and UNRWA clinics were (38.5%) and (39.5%) respectively. Live in village was represented (9.8%) of total respondents, (15.4%) and (7.9%) represented the distribution for both government and UNRWA clinics respectively.

**Table 3: Distribution of health care providers by sociodemographic characteristics**

Characteristics	Government		UNRWA		Total	
	No.	%	No.	%	No.	%
<b>Total</b>	<b>13</b>	<b>100</b>	<b>39</b>	<b>100</b>	<b>52</b>	<b>100</b>
<b>Age</b>						
34 years and less	4	30.8	11	28.2	15	28.8
35-40 years	7	53.8	16	41	23	44.2
41 years +	2	15.4	12	30.8	14	27
<b>Marital status</b>						
Single	2	15.4	1	2.6	3	5.8
Married	10	76.9	37	94.8	47	90.4
Other	1	7.7	1	2.6	2	3.8
<b>Job</b>						
Registered Nurse	4	30.8	4	10.3	8	15.4
Midwife	3	23.1	21	53.8	24	46.2
Physician	3	23.1	5	12.8	8	15.4
Nurse and Midwife	3	23.1	9	23.1	12	23
<b>Residency</b>						
City	6	46.2	20	52.6	26	51
Village	2	15.4	3	7.9	5	9.8
Camp	5	38.5	15	39.5	20	39.2

Table 4 shows the characteristics and distributions of the health care providers by characteristics that reflect the education level, experience years in the current work and qualification.

As shown by table 4 the majority of the subjects had (2years) education, their number 26 subjects represented 50% of the total respondents, the distribution in clinics shows that 46.2% and 51.3% represented the government and UNRWA clinics respectively. There were 16 subjects with (3 to 5 years) education represented 30.8% of total respondents, the distribution in clinics shows that 38.5% and 28.2% represented the government and UNRWA clinics respectively. (6 years and more) category; their number 10 subjects represented 19.2% of total respondents, the distribution in clinics shows that 15.4% and 20.5% represented the government and UNRWA clinics respectively.

The distribution of health care providers by experience years in the current work were represented in three categories, the first category (7 years and less); their number 20 subjects represented 38.5% of total respondents, in government and UNRWA clinics, the distribution represented 69.2% and 28.2% in both respectively. The second category (8 to 14 years); their number 18 subjects represented 34.6% of total respondents, in government and UNRWA clinics, the distribution represented 23.1% and 38.5% in both respectively, the third category (15 years and more); their number 14 subjects represented 26.9% of total respondents, in government and UNRWA clinics, the distribution represented 7.7% and 33.3% in both respectively. The distribution of health care providers by qualification were represented in four categories, the first category practical diploma; their number 12 subjects represented 23.1% of total respondents, the distribution represented 30.8% and 20.5% in both government and UNRWA clinics respectively. The second category registered

diploma degree, their number 22 subjects represented 42.3% of total respondents, in government and UNRWA clinics, the distribution represented 23.1% and 48.7% in both respectively, the third category bachelor; their number 14 subjects represented 26.9% of total respondents, in government and UNRWA clinics, the distribution represented 38.5% and 23.1% in both respectively. The fourth category others (post graduated degree); their number 4 subjects represented 7.7% of total respondents, the distribution represented 7.7% in both government and UNRWA clinics.

**Table 4: Distribution of health care providers by education and work experience.**

Characteristics	Government		UNRWA		Total	
	No.	%	No.	%	No.	%
<b>Total</b>	<b>13</b>	<b>100</b>	<b>39</b>	<b>100</b>	<b>52</b>	<b>100</b>
<b>Education Level</b>						
2 years	6	46.2	20	51.3	26	50
3-5 years	5	38.5	11	28.2	16	30.8
6years +	2	15.4	8	20.5	10	19.2
<b>Experience Years in the current work</b>						
7 years and Less	9	69.2	11	28.2	20	38.5
8-14 years	3	23.1	15	38.5	18	34.6
15 years +	1	7.7	13	33.3	14	26.9
<b>Qualification</b>						
Practical diploma	4	30.8	8	20.5	12	23.1
Registered diploma degree	3	23.1	19	48.7	22	42.3
Bachelor degree	5	38.5	9	23.1	14	26.9
Others (post graduated degree)	1	7.7	3	7.7	4	7.7

Table 5 shows the characteristics and distributions of the health care providers by characteristics that reflect the antenatal training and the duration of training, post graduated degree and work years post graduated.

As shown by table 5 the majority of the subjects had post graduated degree (specialist), represented 69.2% of the total respondents, the distribution in clinics shows that post graduation specialist training was higher in UNRWA than in government with percent 46.2% and 76.9% represented the government and UNRWA clinics respectively. There were 16 subjects had no post graduated degree represented 30.8% of total respondents, the distribution in the clinics shows that 53.8% and 23.1% represented the government and UNRWA clinics respectively. The distribution of health care providers by number of work years after specialization were represented by four categories; the first category, the group with no specialist, represented 37.5% of total respondents, the distribution in the clinics shows that health care providers with no specialist were higher in government with percent 69.2% and 25.7% represented the government and UNRWA clinics respectively. The second category, the group with (1 to 7 work years) after specialization, their number 11 subjects represented 22.9% of total respondents, the distribution in the clinics shows that 23.1% and 22.9% represented the government and UNRWA clinics respectively. The third category, the group with (8 to 12 work years) after specialization, represented 20.8% of total respondents, the distribution in the clinics shows that 7.7% and 25.7% represented the government and UNRWA clinics respectively. The fourth category, the group (13 and more work years) after specialization, represented 18.8% of total respondents, the distribution in the clinics shows that there was no group 13 and more work years post specialist in the

government clinics, and 25.7% represented UNRWA clinics. The last two categories were higher in UNRWA.

The distribution of health care providers by antenatal care training were represented by 2 categories; the first group with antenatal care training, their number were 36 subjects represented 69.2% of total respondents, the distribution in the government and UNRWA clinics were represented by 76.9% and 66.7% respectively. The second group with antenatal care training, their number was 16 subjects represented 30.8% of total respondents, the distribution in the government and UNRWA clinics were represented by 23.1% and 33.3% respectively.

The distribution of health care providers by duration of training were represented by four categories; the first group, no antenatal care training, their number were 16 subjects represented 32% of total respondents, the distribution in the government and UNRWA clinics were represented by 25% and 34% respectively.

The second group, (less than 1 month) training, their number were 15 subjects represented 30% of total respondents, the distribution in the government and UNRWA clinics were represented by 41.7% and 26.3% respectively. The third group, (1-3 months) training, their number were 10 subjects represented 20% of total respondents, the distribution in the government and UNRWA clinics were represented by 25% and (18.4%) respectively. The fourth group, (more than 3 months), their number were 9 subjects represented 18% of total respondents, the distribution in the government and UNRWA clinics were represented by 8.3% and 21.1% respectively.

The distribution of health care providers by date of last training were represented by four categories; the first group, no antenatal care training, their number were 16

subjects represented 34% of total respondents, the distribution in the government and UNRWA clinics were represented by 30% and 35.2% respectively.

The second group, training through the years (1986 to 2002), their number was 9 subjects represented 19.1% of total respondents, the distribution in the government and UNRWA clinics were represented by 30% and 16.2% respectively. The third group, training during the year (2003), their number was 13 subjects represented 27.8% of total respondents, the distribution in the government and UNRWA clinics were represented by 40% and 24.3% respectively. The fourth group, training during the year (2004) till the collection of data, their number was 9 subjects represented 19.1% of total respondents, the distribution in the government and UNRWA clinics were represented by no distribution in this group for government clinics and 24.3% for UNRWA clinics.



**Table 5: Distribution of the health care providers by specialist, work years after specialization, antenatal training, duration of training, date of last training.**

<b>Characteristics</b>	<b>Government</b>		<b>UNRWA</b>		<b>Total</b>	
	<b>No.</b>	<b>%</b>	<b>No.</b>	<b>%</b>	<b>No.</b>	<b>%</b>
<b>Total</b>	<b>13</b>	<b>100</b>	<b>39</b>	<b>100</b>	<b>52</b>	<b>100</b>
<b>Specialist</b>						
Yes	6	46.2	30	76.9	36	69.2
No	7	53.8	9	23.1	16	30.8
<b>Work years after specialization</b>						
No specialist	9	69.2	9	25.7	18	37.5
1- 7 years	3	23.1	8	22.9	11	22.9
8-12 years	1	7.7	9	25.7	10	20.8
13 years +	-	-	9	25.7	9	18.8
<b>Antenatal care training</b>						
Yes	10	76.9	26	66.7	36	69.2
No	3	23.1	13	33.3	16	30.8
<b>Training duration</b>						
No training	3	25	13	34.2	16	32
Less 1 month	5	41.7	10	26.3	15	30
1-3 months	3	25	7	18.4	10	20
More 3 months	1	8.3	8	21.1	9	18
<b>Date of last training</b>						
No training	3	30	13	35.2	16	34
Years 1986-2002	3	30	6	16.2	9	19.1
Year 2003	4	40	9	24.3	13	27.8
Year 2004	-	-	9	24.3	9	19.1

#### **4.2 Distribution of the pregnant women by sociodemographic characteristics.**

Table 6 shows the distribution of pregnant women by sociodemographic variables were as the following, the represented sample of health care providers were 241 subjects distributed as 80 subjects with percent 33.2% of total sample for government clinics, and 161 subjects with percent 66.8% of total sample for UNRWA clinics.

The distributions of pregnant women by age groups were represented in three groups. Firstly (22 years and less), their number was 73 subjects and represented 30.3% of total respondent, the distribution in the government and UNRWA clinics were represented by 26 subjects 32.5% and 47 subjects 29.2% represent the government and UNRWA clinics respectively. The second group from (23 to 30 years) and their number was 104 subjects represented 43.2% of total pregnant women, the distribution in the government and UNRWA clinics were represented by 32 subjects 40% and 72 subjects 44.7% represent the government and UNRWA clinics respectively. The third group from 31 years and more, their number was 64 subjects represented 26.6% of total respondent, the distribution in the government and UNRWA clinics were represented by 22 subjects 27.5% and 42 subjects 26.1% represent the government and UNRWA clinics respectively.

The majority of the pregnant women was housewife and represented 91.7%, the distribution in the government and UNRWA clinics were represented by 95% and 90.1% in the government and UNRWA clinics respectively. Employee category represented 5.4% of total respondents, the distributions in the government and UNRWA clinics were represented by 2.5% and 6.8% in the government and UNRWA clinics respectively. The third category either student or any job else represented by 2.9% of total respondents, the distribution in the government and

UNRWA clinics were represented by (2.5%) and (3.1%) in the government and UNRWA clinics respectively.

As shown in table 6 the distribution of the pregnant women by education level, were represented by three categories; the first group (0 to 6 years) education their number (22) subjects represented (9.1%) of the total respondents, the distribution in government and UNRWA clinics shows that (10%) and (8.7%) represented the government and UNRWA clinics respectively. The second group (7 to 12 years) were represented (66.8%) of total respondents, the distribution in government and UNRWA clinics shows that (78.8%) and (60.9%) represented the government and UNRWA clinics respectively. (13 years and more) category; were represented by (24.1%) of total respondents, the distribution in government and UNRWA clinics shows that (11.3%) and (30.4%) represented the government and UNRWA clinics respectively.

Places of residency are the same in all governorates of Gaza Strip; that it contains the cities, villages and camps. Distributions of the majority of subjects were live in city; their number was (134) subjects represented (55.6%) of total respondents, the distributions in the government and UNRWA clinics were represented by (82.5%) and (42.2%) represented the distributions of the subjects in both government and UNRWA clinics respectively. The second group, live in camp were represented by (25.3%) of total respondents, the distributions in the government and UNRWA clinics were represented by (3.8%) and (36%) represented the distribution for both government and UNRWA clinics respectively. Live in village was represented by (19.1%) of total respondents, the distributions in the government and UNRWA clinics were represented by (13.8%) and (21.7%) represented the distribution for both government and UNRWA clinics respectively.

The distribution of the respondent subjects by monthly income, were represented by four categories; the first category (less than 200 US\$) were represented by (25.2%) of the total respondents, the distribution in government and UNRWA clinics shows that (27.3%) and (24.2%) represented the government and UNRWA clinics respectively. The second category (200 – 300 US\$) were represented (35.5%) of total respondents, the distribution in government and UNRWA clinics shows that (44.2%) and (31.2%) represented the government and UNRWA clinics respectively. The third category (301US\$ to 400 US\$); were represented by (20.9%) of total respondents, the distribution in government and UNRWA clinics shows that (14.3%) and (24.2%) represented the government and UNRWA clinics respectively. The fourth category (more than 400 US\$) were represented by (18.4%) of the total respondents, the distribution in government and UNRWA clinics shows that (14.3%) and (20.4%) represented the government and UNRWA clinics respectively.

**Table 6: Distribution of the pregnant women by sociodemographic and education.**

Characteristics	Government		UNRWA		Total	
	No.	%	No.	%	No.	%
<b>Total</b>	<b>80</b>	<b>100</b>	<b>161</b>	<b>100</b>	<b>241</b>	<b>100</b>
<b>Age</b>						
22 years and less	26	32.5	47	29.2	73	30.3
23-30 years	32	40	72	44.7	104	43.2
31 years +	22	27.5	42	26.1	64	26.6
<b>Job</b>						
House wife	76	95	145	90.1	221	91.7
Employee	2	2.5	11	6.8	13	5.4
Others	2	2.5	5	3.1	7	2.9
<b>Education level</b>						
0 – 6 years	8	10	14	8.7	22	9.1
7 – 12 years	63	78.8	98	60.9	161	66.8
13 years +	9	11.3	49	30.4	58	24.1
<b>Residency</b>						
City	66	82.5	68	42.2	134	55.6
Village	11	13.8	35	21.7	46	19.1
Camp	3	3.8	58	36	61	25.3
<b>Monthly income</b>						
Less than 200 US\$	21	27.3	38	24.2	59	25.2
200-300 US\$	34	44.2	49	31.2	83	35.5
301-400 US\$	11	14.3	38	24.2	49	20.9
More than 400 US\$	11	14.3	32	20.4	43	18.4

Table 7 shows that; the distribution of the respondent subjects (pregnant women) by husband's job, were represented by four categories; the first category, not employee were represented by (9.5%) of the total respondents, the distribution in government and UNRWA clinics were represented by (8.8%) and (9.9%) represented the government and UNRWA clinics respectively. The second category worker, were represented (32.4%) of total respondents, the distribution in government and UNRWA clinics shows that (41.3%) and (28%) represented the government and UNRWA clinics respectively. The third category employee, were represented by (41.4%) of total respondents, the distribution in government and UNRWA clinics shows that (31.3%) and (46%) represented the government and UNRWA clinics respectively. The fourth category others (Private business), were represented by (17%) of the total respondents, the distribution in government and UNRWA clinics shows that (15%) and (16.1%) represented the government and UNRWA clinics respectively.

The distribution of the respondent subjects (pregnant women) by husband's education years, were represented by three categories; the first group (0 to 6 years) education their number (38) subjects represented (15.8%) of the total respondents, the distribution in government and UNRWA clinics were represented by (21.3%) and (13%) represented the government and UNRWA clinics respectively. The second group (7 to 12 years) were represented (44.4%) of total respondents, the distribution in government and UNRWA clinics were represented by (48.5%) and (42.9%) represented the government and UNRWA clinics respectively. (13 years and more) category; were represented by (39.8%) of total respondents, the distribution in government and UNRWA clinics were represented by (31.3%) and (44.1%) represented the government and UNRWA clinics respectively.

