

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



**Women's Evaluation of Prenatal Care at the
Governmental Health Centers in the
Southern Gaza Governorates**

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Msc. Thesis

Jerusalem – Palestine

1440 / 2019

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Governmental Health Centers in the
Southern Gaza Governorates**

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A Thesis Submitted in Partial Fulfillment of
Requirements for the Degree of Master of Maternal Child
Health Nursing

1440 / 2019

Al-Quds University

Deanship of Graduate Studies

Maternal Child Health /Nursing Department



Thesis Approval

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Jerusalem – Palestine

1440 / 2019

Dedication

This Thesis is dedicated to my dear late father and my affectionate mother, actually I wanted to make my father happy for my master degree upon finished, but this is the Fate and destiny, God's Mercy on him. They have lost my endure love due to my study and they did not spare any efforts to pray for me, give me unlimited support during my study. Without their encouragement and understanding it would have been impossible for me to finish this work.

Thanks to my lovely man who did everything easy for me, he is a model of great strength and love and praying for me every time.

Thanks to all my brothers and sisters, they were always supporting me and encouraging me with their best wishes.

Thanks to my spirit of my martyr brother, my daughter Salma.

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 study (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Signed

Asmaa Essa Abdulhadi

Date: / / 2019

Acknowledgment

I highly express my appreciation to all people who gave me assistance in one way or the other in my master thesis. I highly appreciate my supervisors Dr. Samer Alnawajha for his continued guidance and support. I also acknowledge the support given by all lecturers at AlQuds University, faculty of health professions, nursing department for their teaching and mentorship. Finally I appreciate my classmates and more so my group members for their support and encouragement.

Asmaa Issa Abdulhadi

Date: / / 2019

Abstract

The essence of prenatal care is to prepare women for birth and prevent problems for pregnant women through early detection, alleviation and or management of health problems that affect mothers and babies during pregnancy. The main aim of this study was to assess the prenatal care services in the Southern Gaza Governorates based on the women perspectives. The study adopted cross-sectional design on a non-probability convenience sample of 300 pregnant mothers in the Southern Gaza governorates, in which. The researcher used a validated tool for data collection which is the “quality of prenatal care questionnaire”. Different statistical procedures were used for data analysis including percentages, mean, independent sample t test, and One-way ANOVA.

The study results revealed that the highest mean of women’s evaluation domain of prenatal care was information sharing (74.69%), followed by the domain of support and respect (74.39%). While the lowest mean is the domain of approachability (50.25%). Moreover factors which affected significantly the women’s evaluation of prenatal care include the level of women’s income, prenatal care clinic at the primary health care centers, body mass index, the presence of risk, the presence of gestational hypertension, and residence.

The study concluded that the women’s evaluation of prenatal care services in the Southern governorates was not satisfactory especially within two domains: sufficient time provided, and approachability. The researcher recommends conducting workshops at the level of the ministry of health to increase the level of the quality of prenatal care services in the Southern governorates and other governorates. Implementing six approaches of prenatal care: (approach ability, information sharing, respect and support, availability of service, approachability, support and respect), which have been mentioned in the current study, is very important. Further studies should be conducted to reveal other factors which affect the quality of prenatal care services.

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List of Abbreviations

ANC	Antenatal Care
DM	Diabetes Mellitus
FANC	Focused Antenatal Care
HTN	Hypertension
MMR	Maternal Mortality Rate
MoH	Ministry of Health
PCBS	Palestinian Centre Bureau of Statistics
PHC	Primary health care
PHCS	Palestinian Health Care System
QPCQ	Quality of Prenatal Care Questionnaire
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
UNRWA	United Nation Relief and Work Agency
WB	West Bank
WHO	World Health Organization

Chapter One

Introduction

1.1. Background of the Study

Maternal health remains one of the most prominent health challenges in the developing world. According to World Health Organization (WHO), over 300 million women in the developing world experience significant maternal morbidity and 99% of maternal deaths occur in developing countries (Alkema et al., 2016). The essence of prenatal care is to prepare women for birth and prevent problems for pregnant women, mothers and babies through early detection, alleviation and or management of health problems that affect mothers and babies during pregnancy (Lincetto et al., 2010). Prenatal care is an important determinant of safe delivery and represents a key opportunity for reaching pregnant women with services that can improve their health and the health of their unborn baby (Biza et al., 2015).

The success of any prenatal care depends on its policy formulation and implementation (Arthur, 2012). It also depends on functional and operational continuum of care with affordable, accessible, high quality care during and after pregnancy and childbirth (Ajayi and Osakinle, 2013). For prenatal care programme to be effective, important components of prenatal care must be provided (Arthur, 2012). While increased prenatal care coverage is a welcome development, prenatal care coverage alone cannot guarantee success of such services. Besides increase in coverage of prenatal care services, provision of quality prenatal care services will have the greatest impact on women accessing these services (Alkema et al., 2016).

It is not sufficient for a pregnant woman to visit prenatal care facility; she must meet minimum requirements and be offered necessary components of prenatal care. Although there is no consensus on the indicators for quality of prenatal care (Lincetto et al., 2010), it may include early initiation and having four or more prenatal care visits and coverage of essential interventions delivered through prenatal care services (Ajayi and Osakinle, 2013). Skill of prenatal care providers, staff motivation, budgetary provisions, integration with other health programmers and availability of consumables, drugs and basic equipment can seriously impact on the quality of prenatal care services (Kyei et al., 2012). A recently

concluded study found that good quality prenatal care was higher for women attended to by skilled providers (Lincetto et al., 2010), such studies are not available in the Gaza Strip where there is a limited infrastructure and deteriorated healthcare services due to limited financial resources and other important resources. Therefore, the main aim of the current study is to assess the prenatal care services in the Southern Gaza Governorates based on the women perspectives.

1.2. Research Problem

Inadequate prenatal care in terms of coverage, quality, and information sharing, anticipatory guidance, sufficient time, approachability, and availability of the provider; has been associated with adverse pregnancy outcomes (Titaley et al., 2010). Based on joint health sector assessment report in Gaza Strip, preterm labor increased and forming additional burden on maternities and neonatal care units, this may reflect inadequate prenatal care among women, also the report indicated severe decline in prenatal care in Gaza Strip (Gaza Strip Joint Health Sector Assessment Report, 2014). On the other hand, although maternal mortality ratio (MMR) is impacted by many causes including obstetric, social, cultural and economic factors, adequate use of prenatal care could contribute to reduction of the ever high MMR (Ajayi and Osakinle, 2013).

Prenatal care in Palestine especially in the Gaza Strip is covered, while its coverage is a welcome development, prenatal care coverage alone cannot guarantee success of such services. While patient satisfaction has been the focus of many previous studies related to prenatal care and number of appointments attended, there is a need for evaluation of the quality of prenatal care standards based on the components which were mentioned previously (Nair et al., 2014).

Consequently, there is a need to take a detailed look at the content and quality of prenatal care and not simply the number of appointments attended (Nair et al., 2014). Also, the importance of women's evaluation of prenatal care cannot be over emphasized in terms of utilization of prenatal care services. Also, it would be expected that in