**Table 7: Distribution of the study population by education and job of women's husband.**

Characteristics	Government		UNRWA		Total	
	No.	%	No.	%	No.	%
<b>Total</b>	<b>80</b>	<b>100</b>	<b>161</b>	<b>100</b>	<b>241</b>	<b>100</b>
<b>Husband's job</b>						
Employee	25	31.3	74	46	99	41.1
Worker	33	41.3	45	28	78	32.4
Not Employee	7	8.8	16	9.9	23	9.5
Others (Private business)	15	18.8	26	16.1	41	17
<b>Husband's education years</b>						
0 – 6 years	17	21.3	21	13	38	15.8
7 – 12 years	38	47.5	69	42.9	107	44.4
13 years +	25	31.3	71	44.1	96	39.8

#### **4.2.1 Maternity Health**

Table 8 shows that; the distribution of the respondent subjects by maternity health, number of labors were represented by three categories; the first group (1 labor and less) were represented by (39.4%) of the total respondents, the distribution in government and UNRWA clinics were represented by (41.3%) and (38.5%) represented the government and UNRWA clinics respectively. The second group (2 -4 labor) were represented by (35.3%) of total respondents, the distribution in government and UNRWA clinics were represented by (32.5%) and (36.6%) represented the government and UNRWA clinics respectively. (5 labor and more) category; were represented by (25.3%) of total respondents, the distribution in

government and UNRWA clinics were represented by (26.3%) and (24.8%) represented the government and UNRWA clinics respectively.

The distribution of the respondent subjects by number of pregnancies, were represented by three categories; the first group (2 pregnancies and less) were represented by (37.3%) of the total respondents, the distribution in government and UNRWA clinics were represented by (37.5%) and (37.3%) represented the government and UNRWA clinics respectively. The second group (3 -6 pregnancies) were represented by (39%) of total respondents, the distribution in government and UNRWA clinics were represented by (36.3%) and (40.4%) represented the government and UNRWA clinics respectively. (7 pregnancies and more) category; were represented by (23.7%) of total respondents, the distribution in government and UNRWA clinics were represented by (26.3%) and (22.4%) represented the government and UNRWA clinics respectively.

The distribution of the respondent subjects by duration of pregnancy, were represented by three categories; the first group (1 to 4 months) were represented by (27.4%) of the total respondents, the distribution in government and UNRWA clinics were represented by (35%) and (23.6%) represented the government and UNRWA clinics respectively. The second group (5 -6 months) were represented by (32%) of total respondents, the distribution in government and UNRWA clinics were represented by (27.5%) and (34.2%) represented the government and UNRWA clinics respectively. (7 to 9 months) category; were represented by (40.7%) of total respondents, the distribution in government and UNRWA clinics were represented by (37.5%) and (42.2%) represented the government and UNRWA clinics respectively.



The distribution of the respondent subjects by number of antenatal visits, were represented by three categories; the first group (2 visits and less) were represented by (40.7%) of the total respondents, the distribution in government and UNRWA clinics were represented by (42.5%) and (39.8%) represented the government and UNRWA clinics respectively. The second group (3-5 visits) were represented by (38.6%) of total respondents, the distribution in government and UNRWA clinics were represented by (36.3%) and (39.8%) represented the government and UNRWA clinics respectively. The category (6 visits and more); were represented by (20.7%) of total respondents, the distribution in government and UNRWA clinics were represented by (21.3%) and (20.5%) represented the government and UNRWA clinics respectively.

**Table 8: Distribution of the study population (participating women) by maternity health**

Characteristics	Government		UNRWA		Total	
	No.	%	No.	%	No.	%
<b>Total</b>	<b>80</b>	<b>100</b>	<b>161</b>	<b>100</b>	<b>241</b>	<b>100</b>
<b>Number of labor</b>						
1 labor and less	33	41.3	62	38.5	95	39.4
2 -4 labor	26	32.5	59	36.6	85	35.3
5 labor +	21	26.3	40	24.8	61	25.3
<b>Number of pregnancies</b>						
2 pregnancies and less	30	37.5	60	37.3	90	37.3
3 – 6 pregnancies	29	36.3	65	40.4	94	39
7 pregnancies +	21	26.3	36	22.4	57	23.7
<b>Duration of pregnancy</b>						
1 – 4 months	28	35	38	23.6	66	27.4
5 – 6 months	22	27.5	55	34.2	77	32
7 – 9 months	30	37.5	68	42.2	98	40.7
<b>Number of antenatal visits</b>						
2 visits and less	34	42.5	64	39.8	98	40.7
3 – 5 visits	29	36.3	64	39.8	93	38.6
6 visits +	17	21.3	33	20.5	50	20.7

#### **4.2.2 Antenatal care visits schedule**

Table 9 shows the perspective of health care providers to antenatal visits schedule included three items (number of antenatal visits, opinion on number of antenatal visits, duration between antenatal visits). The first, number of antenatal visits; the health care providers in governmental primary health centers were showing the number of antenatal visits (9 visits and less) more than those in the UNWRA primary health centers with percent 72.7% and 34.2% respectively, and (10 to 11 visits) 50% in UNWRA primary health centers, and (12 visits and more) 27.3% and 15.8% respectively. The difference between the two groups reach a statistical significant level ( $P=0.01$ ).

The second opinion on number of antenatal visits; the health care providers in UNWRA primary health centers experienced many number of antenatal visits than those in the governmental primary health centers with percent 23.1% and 8.3% respectively. The difference between the two groups did not reach a statistical significant level ( $P=0.26$ ).

About the duration between antenatal visits the health care providers in both UNRWA and government primary health centers experienced good duration between antenatal visits with percent 92.3% and 91.7% respectively.

The perspective of pregnant women on antenatal care visits schedule is seeing in table 10; included three items (satisfaction with number of antenatal visits, opinion on number of antenatal visits, duration between antenatal visits).

Satisfaction with number of antenatal visits; the women who received antenatal services in the UNRWA and the governmental clinics experienced good number of antenatal visits with percent 87.6% and 87.5% respectively. The second, opinion on number of antenatal visits; the women who received antenatal services in the

UNRWA and the governmental clinics experienced good number of antenatal visits with percent 91.3% and 91.3% respectively.

The third, duration between antenatal visits; the women who received antenatal services in the UNRWA and the governmental clinics experienced good number of antenatal visits with percent 85% and 78.8% respectively. 10% of women attending health services in both UNRWA and government experienced so long duration between antenatal visits.

**Table 9: Antenatal care visits schedule with respect to perspective of care providers.**

Characteristics	Government		UNRWA		Total	
	No.	%	No.	%	No.	%
<b>Total</b>	<b>13</b>	<b>100</b>	<b>39</b>	<b>100</b>	<b>52</b>	<b>100</b>
<b>Number of antenatal visits</b>						
9 visits and less	8	72.7	13	34.2	21	42.8
10 to 11 visits	-	-	19	50	19	38.8
12 visits and +	3	27.3	6	15.8	9	18.4
<b>Opinion on number of antenatal visits</b>						
Many	1	8.3	9	23.1	10	19.6
Good	11	91.7	30	76.9	4	80.4
<b>Spacing between antenatal visits</b>						
Long duration	1	8.3	3	7.7	4	7.8
Good duration	11	91.7	36	92.3	47	92.2

**Table 10: Antenatal care visits schedule with respect to perspective of pregnant women.**

Characteristics	Government		UNRWA		Total	
	No.	%	No.	%	No.	%
<b>Total</b>	<b>80</b>	<b>100</b>	<b>161</b>	<b>100</b>	<b>241</b>	<b>100</b>
<b>Satisfaction with number of antenatal care visits</b>						
Increase number of visits	4	5	7	4.3	11	4.6
Good number of visits	70	87.5	141	87.6	211	87.6
Decrease number of visits	-	-	3	1.9	3	1.2
Do not knew	6	7.5	10	6.2	16	6.6
<b>Opinion on number of antenatal care visits</b>						
Many	1	1.3	3	1.9	4	1.7
Good	73	91.3	146	91.3	219	91.3
little	2	2.5	3	1.9	5	2.1
Do not knew	4	5	8	5	12	5
<b>Spacing between antenatal care visits</b>						
So long duration	8	10	16	10	24	10
Good duration	63	78.8	136	85	199	82.9
Short duration	4	5	6	3.8	10	4.2
Do not knew	5	6.3	2	1.3	7	2.9

### **4.3 Analysis for factors and sub-scale dimensions associated with antenatal care services**

The researcher conducted six dimensions as a factor analysis, these factors labeled as accessibility to antenatal services, qualification and training of care provider, competence of care providers, consultation, interpersonal relation needs and availability of medication and equipment. These factors emerged from the results of the questionnaire of the care providers.

#### **4.3.1 Accessibility to antenatal services**

Table 11 shows the accessibility to antenatal services dimension with respect to perspective of health care providers included four items (previous appointment system, women received care at any time, perfect time to provide care and waiting time). Previous appointment system; the health care providers in UNWRA primary health centers agree the presence of previous appointment system than those in the governmental primary health centers with percent 94.9% and 53.8% respectively and those who disagree 5.1% and 46.2% respectively. The difference between the two groups reach a statistical significant level ( $P=0.00$ ).

Women received care at any time; the health care providers in UNWRA primary health centers agree that women received care at any time of work than those in the governmental primary health centers with percent 94.9% and 84.6% respectively and those who disagree 5.1% and 15.4% respectively. The difference between the two groups did not reach a statistical significant level ( $P=0.29$ ).

Perfect time to provide care; the health care providers in UNWRA primary health centers agree the presence of perfect time to provide care than those in the governmental primary health centers with percent 71.1% and 46.2% respectively

and those who disagree 28.9% and 53.8% respectively. The difference between the two groups did not reach a statistical significant level (P=0.10).

Waiting time to receive services; the health care providers in governmental

<b>Characteristics</b>	<b>Government</b>	<b>UNRWA</b>	<b>Total</b>	<b>P-value</b>
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primary health centers said that the women spending waiting time less than those in the UNWRA primary health centers with percent 66.7% and 20.5% for waiting time less than one hour respectively, waiting time 1 to 1.5 hours with percent 25% and 56.4% respectively and waiting time more than 1.5 hours with percent 8.3% and 23.1% respectively. The difference between the two groups reach a statistical significant level (P=0.01).

Number of care provider is enough to provide care; the health care providers in the governmental primary health centers said that number of care provider is enough to provide care than those in the UNWRA primary health centers with percent 38.5% and 35.9% respectively, and those who said no 61.5% and 64.1% respectively, any how this difference did not reach a statistical significant level (P=0.86).

	No.	%	No.	%	No.	%
<b>Total</b>	<b>13</b>	<b>100</b>	<b>39</b>	<b>100</b>	<b>52</b>	<b>100</b>
<b>Previous appointment system</b>						
						<b>0.00</b>
Yes	7	53.8	37	94.9	44	84.6
No	6	46.2	2	5.1	8	15.6
<b>Women received care at any time of work</b>						
						<b>0.23</b>
Yes	11	84.6	37	94.9	48	92.3
No	2	15.4	2	5.1	4	7.7
<b>Perfect time to provide care</b>						
						<b>0.10</b>
Yes	6	46.2	27	71.1	33	64.7
No	7	53.8	11	28.9	18	35.3
<b>Waiting time</b>						
						<b>0.01</b>
Less than 1 hour	8	66.7	8	20.5	16	31.4
1 hour to 1.5 hours	3	25	22	56.4	25	49
More than 1.5 hours	1	8.3	9	23.1	10	19.6
<b>Number of health care providers is enough to provide care</b>						
						<b>0.87</b>
Yes	5	38.5	14	35.9	19	36.5
No	8	61.5	25	64.1	33	63.5

**Table 11: Accessibility to antenatal services with respect to perspective of care providers.**

The perspective of women on accessibility to antenatal services is seeing in table 12; which shows five items (previous appointment system, women received care at



any time, perfect time to provide care, waiting time and number of care provider is enough to provide care).

Previous appointment system; the pregnant women who received antenatal services in the UNRWA clinics agree on presence of previous appointment system than those received antenatal services in the governmental clinics with percent 92.5% and 73.1% respectively, this difference reach a statistical significant level ( $P=0.00$ ). Pregnant women received care at any time of work; the women who received antenatal services in the governmental clinics agree that women received care at any time of work than those received antenatal services in the UNRWA clinics with percent 73.4% and 67.5% respectively, the difference did not reach a statistical significant level ( $P=0.35$ ).

Perfect time to provide care; the pregnant women who received antenatal services in the governmental primary health centers experienced that there is perfect time to provide care than those who received antenatal services in UNRWA primary health centers with percent 80.8% and 78% respectively, the difference did not reach a statistical significant level ( $P=0.62$ ).

Waiting time to receive services; the pregnant women attending UNRWA antenatal services experienced "less than one hour waiting time" less than those attending governmental health services with percent 30.6% and 20% respectively, while the women attending governmental antenatal services experienced longer waiting time 1 to 1.5 hours than those attending UNRWA health services with percent 43.8% and 35.6% respectively and the women attending governmental antenatal services experienced longer waiting time more than 1.5 hours than those attending UNRWA health services with percent 36.3% and 33.8% respectively, any how this difference did not reach a statistical significant level ( $P=0.19$ ).

Number of care provider is enough to provide care; the pregnant women who received antenatal services in the governmental primary health centers experienced that number of care provider is enough to provide care than those received antenatal

<b>Characteristics</b>	<b>Government</b>	<b>UNRWA</b>	<b>Total</b>	<b>P-value</b>
services in the UNWRA primary health centers with percent	62.5%	41.3%		
respectively, the difference reach a statistical significant level (P=0.00).				

#### **4.3.1.1 Opinion and Satisfaction on waiting time**

Table 13 shows that women attending UNRWA antenatal services reported long duration waiting time more than those attending governmental health services with percent 57.1% and 32.5% respectively with total 49%, while the women attending governmental antenatal services experienced good duration waiting time more than those attending UNRWA health services with percent 58.8% and 37.3% respectively with total 44%, and the women attending governmental antenatal services experienced short duration waiting time less than those attending UNRWA health services with percent 3.8% and 5.6% respectively with total 5%, any how this difference reach a statistical significant level (P=0.00).

The women attending UNRWA antenatal services were less satisfied with waiting time than those attending governmental health services with percent 48.4% and 62.5% respectively with total 53.1%, while the women attending governmental antenatal services were unsatisfied with waiting time more than those attending UNRWA health services with percent 37.5% and 51.6% respectively with total 46.9%, any how this difference reach a statistical significant level (P=0.04).

**Table 12: Accessibility of antenatal services with respect to perspective of**

	No.	%	No.	%	No.	%	
<b>Total</b>	<b>80</b>	<b>100</b>	<b>161</b>	<b>100</b>	<b>241</b>	<b>100</b>	
<b>Previous appointment system</b>							<b>0.00</b>
<b>Yes</b>	<b>57</b>	<b>73.1</b>	<b>149</b>	<b>92.5</b>	<b>206</b>	<b>86.2</b>	<b>P-value</b>
<b>No</b>	<b>21</b>	<b>26.9</b>	<b>12</b>	<b>7.5</b>	<b>33</b>	<b>13.8</b>	
<b>Women received care at any time of work</b>							<b>0.35</b>
<b>Yes</b>	<b>58</b>	<b>73.4</b>	<b>106</b>	<b>67.5</b>	<b>164</b>	<b>69.5</b>	
<b>No</b>	<b>21</b>	<b>26.6</b>	<b>51</b>	<b>32.5</b>	<b>72</b>	<b>30.5</b>	
<b>Perfect time to provide care</b>							<b>0.62</b>
<b>Yes</b>	<b>63</b>	<b>80.8</b>	<b>124</b>	<b>78</b>	<b>187</b>	<b>78.9</b>	
<b>No</b>	<b>15</b>	<b>19.2</b>	<b>35</b>	<b>22</b>	<b>50</b>	<b>21.1</b>	
<b>Waiting time</b>							<b>0.20</b>
<b>Less than 1 hour</b>	<b>16</b>	<b>20</b>	<b>49</b>	<b>30.6</b>	<b>65</b>	<b>27.1</b>	
<b>1 hour to 1.5 hours</b>	<b>35</b>	<b>43.8</b>	<b>57</b>	<b>35.6</b>	<b>92</b>	<b>38.3</b>	
<b>More than 1.5 hours</b>	<b>29</b>	<b>36.2</b>	<b>54</b>	<b>33.8</b>	<b>83</b>	<b>34.6</b>	
<b>Number of health care providers is enough to provide care</b>							<b>0.00</b>
<b>Yes</b>	<b>50</b>	<b>62.5</b>	<b>66</b>	<b>41.3</b>	<b>116</b>	<b>48.4</b>	
<b>No</b>	<b>18</b>	<b>22.5</b>	<b>80</b>	<b>50</b>	<b>98</b>	<b>40.8</b>	
<b>Don't know</b>	<b>12</b>	<b>15</b>	<b>14</b>	<b>8.7</b>	<b>26</b>	<b>10.8</b>	

**Pregnant women.**

**Table 13: Opinion and satisfaction on waiting time with respect to perspective of pregnant women.**

	No.	%	No.	%	No.	%
<b>Total</b>	<b>80</b>	<b>100</b>	<b>161</b>	<b>100</b>	<b>241</b>	<b>100</b>
<b>Opinion on duration of waiting time</b>						<b>0.00</b>
Long duration	26	32.5	92	57.1	118	49
Good duration	47	58.8	60	37.3	219	44.4
Short duration	3	3.8	9	5.6	12	5
Do not knew	4	5	0	0	4	1.7
<b>Satisfaction with waiting time</b>						<b>0.04</b>
Yes	50	62.5	78	48.4	128	53.1
No	30	37.5	83	51.6	113	46.9

#### **4.3.2 Qualification and training of health care providers**

The second dimension is the qualification and training of health care providers is seeing in table 14; which shows five items (getting qualification and training, getting training during work, need for qualification and training, getting special qualification to provide better care and providing training for care providers).

Getting qualification and training; the health care providers in UNWRA primary health centers and governmental primary health centers getting the qualification and training with percent 100% and 92.3% respectively.

Getting training during work; the health care providers in UNWRA primary health centers was getting training during work more than those in the governmental primary health centers with percent 89.7% and 69.2% respectively. The difference between the two groups did not reach a statistical significant level ( $P=0.07$ ).

Need for qualification and training; the health care providers in UNWRA primary health centers show agreement that they need for qualification and training than those in the governmental primary health centers with percent 71.8% and 61.5% respectively. The difference between the two groups did not reach a statistical significant level ( $P=0.48$ ).

Getting special qualification to provide better care; the health care providers in UNWRA primary health centers and governmental primary health centers show agreement that they getting special qualification to provide better care with percent 92.3% and 84.6% respectively. The fifth item- providing training for care providers; the health care providers in UNWRA primary health centers and governmental primary health centers show agreement that they getting the qualification and training with percent 94.9% and 92.3% respectively.

### **4.3.3 Competence of care providers**

The third dimension is the competence of health care providers is seeing in table 15; which shows four items (time spending with care providers, services provided according to guideline, competence of care providers, and team can not provide enough care).

Time spending with care providers; the health care providers in UNWRA primary health centers experienced spending time with client longer than those in

<b>Characteristics</b>	<b>Government</b>	<b>UNRWA</b>	<b>Total</b>	<b>P-value</b>
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the governmental primary health centers with percent 45.9% and 50% respectively for than 10 minutes, and 44.1% and 50% for more than 10 minutes respectively. The difference between the two groups did not reach a statistical significant level (P=0.77).

Services provided according to guideline; the health care providers in UNWRA primary health centers and governmental primary health centers appeared agreement that the services provided according to guideline with percent 97.4% and 84.6% respectively. Competence of care providers; the health care providers in UNWRA primary health centers appeared that the health care providers is competence to provide the care well than those in the governmental primary health centers with percent 100% and 84.6% respectively, The difference between the two groups reach a statistical significant level (P=0.01).

Team can not provide enough care; the health care providers in governmental primary health centers show that team can not provide enough care than those in the UNWRA primary health centers with percent 61.5% and 55.3% respectively, The difference between the two groups reach a statistical significant level (P=0.69).

**Table 14: Qualification and training of health care providers with respect to perspective of care providers.**

	No.	%	No.	%	No.	%	
<b>Total</b>	<b>13</b>	<b>100</b>	<b>39</b>	<b>100</b>	<b>52</b>	<b>100</b>	
<b>Getting qualification and training</b>							<b>0.08</b>
<b>Characteristics</b>	<b>Government</b>	<b>92.3</b>	<b>UNRWA</b>	<b>100</b>	<b>Total</b>	<b>98.1</b>	<b>P-</b>
<b>Yes</b>	<b>12</b>	<b>92.3</b>	<b>39</b>	<b>100</b>	<b>51</b>	<b>98.1</b>	
<b>No</b>	<b>1</b>	<b>7.7</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1.9</b>	
<b>Getting training during work</b>							<b>0.07</b>
<b>Yes</b>	<b>9</b>	<b>69.2</b>	<b>35</b>	<b>89.7</b>	<b>44</b>	<b>84.6</b>	
<b>No</b>	<b>4</b>	<b>30.8</b>	<b>4</b>	<b>10.3</b>	<b>8</b>	<b>15.4</b>	
<b>Need for qualification and training</b>							<b>0.48</b>
<b>Yes</b>	<b>8</b>	<b>61.5</b>	<b>28</b>	<b>71.8</b>	<b>36</b>	<b>69.2</b>	
<b>No</b>	<b>5</b>	<b>38.5</b>	<b>11</b>	<b>28.2</b>	<b>16</b>	<b>30.8</b>	
<b>Better care provide by getting specialist qualification</b>							<b>0.41</b>
<b>Yes</b>	<b>11</b>	<b>84.6</b>	<b>36</b>	<b>92.3</b>	<b>47</b>	<b>90.4</b>	
<b>No</b>	<b>2</b>	<b>15.4</b>	<b>3</b>	<b>7.7</b>	<b>5</b>	<b>9.6</b>	
<b>Providing training for care provider</b>							<b>0.73</b>
<b>Yes</b>	<b>12</b>	<b>92.3</b>	<b>37</b>	<b>94.9</b>	<b>49</b>	<b>94.2</b>	
<b>No</b>	<b>1</b>	<b>7.7</b>	<b>2</b>	<b>5.1</b>	<b>3</b>	<b>5.8</b>	

**Table 15: Competence of health care providers with respect to perspective of care providers.**

	No.	%	No.	%	No.	%	value
<b>Total</b>	<b>13</b>	<b>100</b>	<b>39</b>	<b>100</b>	<b>52</b>	<b>100</b>	
<b>Time spending with care provider</b>							<b>0.77</b>
Less 10 minutes	6	50	17	45.9	23	46.9	
10 to 15 minutes	4	33.3	16	43.2	20	40.8	
More 15 minutes	2	16.7	4	10.9	6	12.3	
<b>Services provided according to presented guideline</b>							<b>0.08</b>
Yes	11	84.6	38	97.4	49	94.2	
No	2	15.4	1	2.6	3	5.8	
<b>Development the competence of care providers</b>							<b>0.01</b>
Yes	11	84.6	38	100	39	96.1	
No	2	15.4	0	0	2	3.9	
<b>Team can't provide enough care</b>							<b>0.69</b>
Yes	8	61.5	21	55.3	29	56.9	
No	5	38.5	17	44.7	22	43.1	

Table 16 shows the perspective of pregnant women on qualification, training and competence of care provider by items (specialist care provider provide better services, trained health care providers provide better services, competency of health care providers and spending time with care providers).



Specialist health care providers provide better services; the women who received antenatal services in the UNRWA clinics experienced that specialist health care providers provide better services than those received antenatal services in the governmental clinics with percent 90.1% and 72.5% respectively, the difference between the two group reach a statistical significant level ( $P=0.00$ ).

Trained health care providers provide better services; the women who received antenatal services in the UNRWA clinics experienced that trained health care providers provide better services than those received antenatal services in the governmental clinics with percent 73.9% and 55% respectively, the difference between the two group reach a statistical significant level ( $P=0.00$ ).

Competency of care providers; the women who received antenatal services in the governmental clinics experienced that health care providers is more competence to provide services than those received antenatal services in the UNRWA clinics with percent 76.2% and 72% respectively, the difference between the two group did not reach a statistical significant level ( $P=0.57$ ).

Spending time with care providers; the women attending governmental antenatal services experienced 5 minutes and less spending time with health care providers more than those attending UNRWA health services with percent 33.7% and 30% respectively, while the women attending governmental antenatal services experienced 6 to 10 minutes spending time with health care providers less than those attending UNRWA health services with percent 35% and 40% respectively and the women attending governmental antenatal services experienced 11 minutes and more spending time with health care providers more longer than those attending UNRWA health services with percent 31.3% and 30% respectively, the difference between the two group did not reach a statistical significant level ( $P=0.73$ ).

### 4.3.3.1 Opinion and Satisfaction on spending time

Table 17 shows that women attending UNRWA antenatal services reported long spending time to receive care more than those attending governmental health

Characteristics	Government	UNRWA	Total	P-value
services with percent	46.4%	30%	40.8%	
pregnant women attending governmental antenatal services reported good spending time to receive care more than those attending UNRWA health services with percent	67.5%	49.4%	55.4%	
and low percent reported short time	2.5%	4.4%		

The difference between the two groups reach a statistical significant level (P=0.02).

A 77.5% of women attending governmental antenatal services reported that they satisfied with spending time to receive care more than attending UNRWA health services with percent 70%, and reported less satisfied than those attendant NURWA health services with percent 22.5% and 30% respectively. The difference between the two groups did not reach a statistical significant level (P=0.22).

Women attending UNRWA antenatal services reported to increase spending time with health care providers more than those attending governmental health services with percent 29.4% and 16.3% respectively, the Women attending governmental antenatal services reported good spending time with health care providers more than those attending UNRWA health services with percent 81.3% and 68.1% respectively, and 2.5% of both reported to decrease time, The difference between the two groups did not reach a statistical significant level (P=0.08).

**Table 16: Qualification, training and competence of health care providers with respect to perspective of pregnant women.**

	No.	%	No.	%	No.	%	
<b>Total</b>	<b>80</b>	<b>100</b>	<b>161</b>	<b>100</b>	<b>241</b>	<b>100</b>	
<b>Opinion on spending time to receive care</b>							<b>0.02</b>
<b>Characteristics</b>	<b>Government</b>	<b>30</b>	<b>UNRWA</b>	<b>46.3</b>	<b>Total</b>	<b>40.8</b>	<b>P-value</b>
<b>Good duration</b>	<b>54</b>	<b>67.5</b>	<b>79</b>	<b>49.4</b>	<b>133</b>	<b>55.4</b>	
<b>Short duration</b>	<b>2</b>	<b>2.5</b>	<b>7</b>	<b>4.4</b>	<b>9</b>	<b>3.8</b>	
<b>Total</b>	<b>80</b>	<b>100</b>	<b>161</b>	<b>100</b>	<b>241</b>	<b>100</b>	
<b>Satisfaction with time of receiving care</b>							
<b>Specialist health care providers provide better services</b>							<b>0.00</b>
<b>No</b>	<b>18</b>	<b>22.5</b>	<b>48</b>	<b>30</b>	<b>66</b>	<b>27.5</b>	
<b>satisfaction about time spending with health care providers</b>							<b>0.08</b>
<b>Increase the time</b>	<b>13</b>	<b>16.3</b>	<b>47</b>	<b>29.4</b>	<b>60</b>	<b>25</b>	
<b>Good time</b>	<b>65</b>	<b>81.3</b>	<b>109</b>	<b>68.1</b>	<b>174</b>	<b>72.5</b>	
<b>Decrease the time</b>	<b>2</b>	<b>2.5</b>	<b>4</b>	<b>2.5</b>	<b>6</b>	<b>2.5</b>	

**Table 17: Opinion and satisfaction on spending time with respect to**

<b>Yes</b>	<b>78</b>	<b>72.5</b>	<b>145</b>	<b>90.1</b>	<b>203</b>	<b>84.2</b>
<b>No</b>	<b>7</b>	<b>8.7</b>	<b>6</b>	<b>3.7</b>	<b>13</b>	<b>5.4</b>
<b>Don't know</b>	<b>15</b>	<b>18.8</b>	<b>10</b>	<b>6.2</b>	<b>25</b>	<b>10.4</b>
<b>Trained health care providers provide better services</b>						<b>0.00</b>
<b>Yes</b>	<b>44</b>	<b>55</b>	<b>119</b>	<b>73.9</b>	<b>163</b>	<b>67.6</b>
<b>No</b>	<b>20</b>	<b>26.2</b>	<b>20</b>	<b>12.4</b>	<b>40</b>	<b>17</b>
<b>Don't know</b>	<b>15</b>	<b>18.8</b>	<b>22</b>	<b>13.7</b>	<b>37</b>	<b>15.4</b>
<b>Competency of health care providers</b>						<b>0.57</b>
<b>Yes</b>	<b>61</b>	<b>76.2</b>	<b>116</b>	<b>72</b>	<b>177</b>	<b>73.4</b>
<b>No</b>	<b>4</b>	<b>5</b>	<b>14</b>	<b>8.7</b>	<b>18</b>	<b>7.5</b>
<b>Don't know</b>	<b>15</b>	<b>18.8</b>	<b>31</b>	<b>19.3</b>	<b>46</b>	<b>19.1</b>
<b>Spending time with care providers</b>						<b>0.73</b>
<b>5 minutes and less</b>	<b>27</b>	<b>33.7</b>	<b>48</b>	<b>30</b>	<b>75</b>	<b>31.3</b>
<b>6 to 10 minutes</b>	<b>28</b>	<b>35</b>	<b>64</b>	<b>40</b>	<b>92</b>	<b>38.3</b>
<b>11 minutes and more</b>	<b>25</b>	<b>31.3</b>	<b>48</b>	<b>30</b>	<b>73</b>	<b>30.4</b>

perspective of pregnant women.

#### 4.3.4 Consultation

The fourth dimension is the consultation by care providers; table 18, shows the items (providing explanation to women, women asking freely, special place for consultation, and advice for referral).

Providing explanation to pregnant women; the health care providers in UNWRA primary health centers and governmental primary health centers providing

explanation to women with percent 97.4% and 100% respectively. The item-women asking freely; the health care providers in UNWRA primary health centers is providing the chance for women to ask freely than those in the governmental primary health centers with percent 94.9% and 92.3% respectively. The difference between the two groups did not reach a statistical significant level ( $P=0.13$ ).

Special place for consultation; the health care providers in governmental primary health centers show agreement that there is a special place for consultation than those in the UNWRA primary health centers with percent 100% and 84.6% respectively. The difference between the two groups did not reach a statistical significant level ( $P=0.488$ ).

Advice for referral the health care providers in UNWRA primary health centers is providing advice for referral to other health centers than those in the governmental primary health centers 92.3% and 61.5% respectively, The difference between the two groups reach a statistical significant level ( $P=0.00$ ).

The results show also; that the health care providers in UNWRA primary health centers and governmental primary health centers show agreement about listening carefully to women and the consultation and explanations is giving clearly with percent 100% for two items in each clinic.

**Table 18: View of the health care providers with respect to service provider consultation.**

Characteristics	Government		UNRWA		Total		P-value
	No.	%	No.	%	No.	%	
<b>Total</b>	<b>13</b>	<b>100</b>	<b>39</b>	<b>100</b>	<b>52</b>	<b>100</b>	
<b>Providing explanation to women</b>							<b>0.56</b>
Yes	13	100	38	97.4	51	98.1	
No	0	0	1	2.6	1	1.9	
<b>Women asking freely</b>							<b>0.13</b>
Yes	12	92.3	37	94.9	49	94.2	
No	1	7.7	2	5.1	3	5.8	
<b>Special place for consultation</b>							<b>0.48</b>
Yes	13	100	33	84.6	46	88.5	
No	0	0	6	15.4	6	11.5	
<b>Advice for referral</b>							<b>0.00</b>
Yes	8	61.5	36	92.3	44	84.6	
No	5	38.5	3	7.7	8	15.4	

Table 19 shows the perspective of women on consultation services provided, there are many items as (women receive answer, women have a chance to ask,

consultation provided clearly, health care providers listen, special place for consultation and advice for referral).

Pregnant women receive answer; the women who attending antenatal services in the UNRWA clinics experienced receive very good answer less than those received antenatal services in the governmental clinics with percent 29.2% and 39.2% respectively, and receive good answer more than those received antenatal services in the governmental clinics with percent 51.6% and 40.5% respectively, this difference is not a statistical significant level ( $P=0.22$ ).

Pregnant women have a chance to ask; the women who attending antenatal services in the UNRWA clinics experienced have very good chance to ask less than those received antenatal services in the governmental clinics with percent 28.7% and 36.7% respectively, and have good chance to ask less than those received antenatal services in the governmental clinics with percent 46.3% and 49.4% respectively, this difference is not a statistical significant level ( $P=0.12$ ).

Consultation provided clearly; the women who attending antenatal services in the UNRWA clinics experienced consultation provided clearly less than those received antenatal services in the governmental clinics with percent 92.4% and 93.2% respectively, this difference is not a statistical significant level ( $P=0.814$ ).

Health care providers listen; the women who attending antenatal services in the UNRWA clinics experienced listening by health care providers less than those received antenatal services in the governmental clinics with percent 78.6% and 91.3% respectively, this difference is a statistical significant level ( $P=0.04$ ).

Special place for consultation; the women who attending antenatal services in the UNRWA clinics experienced consultation in special place more than those received

antenatal services in the governmental clinics with percent 73.1% and 68.8% respectively, this difference is not a statistical significant level ( $P=0.47$ ).

Advice for referral; the women who attending antenatal services in the UNRWA clinics experienced advice for referral more than those received antenatal services in the governmental clinics with percent 68.6% and 54.4% respectively, this difference is a statistical significant level ( $P=0.03$ ).

**Table 19: View of pregnant women with respect consultation services provided**



Characteristics	Government		UNRWA		Total		P-value
	No.	%	No.	%	No.	%	
<b>Total</b>	<b>80</b>	<b>100</b>	<b>161</b>	<b>100</b>	<b>241</b>	<b>100</b>	
<b>Women received answer</b>							<b>0.22</b>
Very good	31	39.2	47	29.2	78	32.5	
Good	32	40.5	83	51.6	115	47.9	
Little	16	20.3	31	19.2	47	19.6	
<b>Women have a chance to ask</b>							<b>0.12</b>
Very good	29	36.7	46	28.7	75	31.4	
Good	39	49.4	74	46.3	113	47.3	
Little	11	13.9	40	25	51	21.3	
<b>Consultation provided clearly</b>							<b>0.81</b>
Very good	44	55.7	84	52.2	128	53.3	
Good	29	36.7	66	41	95	39.6	
Little	6	7.6	11	6.8	17	7.1	
<b>Care provider listen</b>							<b>0.05</b>
Very good	31	38.8	50	31.3	81	33.8	
Good	42	52.5	76	47.5	118	49.2	
Little	7	8.8	34	21.3	41	17	
<b>Special place for consultation</b>							<b>0.48</b>
Yes	55	68.8	117	73.1	172	71.7	
No	25	31.3	43	26.9	68	28.3	
<b>Advice for referral</b>							<b>0.03</b>
Yes	43	54.4	105	68.6	44	63.8	
No	36	45.6	48	31.4	8	36.2	

#### 4.3.4.1 Health education and providing information

Health education and providing information is one of the most important aspect in health, this aspect is being more important in pregnancy because its effect be on the mother and her baby, the health care providers are responsible for this mission. Table 20, shows the provided information the UNRWA and government health centers with respect to perspective of care providers, the following items represented these information (provided information about health during pregnancy, provided information about investigations during pregnancy, provided information about medications during pregnancy, provided information about labor process, provided information about breast feeding, provided information about family planning).

The health care providers in UNRWA and governmental primary health centers show high agreement about providing information related to health and investigations during pregnancy with percent 100% for both.

Regarding the information about medications during pregnancy and labor process, the health care providers in UNRWA and governmental primary health centers show high agreement about providing information about medications during pregnancy with percent 94.9% and 100% for both respectively. The difference between the two groups did not reach a statistical significant ( $P=0.40$ ).

The opinion of health care providers in UNRWA and governmental primary health centers about providing information about breast feeding were agreement for this providing with percent 97.4% and 76.9% respectively. The difference between the two groups reach a statistical significant ( $P=0.01$ ). The health care providers in UNRWA were showing providing information about family planning than those in governmental primary health centers with percent 100% and 61.5% respectively. The difference between the two groups reach a statistical significant ( $P=0.00$ ).

**Table 20: provided information during pregnancy with respect to perspective of care providers.**

Characteristics	Government		UNRWA		Total		P-value
	No.	%	No.	%	No.	%	
<b>Total</b>	<b>13</b>	<b>100</b>	<b>39</b>	<b>100</b>	<b>52</b>	<b>100</b>	
<b>Information is provided about medications during pregnancy</b>							<b>0.41</b>
Yes	13	100	37	94.9	50	96.2	
No	-	-	2	5.1	2	3.8	
<b>Information is provided about labor process</b>							<b>0.41</b>
Yes	13	100	37	94.9	50	96.2	
No	-	-	2	5.1	2	3.8	
<b>Information is provided about breast feeding</b>							<b>0.02</b>
Yes	10	76.9	38	97.4	48	92.3	
No	3	23.1	1	2.6	4	7.7	
<b>Information is provided about family planning</b>							<b>0.00</b>
Yes	8	61.5	39	100	47	90.4	
No	5	38.5	-	-	5	9.6	

Table 21 shows the perspective of pregnant women about information they received, the women who attending UNRWA health services experienced very good or good received information about health during pregnancy more than those who attending governmental health services with percent 65.3% and 61.3% respectively, the women who did not received information represented 24.8% and 32.5% respectively. This difference did not reach a statistical significant level ( $P = 0.32$ ).

The pregnant women who attending UNRWA health services experienced very good or good received information about investigations during pregnancy less than those who attending governmental health services with percent 70.6% and 72.6% respectively, the women who did not received information represented 20% and 23.8% respectively. This difference did not reach a statistical significant level ( $P = 0.22$ ).

The pregnant women who attending UNRWA health services experienced very good or good received information about labor process less than those who attending governmental health services with percent 66.4% and 57.5% respectively, the women who did not received information represented 25.5% and 38.8% respectively. This difference did not reach a statistical significant level ( $P = 0.14$ ).

The pregnant women who attending UNRWA health services experienced no information received about health during pregnancy more than those in who attending governmental health services with percent 75.2% and 78.8% respectively, this difference did not reach a statistical significant level ( $P = 0.881$ ).

The pregnant women who attending UNRWA health services experienced no information received about breast feeding and family planning less than those who

attending governmental health services with percent 67.7% and 76.2% respectively, this difference reach a statistical significant level ( $P = 0.00$ ).

**Table 21: Received information during pregnancy with respect to perspective of participating women.**

Characteristics	Government		UNRWA		Total		P-value
	No.	%	No.	%	No.	%	
<b>Total</b>	<b>80</b>	<b>100</b>	<b>161</b>	<b>100</b>	<b>241</b>	<b>100</b>	
<b>Information is received about health during pregnancy</b>							<b>0.32</b>
Very good	26	32.5	45	28	71	29.5	
Good	23	28.8	60	37.3	83	34.4	
Little	5	6.3	16	9.9	21	8.7	
No information received	26	32.5	40	24.8	66	27.4	
<b>Information is received about investigations during pregnancy</b>							<b>0.22</b>
Very good	27	33.8	41	25.6	68	28.3	
Good	31	38.8	72	45	103	42.9	
Little	3	3.8	15	9.4	18	7.5	
No information received	19	23.8	32	20	51	21.3	
<b>Information is received about medications during pregnancy</b>							<b>0.14</b>
Very good	18	22.5	44	27.3	62	25.7	
Good	28	35	63	39.1	91	37.8	
Little	3	3.8	13	8.1	16	6.6	
No information received	31	38.8	41	25.5	72	29.9	
<b>Information is received about labor process</b>							<b>0.88</b>
Very good	7	8.8	15	9.3	22	9.1	
Good	8	10	18	11.2	26	10.8	
Little	2	2.5	7	4.3	9	3.7	
No information received	63	78.8	121	75.2	184	76.3	
<b>Information is received about breast feeding and family planning</b>							<b>0.00</b>
Very good	12	15	23	14.3	35	14.5	
Good	4	5	29	18	33	13.7	
Little	3	3.8	-	-	3	1.3	
No information received	61	76.2	109	67.7	170	70.5	

#### **4.3.5 Interpersonal relation needs**

The fifth dimension is the Interpersonal relation needs by care providers; table 22, shows the items of this dimension (respect for complain, pathetic with women, meeting and confidentiality, provided for privacy and verbal conflict).

Respect for complain; the health care providers in UNWRA primary health centers are providing the respect for complain women than those in the governmental primary health centers with percent 76.9% and 69.2% respectively. The difference between the two groups did not reach a statistical significant level ( $P=0.57$ ).

Sympathy with women; the health care providers in UNWRA primary health centers are showing pathetic with women than those in the governmental primary health centers with percent 71.8% and 53.8% respectively. The difference between the two groups did not reach a statistical significant level ( $P=0.23$ ).

Meeting and confidentiality; the health care providers in UNWRA primary health centers are providing assurance to women about confidentiality of information and meeting more than those in the governmental primary health centers with percent 92.3% and 76.9% respectively. The difference between the two groups did not reach a statistical significant level ( $P=0.13$ ).

Provided for privacy for women; the health care providers in UNWRA primary health centers and governmental primary health centers experienced providing privacy to women with percent 100% and 92.3% respectively.

Conflict between health care providers and women; the health care providers in UNWRA primary health centers are appearing verbal conflict with women less than those in the governmental primary health centers with percent 25.6% and 38.5%

respectively. The difference between the two groups did not reach a statistical significant level (P=0.37).

The health care providers reported very good score to welcome for women in governmental clinics more than those in UNRWA clinics with percent 66.7% and 61.5% respectively, and 33.3% and 35.9% of them reported good score respectively.

**Table 22: Perspective of health care providers to Interpersonal relation needs.**

Characteristics	Government		UNRWA		Total		P-value
	No.	%	No.	%	No.	%	
<b>Total</b>	<b>13</b>	<b>100</b>	<b>39</b>	<b>100</b>	<b>52</b>	<b>100</b>	
<b>Respect for complain</b>							<b>0.57</b>
Very good	9	69.2	30	76.9	39	75	
Good	4	30.8	9	23.1	13	25	
<b>Sympathy with women</b>							<b>0.23</b>
Very good	7	53.8	28	71.8	35	67.3	
Good	6	46.2	11	28.2	17	32.7	
<b>Meeting and confidentiality</b>							<b>0.13</b>
Very good	10	76.9	36	92.3	46	88.5	
Good	3	23.1	3	7.7	6	11.5	
<b>Provided for privacy</b>							<b>0.08</b>
Yes	12	92.3	39	100	51	98.1	
No	1	7.7	0	0	1	1.9	
<b>Verbal conflict</b>							<b>0.33</b>
Yes	5	38.5	10	25.6	15	28.8	
No	8	61.5	29	74.4	37	71.2	



The fifth dimension is the Interpersonal relation needs by care providers; table 23, shows perspective of women on the Interpersonal relation needs, the items of this dimension are (welcome for women, respect for complain, meeting and confidentiality, provided for privacy and verbal conflict).

Welcome for women; the women attending governmental primary health centers experienced welcome for women during receiving the care more than those in the UNWRA primary health centers with percent 30.4% and 16.8% for welcome by very good way, and 53.1% and 55.9% for welcome by good way respectively. The difference between the two groups reach a statistical significant level ( $P=0.02$ ).

Respect for complain; the women attending governmental primary health centers experienced respect for complain during receiving the care less than those in the UNWRA primary health centers with percent 42.3% and 57% for welcome by very good way, and 46.2% and 68% for welcome by good way respectively. The difference between the two groups did not reach a statistical significant level ( $P=0.20$ ).

Meeting and confidentiality; the women attending governmental primary health centers experienced assurance about confidentiality of information and meeting during receiving the care more than those in the UNWRA primary health centers with percent 66.2% and 53.9% respectively. The difference between the two groups did not reach a statistical significant level ( $P=0.17$ ).

Provided for privacy for women; the women attending governmental primary health centers experienced privacy providing during receiving the care more than those in the UNWRA primary health centers with percent 95% and 76.9% respectively. The difference between the two groups reach a statistical significant level ( $P=0.00$ ).

Verbal conflict between health care providers and women; the women attending governmental primary health centers experienced verbal conflict by the health care providers during receiving the care more than those in the UNWRA primary health centers with percent 16.3% and 7.5% respectively. The difference between the two groups reach a statistical significant level ( $P=0.03$ ).

**Table 23: Interpersonal relation needs with respect to perspective of pregnant women.**

Characteristics	Government		UNRWA		Total		P-value
	No.	%	No.	%	No.	%	
<b>Total</b>	<b>80</b>	<b>100</b>	<b>161</b>	<b>100</b>	<b>241</b>	<b>100</b>	
<b>Welcome for women</b>							<b>0.02</b>
Very good	24	30.4	27	16.8	51	21.3	
Good	42	53.1	90	55.9	132	55	
Little	13	16.5	44	27.3	57	23.7	
<b>Respect for complain</b>							<b>0.20</b>
Very good	33	42.32	57	36.1	90	38.1	
Good	36	46.2	68	43	104	44.1	
Little	9	11.5	33	20.9	42	17.8	
<b>Meeting and confidentiality</b>							<b>0.17</b>
Yes	51	66.2	83	53.9	134	58	
No	26	33.8	71	46.1	97	42	
<b>Provided for privacy</b>							<b>0.00</b>
Yes	76	95	123	76.9	199	82.9	
No	4	5	37	23.1	41	17.1	
<b>Verbal conflict</b>							<b>0.03</b>
Yes	13	16.3	12	7.5	25	10.4	
No	67	83.7	149	92.5	216	89.6	

#### **4.3.6 Availability of medication and equipment**

The dimension is the availability of medication and equipment; table 24, shows the items of this dimension (availability of medication and availability of equipment).

Availability of equipment; the health care providers in UNWRA primary health centers experienced that the equipment was available more than those in the governmental primary health centers with percent 66.7% and 58.3% respectively. The difference between the two groups did not reach a statistical significant level (P=0.59).

Availability of medication; the health care providers in UNWRA primary health centers experienced that the medication was available more than those in the governmental primary health centers with percent 64.1% and 50% respectively. The difference between the two groups did not reach a statistical significant level (P=0.18).

Table 22 shows perspective of women on the availability of medication and equipment, the item-availability of equipment; the women attending UNWRA health services experienced that the equipment was available less than those attending governmental health services with percent 62.1% and 77.5% respectively. The difference between the two groups did not reach a statistical significant level (P=0.07).

Availability of medication; the women attending UNWRA health services experienced that the medication was available more than those attending governmental health services with percent 70.2% and 39.9% respectively. The difference between the two groups did not reach a statistical significant level (P=0.00).

The table shows that the women attending UNWRA and governmental health services experienced that the investigations were done in both with percent 96.3% and 93.7% respectively. The women attending UNWRA and governmental health services experienced that the investigations were not done in both with percent 4.63% and 6.3% respectively. The difference between the two groups did not reach a statistical significant level (P=0.36).

**Table 24: Availability of medication and equipment with respect to perspective of health care providers.**

Characteristics	Government		UNRWA		Total		P-value
	No.	%	No.	%	No.	%	
<b>Total</b>	<b>13</b>	<b>100</b>	<b>39</b>	<b>100</b>	<b>52</b>	<b>100</b>	
<b>Availability of equipment</b>							<b>0.59</b>
Very good	7	58.3	26	66.7	33	64.7	
Good	5	41.7	13	33.3	18	35.3	
<b>Availability of medication</b>							<b>0.18</b>
Very good	6	50	25	64.1	31	60.8	
Good	4	33.3	13	33.3	17	33.3	
Little	2	16.7	1	2.6	3	5.9	

**Table 25: Availability of medication and equipment with respect to perspective of pregnant women.**

Characteristics	Government		UNRWA		Total		P-value
	No.	%	No.	%	No.	%	
<b>Total</b>	<b>80</b>	<b>100</b>	<b>161</b>	<b>100</b>	<b>241</b>	<b>100</b>	
<b>Availability of equipment</b>							<b>0.07</b>
Very good	22	27.5	28	17.4	50	20.7	
Good	40	50	72	44.7	112	46.5	
Little	11	13.8	39	42.2	50	20.7	
Don't know	7	8.8	22	13.7	29	12	
<b>Availability of medication</b>							<b>0.00</b>
Very good	13	16.2	56	34.8	68	28.6	
Good	19	23.7	57	35.4	76	31.5	
Little	27	33.8	28	17.4	55	22.9	
Don't know	21	26.3	20	12.4	41	17	
<b>Investigation is done in the clinic</b>							<b>0.36</b>
Yes	74	93.7	155	96.3	229	95.4	
No	5	6.3	6	3.7	11	4.6	

## Chapter 5

# Discussion

The findings have provided an assessment of antenatal care services provided at UNRWA and government primary health centers in Gaza Strip by the perspective of health care providers and participating women. The study has shown the perspective of health care providers and participating women on provided antenatal care services. This chapter seeks to discuss the results of the study with the data presented in the literature review.

### 5.1 Sociodemographic situation

The findings, show high proportion of the health care providers 73% was young age (less than 40 years) that they can be active and giving, while the low proportion of them was over 40 years which considered in our area old age. A 90.4% of the health care providers were married. These results may reflect the services provided and affect the outcomes of the provided services. By other words the marital status and the social concepts and the problems of life take place for those providers, so the young age can giving more and be more active regardless the experience years.

Around 70% of the health care providers are either midwives 46.2% or nurse/midwife 23.1%, and the low proportion are physicians 15.4%, these results comes in different with (Ozvaris, SB. And Akin, A. 2002) study in Turkey when they find 6.9% of health care providers were midwife/nurse and 60.8% of them were physicians. This difference is referred to many reasons, the Turkish mothers contact the public PHC centers and preferred to receive the ANC by the private physicians, and in our area the mothers preferred the free paid public PHC centers due to low economic status of the area. Also the organizations policy depends on the nurses

and midwives to provide these services than the physicians because the pregnant women are not receiving services by specialists in each visit, but they do when need.

The findings show that most of health care providers 80.8% had 2-5 years specialized educations and the residual portion of them 19.2% had 6 years and more specialized educations after secondary education. The high proportion of health care providers 65.4% has a diploma qualification, either diploma; the other portion of them 34.6% has either a bachelor 26.9% or specialists 7.7%. To provide the recommended antenatal care services; the health care providers need to be good qualified and trained; this can be provided by good education and qualification. Concerning the present information component, half of attendant health care providers were with two years education and thirty two had practical diploma, so these results reflect the perspective of the health care providers on the provided services, the outcome of services and reflect their opinion on needs for education and qualification by asking for training and workshops and to provide good and high qualified health care providers to the organization.

The findings show about 70% of the health care providers has post graduation specialist or antenatal training, while low proportion of them 30% has not post graduation specialist or antenatal training. Around 50% of the health care providers have training 1-3 months duration, and about (16%) of them have more than 3 months duration, and only 28% of them were trained through the years 1986-2002.

The quality of antenatal care services is based on a scientific base, the services is provided by the health care providers who perform the most important portion of these services, so the care provider must be a good qualified, trained and have a good experience, and to be specialist in this care. These results demonstrate that



there are not enough training and qualification provided to health care providers either by them self or by the organizations.

The findings show 70.3% of the attendant women were 20-35 years old and, these results comes in accordance with EL-Gilany, AH and Aref, Y. study in Sudia Arabia, when they find 70.4% of the attending women were 20-35 years old. Our results come in accordance also with Ozvaris, SB. And Akin, A study in Turkish, when they find 78% of them 20-35 years. Around 20% of the attendant women were aged less than 20 years, this results comes in difference with EL-Gilany, AH and Aref, Y. study when they find 5.4% of women aged less than 20 years, and comes in difference with Ozvaris, SB. And Akin, A study, when they find 14.6% of attendants less than 20 years. This difference is referred to very common early marriage in our area.

About 9.1% of the pregnant women had received elementary education, this results comes in difference with Ozvaris, SB. And Akin, A when they find 27% of attendants women had received elementary education. In our study about 24% of the women had received secondary education and more, these results comes in different with Ozvaris, SB. And Akin, A when they find 12% of attendants women had received secondary education and more. This difference is referred to the concept of our area about the importance of education.

Our study shows 91.7% of participating women were housewives, these results comes in accordance with Matthews, Z. et al, study when they find 90% of women were housewives and comes in accordance with the EL-Gilany, AH and Aref, Y study when they find 87.1% of attendants were housewife. Any how this finding is more than the percentage reported by other investigations in Thailand (40%), Argentina (43%) and Cuba (30%), and in accordance with the study which done in

Saudi Arabia, the finding shows more than 80% were housewives (Nigenda, G. et al 2003). These results are referred to the nature and culture of the Arabic society in Gaza and Saudi Arabia and the accordance with the rural area in India.

The study show high proportion 60.7% of participating women have monthly income US\$ 300 and less, 39.3% of them have monthly income more than US\$ 300, this referred to the low economic status of the area due to economic crisis.

### **5.1.1 Maternity health**

The findings show that most of the attendants pregnant women 76% reported up to 6 pregnancies and 24% of them had 7 pregnancies and more. These results come in difference with EL-Gilany, AH and Aref, Y study –which done in Sudia Arabia- when they find 50.8% had up to 5 pregnancies and 49.2% of them had 7 pregnancies and more. This difference is referred to the concepts about early marriage in our community and the fertility rate.

The findings show that 39.4% of the attendants pregnant women reported that they have 1 labor or they have not labor yet, and 25.3% of them reported 5 labors or more, these results come in accordance with Ozvaris, SB. And Akin, A. study – which done in Turkey- when they find 34.9% of attendants reported 1 labor, but the results differ when they find 9.7% of attendants reported 6 labors or more. This difference is referred to culture and believes about size of the family, that to be big family size.

Around 60% of the attendant pregnant women reported their pregnancy in the first or second semester of pregnancy, and 40 % of them reported in the last semester of pregnancy, these results comes in different with Ozvaris, SB And Akin, A study when they find 92.6% of attendants reported up to six months duration of

pregnancy, and 6.8% of them reported the last semester of pregnancy. This difference is referred to the nature of the study of them which is retrospective survey.

The findings show high proportion of the attendants (79%) reported up to 5 visits of antenatal visits and 21% of them reported 6 visits or more of antenatal visits, this result comes in different with Ozvaris, SB. And Akin, A study when they find 67% of the attendant women reported 4 visits or more of antenatal visits. This difference is referred to the concepts of the women in Gaza about the importance of antenatal check up and antenatal care services and due to provided material to pregnant women as milk or others.

A very low portion of the attendant pregnant women were unsatisfied with antenatal visits schedule and want to decrease the number of visits, these results comes in accordance with Nigenda, G. et al study when they find that the attendants women in Thailand reported to decrease the number of visits to be good. In this study most of the attendant women (87.6%) were satisfied with antenatal visits schedule, these results comes in accordance with Nigenda, G. et al study when they find that the attendant women in Aregentina and Saudi Arabia satisfied with the traditional number of visits.

The attendant women in our study reported their opinion about the number of antenatal visits that 91.3% of them satisfied with this number and considered it well. These results comes in accordance with Langer, A. et al study when they find 85.2% of attendants satisfied with standard antenatal care schedule.

The results show that attendant pregnant women reported their opinion about the spacing between antenatal visits 82.9% of the attendants satisfied with the spacing between and considered it well, 10% of them reported long duration between

antenatal visits and they unsatisfied with it. These results comes in accordance with Langer, A. et al study when they find 81% of attendants satisfied with standard antenatal care schedule.

## **5.2 Accessibility to antenatal care services**

Information about accessibility to antenatal care services is provided by many items and many factors, in our study five points were used to assess the accessibility to antenatal care services. In our study the high proportion 84.6% of the health care providers reported that there is a previous appointment system used in their clinics with a significant difference more in UNRWA clinics than government. Also high proportion 86.2% of the attendant women both in UNRWA and governmental clinics reported that there is a previous appointment system used in their clinics with a significant difference more in UNRWA clinics. As seen the perspective of health care providers and women is the same, these results show that both were equally well accepted by women and providers, suggesting the adoption of this system, this system is using in UNRWA clinics more than in government because of high numbers of women who attended the antenatal services in UNRWA clinics and to ensure providing care to these high numbers of women.

The study showed a difference between the perspective of both health care providers and pregnant women, that most of the health care providers 92.3% reported that pregnant women received care at any time of work with more in UNRWA clinics than those in government clinics. Around 70% of the attendant women reported that the women received care at any time of work with less in UNRWA clinics than those in government clinics, the health care providers gave them selves high scores, but this comes in difference with their answer about the

number of health care providers is enough to provide care when about 64% of them said no, and when they asked to increase the number of care providers. Also number of women who attended the services in UNRWA clinics is more than in government, so this may explain why the attendant women in government reported high percent than those in UNRWA clinics.

The findings show around 65% of the health care providers reported that there is perfect time to provide care in the clinics. While about 80% of the attendant women reported that there is perfect time to provide care in the clinics. There is a difference between the opinion of health care providers and women, that the health care providers reported low percent regarding perfect time than attending women. In UNRWA clinics health care providers reported more than those in government clinics, this difference is referred to using the previous appointment system in UNRWA more than government. Also number of women who attended the antenatal services in UNRWA clinics is more than in government, so this may explain why the attendant women in government reported high percent regarding perfect time than those in UNRWA clinics.

A high proportion of the health care providers 80% reported waiting time up to one and half hours, but health care providers in government clinics reported less time than those in UNRWA. Around 65% of the total attendant women reported waiting time up to one and half hours but they reported in UNRWA clinics more than those in government. About 20% of the health care providers reported more than one and half hours waiting time, and about 35% of the attendant women reported more than one and half hours waiting time. The results show that the health care providers reported longer waiting time than the attendant women, and they reported more percentage in UNRWA clinics than government clinics with a

statistical significant, this difference referred to high number of attendant women and narrowing of places, crowded and insufficient number of health care providers to provide the recommended care. But the women reported more percent in government clinics than UNRWA. Any way the view of the women reflect the view of health care providers and this comes with their answers about their advices for better care that most of answers were to provide wider places, decrease the crowded and increase the number of care providers.

Regarding the satisfaction of attendant pregnant women, the findings show 49% of the attendant pregnant women reported long waiting time with more in UNRWA clinics than those in government clinics. These results comes in difference with Tucker et al when they find 79% of attendant women reported good waiting time, and 18% of them reported long time. Also around 53% of attendant pregnant women reported satisfaction with waiting time with less satisfaction of women who attend antenatal services in UNRWA clinics than those in government clinics, and about 47% of the attendant women were unsatisfied. These results comes in difference with Langer, A. et al study when they find 78.3% and 77.6% satisfied with waiting time in new and traditional antenatal care. This difference is referred to high number of attendant women and narrowing of places, crowded and insufficient number of health care providers in UNRWA and governmental clinics.

The study showed 63% of the health care providers reported that the number of health care providers is not enough to provide care with the percent for both clinics. Around 41% of the attendant women reported that the number of health care providers is not enough to provide care. These results show that both women and health care providers were not accepted to the number of care providers, and this

suggesting that the health care providers and women would face obstacles to accessibility of antenatal care services.

### **5.3 Qualification, Training and Competence of health care providers**

This dimension to assess antenatal care services is qualification, training and competence of care providers, the health care providers give their assessment that most of health care providers 98% reported that they getting qualification and training which need to give the recommended care, also a high proportion of health care providers 85% reported that they received training during their work to improve the provided care. About the perspective of health care providers if their organizations act to provide training for them, around 94% of them reported yes.

According to these results we observe that the health care providers give high assessment to qualification and training, these results comes in difference with their answers about need for qualification and training, the opinion of health care providers around 69% of them reported yes that they need, this mean that even they qualified and have training but they need more training and qualification.

The findings suggest that the health care providers give them selves and their organizations the best on work than the others, about 88% of health care providers reported time spending with health care providers fifteen minutes or less, about 94% of health care providers reported that the services provided according to guide lines presented and known by them. Also around 96% of health care providers reported that their organizations develop their skills. 56.9% of health care providers reported that the team can not provide enough care.

The health care providers give themselves and their organizations high scores with more in UNRWA clinics than those in government clinics. This can be seen by

the other answers when 69% of them said yes about post graduated degree (specialist) and antenatal care training, and 32% of health care providers did not received training during their work.

The study shows the opinion of attendant women on competence of health care providers was shown on their answers, about 84% of the attendant women reported that if the health care providers have a specialist, they can provide better care. Around 68% of the attendant women reported that the health care providers can provide better care by training. The answer of the question if the health care providers are competent, about 74% of attendant pregnant women reported that the health care providers are competent. These results come in different with the results of care providers, this mean as mentioned above that the health care providers gave them self and their organizations high scores with more in UNRWA clinics than those in government clinics, also the pregnant women do not have the right tool to judge the services they received, this can be seen by the percent who answer do not know.

The finding shows 70% of the attendant women reported up to ten minutes spending time with health care providers and 30% of them reported eleven minutes and more spending time with care providers. Satisfaction of women on spending time with health care providers was as; around 73% of the attendants reported good time. About satisfaction the results comes in accordance with Nigenda, G. et al study when they find 79% of attendants satisfied with time spent with health care providers in traditional antenatal care, but in the same study the attendants of new model ANC were more satisfied (86%). This difference is referred to low number of visits in the new model of ANC and the women can receive care without problems



as over crowded, insufficient number of health care providers and long waiting time to provide recommended care.

#### **5.4 Consultation**

One of the most important dimensions in this study is consultation, in this dimension assessment of provided information health education. In this study the perspective of health care providers still go as suggest that they provide the best services in their organizations. All the health care providers 100% reported that they listening carefully to women and the consultation and explanations are giving clearly to women in both UNRWA and governmental clinics, a high proportion of health care providers 98% reported that they provided explanation to women. Around 94 % of health care providers reported that women asking freely, about 85% of health care providers reported with a statistical significant that they advice women for referral to other health centers, with higher percentage in UNRWA clinics than government clinics. Around 86% of health care providers reported that there is a special place for consultation, with more in government than UNRWA clinics.

The results show that around 80% of the attendant women reported that they received answers, a high proportion of the attendant women 93% reported that they received consultation clearly, and 72% of the attendant women reported that there is a special place for consultation, with equally in both UNRWA and government clinics. Around 79% of the attending pregnant women reported that they had a chance to ask, and 83% of the attending pregnant women reported with a statistical significant that the health care providers listen to them, with more in government clinics than UNRWA. Around 64% of the attendant pregnant women reported with

more in UNRWA clinics than government clinics, and with a statistical significant that they received advice for referral to other health centers. The difference referred to low number of attending women into government clinics, insufficient numbers of care providers, narrow places and over crowded.

Regarding the health education and providing information, in this study 100% of the health care providers reported that; information is provided about health during pregnancy, and about investigations done during pregnancy. They reported that information is provided about medications during pregnancy and about labor process with percent 96.2%. Also they reported that information is provided about breast feeding and about family planning with percent 92.3% and 90.4% respectively.

The study shows a high difference between the opinion of health care providers and women especially in the points of labor process and breast feeding and family planning, the difference referred to care provision either the organizations or the health care providers who gave the high score to themselves and their opinion that they are the best. This can be seen by their answer when around 64% of health care providers reported that the number of health care providers is not enough to provide care.

The findings show 64% of the attendant pregnant women reported that they received both very good or good information about health during pregnancy, and 36%) of them reported that they received a little or did not received information at all. This results comes in difference with Young, L and Phung, H when they found 79% of women got enough advice about themselves, also the results comes in difference with Langer et al study when they find 79.7% and 79.5% of attendant pregnant women satisfied with the information received about their own health during pregnancy in the new and traditional ANC respectively.

Around 71% of the attendant pregnant women reported that they received good and very good information about investigations during pregnancy, and 21% of them reported that they did not received information at all. These results comes in difference with Langer et al study when they find 86.8% and 83.2% of attendant pregnant women satisfied with the information received about investigations during pregnancy in the new and traditional ANC respectively.

Regarding the information about medications received during pregnancy about 64% of the attendant pregnant women reported that they received both very good and good information, and 30% of them reported that they did not received information at all. These results comes in accordance with Langer et al study when they find (62% and 68%) of attendant pregnant women satisfied with the information received about their medication during pregnancy in the new and traditional ANC respectively.

Around 20% of the attendant pregnant women reported that they received both very good and good information about labor process, and 76.3% of them reported that they did not received information at all. These results comes in difference with Langer et al study when they find 70% and 59.5% of attendant pregnant women satisfied with the information received about labor process in the new and traditional ANC respectively. These results also comes in difference with Tucker et al study when they find 87% of attendant pregnant women reported that they received both very good or good information and 10% of them reported little score with the information received about labor process.

Regarding the received information about breast feeding and family planning, about 28% of the attendant pregnant women reported that they received both very good or good information, and 72% of them reported that they received a little or did

not received information at all. These results comes in difference with Langer et al study when they find 71% and 59.5% of attendant pregnant women satisfied with the information received about breastfeeding and family planning in the new and traditional ANC respectively.

All these differences are referred to insufficient number of care providers, over crowded of the places, increase the number of attendants, insufficient training and specialist for health care providers and the there is shortage in the number of care providers.

### **5.5 Interpersonal relationship**

The interpersonal relationship between the health care providers and the attendant women, this relationship is very important; it is a dimension in our study to assess the antenatal services provided at the clinics. In this study the health care providers reported their perspective on welcome for women, the most of health care providers 98% reported their perspective by high scores; (62.7% reported very good and 35.3% good), with more in UNRWA clinics than those in government clinics, the perspective of women is differ when (21.3% reported very good and 55% good), with less in UNRWA clinics than those in government clinics.

The study differs with Tucker et al study when they found 70% of women reported very good relation with health care providers and 30% of women reported well. This difference is due to high numbers of attending women to the clinics in our area, crowded, narrowing places and long waiting time.

The study suggests that the health care providers give the high scores to themselves and to their organizations, this can be seen by the answers 75% of them reported very good to respect for complain, around 67% of them reported very good

score to pathetic with women, about 89% of them reported very good score to security of meeting and confidentiality, and 98% of the health care providers reported yes to ensure privacy during services, and 71.2% of them reported no to occur conflict with women, with more in UNRWA clinics than those in government clinics.

The perspective of pregnant women reported difference when 38% of attendant pregnant women reported very good score to respect for complain, and 58% of attendant pregnant women reported yes to security of meeting and confidentiality, around 83% of attendant pregnant women reported yes to ensure privacy during services.

The attendant pregnant women reported a different opinion about the health care providers that around 90% of pregnant women reported no conflict occurred between health care providers and pregnant women, with more in UNRWA clinics than those in government clinics. These results comes in accordance with Young, L and Phung, H when they find 10% of women reported difficulty in communication. The difference between results comes due to insufficient number of care providers; increase the number of attendant pregnant women, over crowded of the places, and the there is shortage in the number of care providers.

## **5.6 Availability of medication and equipment**

In this study most of health care providers (94.1%) reported that medication is available either by very good or good score, they reported that availability of medication more in UNRWA clinics than in government clinics. The results show around 60.1% of attendant pregnant women reported very good score or good to availability of medication, but about 23% of them reported that availability of

medication is little; the attending women reported availability of medications in UNRWA clinics more than in government clinics. This results comes in difference with Nigenda, G. et al study when they find that all the women were high satisfied with treatment.

Our results show that all the health care providers reported either very good score (64.7%) or good score (35.3%) to availability of equipment, with more in UNRWA clinics than those in government clinics. These results are different with results of women when 20.7% of attendant pregnant women reported very good score to availability of equipment and 46.5% of them reported good score to availability of equipment, with less in UNRWA clinics than those in government clinics.

This difference is referred to that the health care providers judged on the situation according a scientific base but they also want to give organizations the high scores. Although the health care providers asking to provide more equipments especially in government clinics.

## Chapter 6

# Conclusion and Recommendations

### 6.1 Conclusion

In order to assess the perspective of health care providers and pregnant women toward the antenatal care services provided at government and UNRWA clinics, a cross sectional study was conducted at six centers in three governorates; Gaza North, Gaza and KhanYounis governorate. In each governorate, the largest two centers of government and UNRWA were conducted; this study is coming following to many previous studies in Gaza Strip has been conducted for this purpose. The study findings might help in improving the weak areas in the current antenatal care services.

Most of health care providers are nurses and midwives; they represent 77% in government clinics and 87% in UNRWA clinics, the percentage of midwives is higher in UNRWA clinics (54%) than in government clinics (23%). About half of health care providers in government and UNRWA clinics have two years educations. The health care providers in UNRWA clinics have post graduated degree than those in government clinics that means UNRWA pay attention to specialists than government, but the results show that health care providers have antenatal training in government than those in UNRWA clinics, this training duration is short. High portion have up to three months training courses during their employment, the health care providers in UNRWA clinics have more than 3 months training courses during their employment. The results show a low portion 19% of health care providers received training through six years (1986-2002).

Regarding the maternity health about 40% of the pregnant women were labored one labor or have no labor and about 37% of them reported two pregnancies or less.

Around half of pregnant women were visited the clinics to receive antenatal care two visits or less, this shows that the pregnant women do not pay attention or do not know the importance of the antenatal care visits.

The opinion of health care providers was different about antenatal care visits schedule, high portion of health care providers in government clinics said that the standard number of antenatal care visits is 9 visits or less and half of health care providers in UNRWA clinics said that the standard number of antenatal care visits is 10 to 11 visits, the high proportion of health care providers reported good duration between antenatal visits.

The high portion of pregnant women were satisfied with the number of antenatal visits and said good number of antenatal visits, the women accept and said good duration between the visits.

The study shows in UNRWA clinics usage a previous appointment system more than government clinics, the study also shows that the pregnant women can receive care at any time of work in UNRWA clinics more than government. The study shows long waiting time in UNRWA clinics more than government clinics. The number of health care providers in UNRWA and government clinics is not enough to provide the recommended care.

The results show that the pregnant women attending UNRWA antenatal services reported long duration waiting time, and they were unsatisfied more than those attending governmental antenatal services whom were less satisfied.

Regarding the qualification, training and competence of health care provider; the study shows that the health care providers were getting qualification, but more to those in UNRWA clinics, also the health care providers were getting training in UNRWA clinics more than those in government, the study shows also need for



qualification and training, the organizations provided training for health care providers. The health care providers in UNRWA clinics provide care according to guide lines with more than those in government clinics. UNRWA act to develop the competence of health care providers more than government.

A high portion of pregnant women said that they spend less than 10 minutes with health care providers, the pregnant women attending UNRWA clinics considered this time as good time, and satisfied with this time were less than those in government clinics. In general the pregnant women attending government clinics were satisfied with time of receiving care more than those attending UNRWA clinics.

The perspective of health care providers show that explanations is provided to pregnant women and the pregnant women can asked freely in both clinics by high percentage, but the health care providers in UNRWA clinics advice the women for referral more than those in government clinics.

The pregnant women reported that the health care providers in governmental clinics listen to them more than those in UNRWA clinics and they reported that there is special place for consultation. The pregnant women attending UNRWA health services said that they received advice for referral more than those attending governmental antenatal services.

The health care providers in governmental primary health centers provide information about breast feeding and family planning less than those in UNRWA primary health centers.

A high portion of pregnant women (76%) attending governmental and UNRWA clinics were not received information about labor process, and the pregnant women who did not receive information about breast feeding and family planning in

governmental clinics more than those attending UNRWA clinics, the percentage was 76% and 67% respectively.

The health care providers in both government and UNRWA clinics respect for complain of women, sympathy with women and insure security of meeting and confidentiality, and they provided privacy for women. The health care providers in government clinics have a verbal conflict with women more than those in UNRWA clinics.

The pregnant women attending governmental primary health centers received welcome during receiving the care, respect for complain during receiving the care, assurance about confidentiality of information and meeting, privacy providing during receiving the care, and they have verbal conflict with the health care providers during receiving the care more than those in the UNWRA clinics.

The medication is available in both clinics, but the pregnant women reported that the medication is available in the UNWRA clinics more than governmental clinics.

## **6.2 Recommendations**

The recommendations might help to strengthen the weak points, to come over the gaps and to solve current problems and to improve the ANC services. The researcher is suggesting recommendations to the policy makers, the managers and to the researchers for further researches.

The respondents either the health care providers or attendant pregnant women, reported positive perspective about the antenatal care services and that could be improved through considering the findings of the study.

The identified dimensions in the study (accessibility to antenatal services, qualification and training of health care provider, competence of health care providers, consultation, interpersonal relation needs and availability of medication and equipment), may be used as a part of the dimensions to assess antenatal care services and can be considered as a constructing frame which lead to improve the antenatal care services.

- To enhance and improve the health education especially on health and medications during pregnancy, and to concentrate on labor process and breast feeding and family planning, by providing programs for post graduation specialist, continuous training to the care providers and increase the knowledge of health care providers to guidelines and standards of services.
- Enhancing the accessibility to ANC services by improving and increasing usage of a previous appointment system, act to provide care at perfect time,

and decreasing the waiting time by provide wider places, decrease the crowded and increase the number of care providers.

- Enhancing the health care provider's skills on the interpersonal relation needs and consultation; by programs in how to communicate, how to listen, welcome for pregnant women, providing the privacy for pregnant women, to be confidential, providing special training programs on consultation skills, special place for consultation and providing the educational materials to all aspects of consultation.

#### **6.2.1 Areas for further research**

- Further analysis of the present research data to detect other perspective of health care providers and women on other relation between variables such as education, job, income and residency characteristics and the six dimensions which used in the study.
- Further studies to assess the ANC services in other areas specially care provider's perspective to include qualification, experience years, education years, qualification and training characteristics and the six dimensions which used in the study.

## Chapter 7

# References and Annexes

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Annex (1)

Helsinki Committee approval letter

Palestinian National Authority  
Ministry of Health  
Helsinki Committee

بسم الله الرحمن الرحيم



السلطة الوطنية الفلسطينية  
وزارة الصحة  
لجنة هلسنكي

Date: 21/12/2003

التاريخ: 2003/12/21

Mr./ Bassam Mohammed Shaheen

السيد: بسام محمد شاهين

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

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم  
حول:-

Assessment of antenatal care services  
provided at MOH and UNRWA clinics

تقييم الخدمات الصحية المقدمة للسيدات الحوامل في عيادات  
وزارة الصحة ووكالة الغوث الدولية

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

و ذلك في جلستها المنعقدة لشهر ديسمبر 2003

To approve the above mention research study.

و قد قررت ما يلي:-

الموافقة على البحث المذكور عالياه.

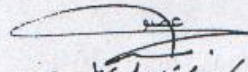
Signature

توقيع

Member

Member

Chairperson

  
د. فوزان اسليبي  
٢٠٠٤/١٢

  
٢٠٠٤/١٢



Conditions:-

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

Annex (2)

Ministry of Health Permission Letter



وزارة الصحة

كلية الصحة العامة-فلسطين  
School of Public Health

فلسطين-القدس



جامعة القدس

2004/1/24  
الدكتور د. منصف بركات  
الدكتور د. ب. طيب (معلم)  
م. الجوزي، مدير لبرنامج  
1-2-3-4-5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100

حضرة الأخ/د. عبد الرحمن برقاي المحترم  
مدير عام وزارة الصحة  
تحية طيبة وبعد،،،

الموضوع: مساعدة الطالب بسام شاهين

يقوم الطالب المذكور أعلاه بإجراء مشروع بحث بعنوان:

تقييم خدمات العناية قبل الولادة بالمؤسسات الصحية

كمطلب للحصول على درجة الماجستير في مجال صحة الأم والطفل علماً بأن المعلومات سوف تكون متوفرة لدى الباحث فقط. و عليه نرجو من سيادتكم التكرم للإيعاز لمن ترونه مناسب لتسهيل مهمة الطالب في جمع البيانات الخاصة بالبحث باستخدام استبانته. علماً بأن الطالب حصل على موافقة لجنة هلسنكي للأبحاث عملاً بالنظام المعمول به.

موافقتكم دعماً للمسيرة الأكاديمية

واقبلوا التحية،،،

٥٦٨  
٤٤٨

د. سوزان شعشاعة

مدير إدارة برامج جامعة القدس/غزة

مساعد عميد كلية الصحة العامة

كلية الصحة العامة / غزة  
رقم الصادر: 2004/09  
تاريخ الصادر: 2004/11/24

130

ص. ٥٦٨  
و. ٤٤٨  
٤٤٨/١/٢٤

Annex (3)

UNRWA Permission Letter

٥ فبراير ٢٠٠٤

هـ م ج/م/٢٠٠٤-١

إلى : السادة أطباء العيادات المسؤولين

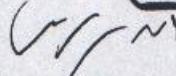
من : مدير البرامج الصحية بوكالة الغوث

الموضوع : مساعدة الطالب بسام شاهين

الرجاء تسهيل مهمة الطالب بسام شاهين في جمع البيانات الخاصة بالبحث باستخدام

استبيانه.

Health Programme  
UNRWA - Gaza



د. أيوب العالم

Dr. Ayoub EL Alem  
Chief Field Health Programme  
UNRWA - Gaza



Annex (4)

Formula of the study sample size

Population Survey or Descriptive Study Using Random (Not Cluster) Sampling

Population Size	:	40,972
Expected Frequency	:	80.00 %
Worst Acceptable	:	75.00 %
Confidence Level		Sample Size
	-----	-----
80 %		105
90 %		172
95 %		244
99 %		420
99.9 %		681
99.99 %		946

Formula : Sample Size =  $n / (1 - (n / \text{population}))$   
 $n = Z * Z(P(1-P)) / (D * D)$

Reference : Kish & Leslie, Survey Sampling, John Wiley & Sons,  
NY, 1965



## **Annex (5)**

### **Questionnaire**

#### **Assessment of antenatal care services provided at MOH and UNRWA clinics in**

#### **Gaza Strip, Palestine**

I will appreciate you for participation to fill this questionnaire; this study is a partial fulfillment of the requirement for the degree of Master of Mother and Children Health. The aim of the study is to assess antenatal care services provided at MOH and UNRWA clinics in Gaza Strip, you have the rights to participate or not, or to stop your participation at any time, also you have the right to refuse for answering ant question.

The received data will keep secret; no need to for names and your opinion will be appreciated.

The questionnaire is need for ten to fifteen minutes to fill. I hope that you will participate to help to assess and improve the services provided.

Thanks for your participation.

Bassam M. Shaheen



❖ Antenatal Care Services

13- According to your opinion, the quality of services in this clinic is:

1- very good      2- good      3- bad     

14- According to guidelines in this clinic, number of visits for antenatal care is:

15- In your opinion, antenatal care visits is:

1- many      2- good      3- little     

16- In your opinion, the duration between visits is:

1- long duration      2- good duration      3- short     

17- Waiting time to receive care is:

1- hour       2- minute

18- The duration of this waiting time is:

1- long duration      2- good duration      3- short     

19- In your opinion, are women satisfied with this waiting time:

1- yes      2- no     

20- time spend by health care provider to provide care:

1- minute

21- Equipments and supplies are available in the clinic:

1- yes      2- no     

22- Medications are available in the clinic:

1- yes      2- no     

23- Investigations are done in the clinic:

1- yes      2- no     

24- Services are accessible for all women:

1- yes      2- no

25- A previous appointment system used in the clinic:

1- yes

2- no

26- Are the place of clinic near the residency place:

1- yes

2- no

27- Arrival for clinic is easy:

1- yes

2- no

28- Are you feel that women satisfied with these services:

1- yes

2- no

29- Are the women facing difficulty to receive care:

1- yes

2- no

30- Women receive care at any time of work day:

1- yes

2- no

31- Are there perfect time to provide care:

1- yes

2- no

32- Are you provide care to women who prefer you to provide:

1- yes

2- no

33- Are there written guidelines for antenatal care:

1- yes

2- no

34- Are care provided according to these guidelines?

1- yes

2- no

35- Is it possible to provide better care:

1- yes

2- no

❖ **Health care providers (Number, Competence and Training)**

36- I got qualification and training need to provide care:

1- yes

2- no

37- Are you obtained training courses during work:

1- yes

2- no

38- The policy clinic to provide better care:

1- yes

2- no

39- I need more qualification and training:

1- yes

2- no

40- By special courses, better care can provided:

1- yes

2- no

41- Increase competence for care provider are available:

1- yes

2- no

42- Training courses for health care providers are available:

1- yes

2- no

43- The staff (man power) is enough :

1- yes

2- no

44- Services are provided to large number of women that the staff cannot provide  
a proper care:

1- yes

2- no

❖ **Consultation and Medical Advice**

45- Consultation and advice is provided to pregnant women:

1- yes

2- no

46- I listen carefully to pregnant women:

1- yes

2- no

47- I give explanations that need the pregnant women:

1- yes

2- no

48- I give a chance for women to ask freely:

1- yes

2- no

49- The women feel satisfied with information and advices that they got:

1- yes

2- no

50- Questions of women are answered great full:

1- yes

2- no

51- Consultation and advices are provided clearly:

1- yes

2- no

52- Information are provided about: (answer each item either yes or no)

a- Health during pregnancy

b- Investigations during pregnancy

c- Medications during pregnancy

d- Labor process

e- Breast feeding

f- Family planning

53- There is special place to provide consultation and medical advice

1- yes

2- no

54- I explain for women even if she did not ask:

1- yes

2- no

❖ **Interpersonal Relationship**

55- I do to keep the relation with pregnant women:

1- very good

2- good

3- normal

56- Welcome for women by you:

1- very good

2- good

3- little

57- I respect the complain of women:

1- very good

2- good

3- little

58- I am sympathy with the pregnant women:

1- very good

2- good

3- little

59- I keep confidentiality for information of pregnant women:

1- very good

2- good

3- little

60- The privacy is kept during care:

1- yes

2- no

61- Verbal conflicts and facing are occurred between women and care providers:

1- yes

2- no

62- Advice for referral to other health centers is provided for women:

1- yes

2- no

63- I advice my relevant and friends to receive care in this clinic:

1- yes

2- no

64- From points of view, what are the shortages in the antenatal care services in this clinic?

.....

.....

.....

.....

.....

65- What are your advices to improve the antenatal care services?

.....

.....

.....

.....

.....



**Annex (7)**

**Assessment of Antenatal Care Services at UNRWA and Government Clinics in  
Gaza Strip (Women questionnaire)**

- Serial number
- Date
- Governorate
- Clinic                    1-government    2-UNRWA

❖ **Personal Data**

- 1- Age
- 2- Job
- 3- Education years    1- (0-6)    2- (7-12)    3- (13 +)
- 4- Residency        1- city    2- village    3- camp
- 5- Monthly income
- 6- Occupation of husband
- 7- Education years of husband    1- (0-6)    2- (7-12)    3- (13 +)
- 8- Number of labors
- 9- Number of pregnancies
- 10- Duration of pregnancies
- 11- Number of antenatal visits from beginning of pregnancy till now  
with this visit

❖ **Antenatal Care Services**

12- Are you satisfied with number of antenatal care visits or you prefer:

1- increase the number      2- number is good

3- decrease the number      4- do not knew

13- Number of visits for antenatal care is:

1- many      2- good      3- little      4- do not knew

14- In your opinion, the duration between visits is:

1- long duration      2- good duration      3- short      4- do not knew

15- Waiting time to receive care is:

1- hour

2- minute

16- The duration of this waiting time is:

1- long duration      2- good duration      3- short      4- do not knew

17- Are you satisfied with this waiting time:

1- yes

2- no

18- The time you spend with health care provider to provide care:

1- minute

19- The time you spend since your coming till finish receiving care:

1- many      2- good      3- little

20- Are you satisfied with time you spend since your coming till finish receiving care:

1- yes

2- no

20- Are you satisfied with time you spend with health care provider:

1- yes

2- no

21- The time you spend with health care provider is enough or you prefer:

1- increase the time      2- time is good      3- decrease the time

22- Equipments and supplies are available in the clinic:

1- very good 2- good 3- little 4- do not know

23- Medications that need pregnant are available in the clinic:

1- very good 2- good 3- little 4- do not know

24- Investigations are done in the clinic:

1- yes 2- no

25- Services are accessible for all women:

1- yes 2- no

26- A previous appointment system used in the clinic:

1- yes 2- no

27- Are the place of clinic near your residency place:

1- yes 2- no

28- Arrival for clinic is easy:

1- yes 2- no

29- Are you satisfied with these services:

1- yes 2- no

30- Are the women facing difficulty to receive care:

1- yes 2- no

31- Women receive care at any time of work day:

1- yes 2- no

32- Are there perfect time to provide care:

1- yes 2- no

33- When prefer you to provide, is he provide care to you:

1- yes 2- no

34- Is it possible to provide better care:

1- yes

2- no

❖ **Health care providers (Number, Competence and Training)**

35- In your opinion, the care provider who got specialist qualification can provide better care:

1- yes

2- no

3- do not knew

36- In your opinion, the care provider who got training courses can provide better care:

1- yes

2- no

3- do not knew

37- Do you think that it is done to provide better care:

1- yes

2- no

3- do not knew

38- Health care providers work by more effort on providing care:

1- yes

2- no

3- do not knew

39- Health care providers in this clinic are competence:

1- yes

2- no

3- do not knew

40- The staff (man power) is enough to provide need care:

1- yes

2- no

3- do not knew

❖ **Consultation and Medical Advice**

41- Consultation and advice is provided to you:

1- very good

2- good

3- little

4- no information received

42- Do you receive information about health during pregnancy:

1- yes

2- no

(if yes answer question 43)

43- The received information about health during pregnancy is:

1- very good 2- good 3- little 4- no information received

44- Do you receive information about investigations during pregnancy:

1- yes 2- no (if yes answer question 45)

45- The received information about investigations during pregnancy is:

1- very good 2- good 3- little 4- no information received

46- - Do you receive information about medications needed during pregnancy:

1- yes 2- no (if yes answer question 47)

47- The received information about medications during pregnancy is:

1- very good 2- good 3- little 4- no information received

48- Do you receive information about labor process:

1- yes 2- no (if yes answer question 49)

49- The received information about labor process is:

1- very good 2- good 3- little 4- no information received

50- Do you receive information about breast feeding and family planning:

1- yes 2- no (if yes answer question 51)

51- The received information about breast feeding and family planning is:

1- very good 2- good 3- little 4- no information received

52- You received answer or explanation for any matter:

1- very good 2- good 3- little

53- You have a chance to ask freely

1- very good 2- good 3- little

54- Your questions are answered great full:

1- very good 2- good 3- little



66- I advice my relevant and friends to receive care in this clinic:

1- yes

2- no

67- I want to continue to receive care in this clinic:

1- yes

2- no

68- What are the matters you like in this clinic?

.....

.....

.....

.....

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69- What are the matters you dislike in this clinic?

.....

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.....

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## Annex (8)

### استبانة

حول تقييم الخدمات المقدمة للسيدات الحوامل في عيادات وزارة الصحة والوكالة في قطاع غزة

### Assessment of antenatal care services provided at MOH and UNRWA clinics in Gaza Strip, Palestine

يسعدني أن أقدم لكم كل الاحترام وجزيل الشكر علي مشاركتكم البناءة والمثمرة إن شاء الله علي إكمال هذه الدراسة والتي هي جزء من دراسة الماجستير في كلية الصحة العامة- جامعة القدس, تخصص صحة الأم والطفل. تهدف هذه الدراسة للتعرف علي الخدمات المقدمة للسيدات الحوامل وتقييم هذه الخدمات, وحيث من الأهمية الاستمرار في منح صحة عالية للأمهات الحوامل ولأطفالهن, وحيث أن المعرفة والجودة في الأداء تكون بتعاونك معنا كمشاركة في الدراسة, وبمشاركتك تطوري في الأداء الصحي من أجل الأجيال القادمة.

لقد استوفي الباحث المتطلبات القانونية والأخلاقية للبحث العلمي, ومشاركتك طوعية ولك الحرية في المشاركة أو عدمها, كما يمكنك الانسحاب في أي وقت تشائين دون إبداء الأسباب, ولن يكون لذلك أي أثر سلبي علي العلاقة مع الباحث.

من حقاك المشاركة بالدرجة التي تريدينها ولك الحق في الامتناع عن إجابة أي سؤال, وستظل المعلومات المتلقاة في إطار السرية التامة فأنا لا أنشر أي أسماء أو عناوين خاصة في مجال الدراسة, وسيكون رأيك الخاص موضع تقدير واحترام وستنشر النتائج من خلال صورة جماعية وليست فردية. إن تعبئة هذه الاستبانة تستغرق عشرة أو خمسة عشر دقيقة لذا نرجو من سيادتكم تخصيص بعض الوقت للإسهام في رفعة العلم والعمل مع فائق الامتنان.

أتمني مشاركتك الفعالة لكي تساعدي بمعلوماتك الصريحة في تقييم الخدمة المقدمة بشكل صحيح والاستفادة من ذلك في وضع الخطط وتحسين الأداء. نشكر لك حسن التعاون ونقدر قرارك الإيجابي للاشتراك في البحث.

الباحث

بسام محمد عمر شاهين



Annex (9)

تقييم الخدمات المقدمة للسيدات الحوامل في عيادات وزارة الصحة ووكالة الغوث في قطاع غزة

(استبانة مقدمي الخدمة)

<input type="text"/>	1. الرقم المسلسل
<input type="text"/>	2. التاريخ
<input type="text"/>	3. المحافظة
<input type="text"/>	4. العيادة
<input type="checkbox"/>	1- حكومة
<input type="checkbox"/>	2- وكالة

❖ بيانات شخصية	
<input type="text"/>	1. العمر
<input type="text"/>	2. الحالة الاجتماعية
<input type="checkbox"/>	3. المهنة 1- ممرضه مؤهلة 2- قابلة قانونية 3- طبيب 4- (2+1) أخرى
<input type="checkbox"/>	4. السكن 1- مدينة 2- قرية 3- مخيم
<input type="text"/>	5. عدد سنوات الدراسة الأساسية
<input type="text"/>	6. عدد سنوات الخدمة في العمل الحالي
<input type="checkbox"/>	7. الشهادة الدراسية 1- دبلوم عملي 2- دبلوم مؤهل 3- بكالوريوس 4- أخرى
<input type="checkbox"/>	8. دراسة تخصصية في مجال رعاية الحوامل 1- نعم 2- لا
<input type="text"/>	9. عدد سنوات العمل بعد الدراسة التخصصية
<input type="checkbox"/>	10. دورات تدريبية في مجال رعاية الحوامل 1- نعم 2- لا
<input type="text"/>	11. مدة هذه الدورات التدريبية
<input type="text"/>	12. تاريخ الحصول علي آخر هذه الدورات التدريبية

## ❖ الخدمات المقدمة للسيدات الحوامل

14- حسب رأيك كمقدم خدمة, الخدمة التي تقدم لرعاية السيدات الحوامل في هذه العيادة

1- جيدة جدا 2- جيدة 3- سيئة

15- حسب نظام رعاية الحوامل المتبع في هذه العيادة, ما هو عدد الزيارات التي يجب أن تقوم بها السيدة الحامل

16- حسب رأيك, هل عدد الزيارات المتبعة لرعاية السيدات الحوامل خلال فترة الحمل في هذه العيادة

1- كثيرة 2- جيدة 3- قليلة

17- حسب رأيك, هل الفترة الزمنية بين هذه الزيارات

1- فترة زمنية طويلة 2- فترة زمنية جيدة 3- فترة زمنية قصيرة

18- مقدار الفترة الزمنية التي تقضيها السيدة منذ وصولها للعيادة حتى تتلقي الخدمة

2- دقيقة

1- ساعة

19- هل هذه الفترة الزمنية التي تقضيها السيدة في انتظار الحصول علي الخدمة.

1- فترة زمنية طويلة 2- فترة زمنية جيدة 3- فترة زمنية قصيرة

20- هل تشعرين أن السيدة الحامل راضية عن فترة الانتظار هذه

1- نعم 2- لا

21- كم من الوقت يمكث مقدم الخدمة مع السيدة الحامل لتقديم الخدمة

1- دقيقة

22- تتوفر الأجهزة والمعدات اللازمة لتقديم الخدمة للسيدة الحامل في هذه العيادة

1- بشكل جيد جدا 2- بشكل جيد 3- بشكل قليل

23- العلاجات التي تلزم للسيدة الحامل أثناء الحمل متوفرة في هذه العيادة

1- بشكل جيد جدا 2- بشكل جيد 3- بشكل قليل

24- الفحوصات والتحاليل الأساسية اللازمة للسيدة الحامل تتم داخل العيادة

<input type="checkbox"/>	1- نعم	2- لا	25- هل الخدمة سهلة وميسورة لجميع السيدات.
<input type="checkbox"/>	1- نعم	2- لا	26- هل يستخدم نظام الحجز المسبق في هذه العيادة
<input type="checkbox"/>	1- نعم	2- لا	27- هل توجد العيادة في مكان قريب من مكان السكن
<input type="checkbox"/>	1- نعم	2- لا	28- هل يمكن الوصول بسهولة إلى مكان العيادة
<input type="checkbox"/>	1- نعم	2- لا	29- أشعر أن السيدات المتلقيات للخدمة راضيات عن هذه الخدمة
<input type="checkbox"/>	1- نعم	2- لا	30- هل تجد السيدات الحوامل صعوبة في الحصول علي الخدمة
<input type="checkbox"/>	1- نعم	2- لا	31- يتم تقديم الخدمة في أي وقت للسيدة الحامل التي تأتي أثناء الدوام الرسمي
<input type="checkbox"/>	1- نعم	2- لا	32- هل توجد مواعيد دقيقة لتقديم الخدمة و ينضبط بها الجميع في هذه العيادة
<input type="checkbox"/>	1- نعم	2- لا	33- أقوم بتقديم الخدمة للسيدة الحامل التي ترغب أن أقدمها لها شخصيا
<input type="checkbox"/>	1- نعم	2- لا	34- هل يوجد مقاييس أو قواعد مكتوبة لخدمة رعاية السيدات الحوامل في هذه العيادة
<input type="checkbox"/>	1- نعم	2- لا	35- هل يتم التقيد بهذه الأسس والقواعد عند تقديم الخدمة للسيدات الحوامل

<input type="checkbox"/>	1- نعم 2- لا	36- هل يمكن العمل علي تقديم خدمة أفضل من الخدمة الحالية
<input type="checkbox"/>	1- نعم 2- لا	
<b>❖ مقامي الخدمة من حيث (العدد المتوفر, الكفاءة, التدريب)</b>		
<input type="checkbox"/>	1- نعم 2- لا	37- حصلت على المؤهل العلمي والتدريب العملي الذي يمكنني من تقديم الخدمة اللازمة
<input type="checkbox"/>	1- نعم 2- لا	38- تلقيت دورات تدريبية مهنية أثناء العمل لتحسين الخدمة المقدمة
<input type="checkbox"/>	1- نعم 2- لا	39- يتم العمل على تقديم أفضل خدمة ممكنة
<input type="checkbox"/>	1- نعم 2- لا	40- أشعر بحاجة للحصول على مؤهل علمي وتدريب عملي متقدمين لتقديم خدمة أفضل
<input type="checkbox"/>	1- نعم 2- لا	41- يمكن تقديم خدمة أفضل بالحصول علي دورات دراسية تخصصية
<input type="checkbox"/>	1- نعم 2- لا	42- يتم العمل على تطوير كفاءة مقامي الخدمة
<input type="checkbox"/>	1- نعم 2- لا	43- يتم العمل على تقديم دورات تدريبية مهنية لمقامي الخدمة
<input type="checkbox"/>	1- نعم 2- لا	44- عدد مقامي الخدمة يكفي لتقديم الخدمة المطلوبة
<input type="checkbox"/>	1- نعم 2- لا	45- يتم تقديم الخدمة لعدد كبير من السيدات بحيث لا يمكن للطاقم العامل تقديم الخدمة اللازمة بشكل جيد
<input type="checkbox"/>	1- نعم 2- لا	
<b>❖ الاستشارة الطبية والنصيحة</b>		

46- تقدم النصيحة والاستشارة اللازمة للسيدة الحامل

1- نعم 2- لا

47- أستمع باهتمام لما تقوله السيدة الحامل

1- نعم 2- لا

48- أعطي أي تفسير تطلبه السيدة الحامل عن الخدمة المقدمة لها

1- نعم 2- لا

49- أترك المجال مفتوحاً وبدون مقاطعة لأي سؤال من السيدة الحامل

1- نعم 2- لا

50- تشعر السيدة بأنها حصلت على المعلومات والنصائح بشكل مرضي

1- نعم 2- لا

51- الأسئلة التي تطرحها السيدة يجب عليها بشكل مرضي

1- نعم 2- لا

52- يتم تقديم الشرح والنصيحة للسيدة الحامل بلغة واضحة ومفهومة لها

1- نعم 2- لا

53- في خلال زيارة السيدة الحامل، هل يتم تقديم المعلومات لها حول الأمور الآتية:

(أجب علي كل عنصر :- 1- نعم 2- لا)

أ- الصحة أثناء الحمل

ب- الفحوصات أثناء الحمل

ت- العلاجات أثناء الحمل

ث- عملية الولادة

ج- عملية الرضاعة

ح- تنظيم الأسرة

54- يتم تقديم النصيحة والاستشارة الطبية للسيدة الحامل في مكان مخصص لذلك داخل العيادة

1- نعم 2- لا

55- يتم الشرح والتوضيح للسيدة الحامل حتى لو لم تطلب أي توضيح

1- نعم 2- لا

### ❖ العلاقة والاتصال بين مقدم الخدمة والسيدة الحامل

56- أعمل على أن تكون العلاقة بيني وبين السيدة الحامل علاقة

1- جيدة جدا 2- جيدة 3- عادية

57- يتم الترحيب بالسيدة المتلقية للخدمة

1- بشكل جيد جدا 2- بشكل جيد 3- بشكل قليل

58- أحترم وأتعامل بجدية مع الشكوى المقدمة من السيدة الحامل

1- بشكل جيد جدا 2- بشكل جيد 3- بشكل قليل

59- أتعاطف مع السيدة المتلقية للخدمة

1- بشكل جيد جدا 2- بشكل جيد 3- بشكل قليل

60- أطمئن السيدة من ناحية اللقاء و سرية المعلومات التي تقدمها لي

1- بشكل جيد جدا 2- بشكل جيد 3- بشكل قليل

61- أثناء تقديم الخدمة للسيدة الحامل, يتم توفير الخصوصية لها

1- نعم 2- لا

62- تحصل مواجهات أو مشادات كلامية بين مقدم الخدمة والسيدة الحامل

1- نعم 2- لا

63- تقدم النصيحة للسيدة الحامل بالتوجه إلى المركز الصحي المناسب لتلقي خدمة غير متوفرة في العيادة

1- نعم 2- لا

64- أنصح صديقاتي وقريباتي بتلقي الخدمة في هذه العيادة

1- نعم 2- لا

65- ما هي النواقص التي تراها في نظام خدمة رعاية السيدات الحوامل المطبق في هذه العيادة

66 - ما هي النصائح التي تقترحها لتحسين خدمة رعاية السيدات الحوامل

Annex (10)

تقييم الخدمات المقدمة للسيدات الحوامل في عيادات وزارة الصحة ووكالة الغوث في قطاع غزة

(استبانة السيدات)

<input type="text"/>	الرقم المسلسل	5.
<input type="text"/>	التاريخ	6.
<input type="text"/>	المحافظة	7.
<input type="text"/>	العيادة	8.
<input type="text"/>	1- حكومة	2- وكالة
<b>❖ بيانات شخصية</b>		
<input type="text"/>	1- العمر	
<input type="text"/>	2- المهنة	
<input type="text"/>	3- سنوات التعليم	1- (6-.) 2- (7-12) 3- (13 فما فوق)
<input type="text"/>	4- السكن	1- مدينة 2- قرية 3- مخيم
<input type="text"/>	5- الدخل الشهري للعائلة	
<input type="text"/>	6- مهنة الزوج	
<input type="text"/>	7- سنوات التعليم للزوج	1- (6-.) 2- (7-12) 3- (13 فما فوق)
<input type="text"/>	8- عدد مرات الولادة	
<input type="text"/>	9- عدد مرات الحمل	
<input type="text"/>	10- مدة الحمل	
<input type="text"/>	11- عدد زيارات المتابعة من بداية الحمل حتى الآن بما فيها هذه الزيارة	

**❖ الخدمات المقدمة للسيدات الحوامل**



12- هل أنت راضية عن عدد الزيارات المقررة للمتابعة خلال الحمل أم تفضلين

1- زيادة عدد الزيارات 2- عدد الزيارات جيد 3- تقليل عدد الزيارات 4- لا أعرف

13- عدد مرات الزيارات المقررة للمتابعة خلال فترة الحمل

1- كثيرة 2- جيدة 3- قليلة 4- لا أعرف

14- الفترة الزمنية بين الزيارات المقررة للمتابعة خلال فترة الحمل

1- فترة زمنية طويلة 2- فترة زمنية جيدة 3- فترة زمنية قصيرة 4- لا أعرف

15- مقدار الفترة الزمنية التي تقضيها من وصولك للعيادة حتى تتلقى الخدمة

1- ساعة  2- دقيقة

16- الفترة الزمنية التي تقضيها في انتظار الحصول علي الخدمة

1- فترة زمنية طويلة 2- فترة زمنية جيدة 3- فترة زمنية قصيرة 4- لا أعرف

17- هل أنت راضية عن فترة الانتظار التي تقضيها في انتظار الحصول علي الخدمة

1- نعم 2- لا

18- كم دقيقة من الوقت تمكثين مع مقدمي الخدمة لتلقي الخدمة

1- دقيقة

19- الوقت الذي تقضيه في تلقي الخدمة منذ وصولك للعيادة حتى الانتهاء من تلقي الخدمة

1- الوقت كثير 2- الوقت جيد 3- الوقت قليل

20- هل أنت راضية عن الوقت الذي تقضيه في تلقي الخدمة

1- نعم 2- لا

21- الوقت الذي تقضيه مع مقدمي الخدمة كافي أم تفضلين

1- الزيادة من الوقت 2- الوقت جيد 3- التقليل من الوقت

22- تتوفر الأجهزة والمعدات اللازمة لتقديم الخدمة للسيدة الحامل أثناء الحمل في هذه العيادة

1- بشكل جيد جدا 2- بشكل جيد 3- بشكل قليل 4- لا أعرف

23- العلاجات التي تلزم للسيدة الحامل أثناء الحمل متوفرة في هذه العيادة

1- بشكل جيد جدا 2- بشكل جيد 3- بشكل قليل 4- لا أعرف

24- الفحوصات والتحليل الأساسية اللازمة للسيدة الحامل تتم داخل العيادة

1- نعم  
2- لا

25- هل الخدمة سهلة وميسورة لك

1- نعم  
2- لا

26- هل يستخدم نظام الحجز المسبق في هذه العيادة

1- نعم  
2- لا

27- هل توجد العيادة في مكان قريب من مكان سكنك

1- نعم  
2- لا

28- هل يمكنك الوصول بسهولة إلي مكان العيادة

1- نعم  
2- لا

29- هل أنت راضية عن الخدمة المقدمة لك في هذه العيادة

1- نعم  
2- لا

30- هل تواجه السيدات الحوامل صعوبة في الحصول علي الخدمة

1- نعم  
2- لا

31- يتم تقديم الخدمة لك في أي وقت تأتي أثناء الدوام الرسمي

1- نعم  
2- لا

32- هل يوجد مواعيد لتقديم الخدمة وهذه المواعيد دقيقة و ينضبط بها الجميع

1- نعم  
2- لا

33- عندما تفضلين شخصا معين ليقدم الخدمة لك, هل هو من يقدمها لك شخصيا

1- نعم  
2- لا

34- هل يمكن العمل علي تقديم خدمة أفضل من الخدمة الحالية

1- نعم  
2- لا

❖ مقدمي الخدمة من حيث (العدد المتوفر , الكفاءة , التدريب)

35- هل تعتقد أن مقدم الخدمة الحاصل على مؤهل علمي تخصصي في مجال رعاية الحامل يقدم

خدمة أفضل

1- نعم      2- لا      3- لا أعلم

36- هل تعتقد أن مقدم الخدمة الحاصل على دورات تدريبية في مجال رعاية الحامل يقدم خدمة

أفضل

1- نعم      2- لا      3- لا أعلم

37- هل تعتقد أنه يتم العمل على تقديم أفضل خدمة من مقدمي الخدمة

1- نعم      2- لا      3- لا أعلم

38- مقدمي الخدمة يبذلون جهودا إضافية في تقديم الخدمة

1- نعم      2- لا      3- لا أعلم

39- مقدمي الخدمة في هذه العيادة ذو كفاءة

1- نعم      2- لا      3- لا أعلم

40- عدد مقدمي الخدمة يكفي لتقديم الخدمة اللازمة

1- نعم      2- لا      3- لا أعلم

❖ الاستشارة الطبية والنصيحة

41- هل تقدم النصيحة و الاستشارة الطبية لك

1- بشكل جيد جدا      2- بشكل جيد      3- بشكل قليل      4- لم أتلقى معلومات

42- هل قدمت لك معلومات حول النواحي الصحية لديك أثناء الحمل

1- نعم      2- لا      (إذا كان نعم أجيب السؤال 43)

43- المعلومات المقدمة لك حول النواحي الصحية لديك أثناء الحمل كافية

1- جيدة جدا      2- جيدة      3- قليلة      4- لم أتلقى معلومات

44- هل قدمت لك معلومات حول الفحوصات الطبية التي تلزمك أثناء الحمل

1- نعم 2- لا (إذا كان نعم أجبني السؤال 45)

45- المعلومات المقدمة لك حول الفحوصات الطبية التي تلزمك أثناء الحمل

1- جيدة جدا 2- جيدة 3- قليلة 4- لم أتلقى معلومات

46- هل قدمت لك معلومات حول العلاج الذي يمكن أن تحتاجينه أثناء الحمل

1- نعم 2- لا (إذا كان نعم أجبني السؤال 47)

47- المعلومات المقدمة لك حول العلاج الذي يمكن أن تحتاجينه أثناء الحمل

1- جيدة جدا 2- جيدة 3- قليلة 4- لم أتلقى معلومات

48- هل قدمت لك معلومات حول الولادة

1- نعم 2- لا (إذا كان نعم أجبني السؤال 49)

49- المعلومات المقدمة لك حول الولادة

1- جيدة جدا 2- جيدة 3- قليلة 4- لم أتلقى معلومات

50- هل قدمت لك معلومات حول الرضاعة, ووسائل تنظيم الأسرة

1- نعم 2- لا (إذا كان نعم أجبني السؤال 51)

51- المعلومات المقدمة لك حول الرضاعة, ووسائل تنظيم الأسرة

1- جيدة جدا 2- جيدة 3- قليلة 4- لم أتلقى معلومات

52- تتلقي جوابا أو تفسيراً لأي أمر تطلبه حول الخدمة أو الحمل

1- بشكل جيد جدا 2- بشكل جيد 3- بشكل قليل

53- يترك المجال مفتوحاً وبدون مقاطعة للأسئلة التي تسألها

1- بشكل جيد جدا 2- بشكل جيد 3- بشكل قليل

54- يجاب على أسئلتك بشكل مرضي

1- بشكل جيد جدا 2- بشكل جيد 3- بشكل قليل

55- تقدم لك النصائح والاستشارة بلغة واضحة ومفهومة

1 - بشكل جيد جدا 2- بشكل جيد 3- بشكل قليل

56- يقدم لك الشرح والتوضيح والاستشارة حتى لو لم تطلبي ذلك

1 - بشكل جيد جدا 2- بشكل جيد 3- بشكل قليل

57- يستمع مقدمي الخدمة لك باهتمام لما تقولين

1 - بشكل جيد جدا 2- بشكل جيد 3- بشكل قليل

58- هل تقدم النصيحة والاستشارة الطبية للسيدة الحامل في مكان مخصص لذلك داخل العيادة

1 - نعم 2- لا

### ❖ العلاقة والاتصال بين مقدم الخدمة والسيدة الحامل

59- هل العلاقة بينك كسيدة حامل متلقية للخدمة و بين مقدم الخدمة

1 -جيدة جدا 2- جيدة 3- عادية

60- تشعرين أنه يتم الترحيب بك عند قدومك لتلقي الخدمة

1 - بشكل جيد جدا 2- بشكل جيد 3- بشكل قليل

61- يتم التعامل باحترام وجدية مع الشكوى المقدمة منك

1 - بشكل جيد جدا 2- بشكل جيد 3- بشكل قليل

62- يتم طمأنتك حول اللقاء وسرية المعلومات التي تقدميها

1 - بشكل جيد جدا 2- بشكل جيد 3- بشكل قليل

63- يتم الحفاظ علي خصوصيتك وخصوصية المكان عند فحصك

1- نعم 2- لا

64- تحصل مشادات كلامية بينك وبين مقدم الخدمة

1- نعم 2- لا

65- تقدم لك النصيحة بالتوجه لمركز صحي مناسب لتلقي خدمة غير متوفرة في العيادة

1- نعم  
2- لا

66- أنصح قريباتي وصديقاتي بتلقي الخدمة في هذه العيادة

1- نعم  
2- لا

67- أنوي الاستمرار في تلقي الخدمات في هذه العيادة

1- نعم  
2- لا

• ما هو أكثر شيء أحببتيه في العيادة

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• ما هو أكثر شيء كرهتيه في العيادة

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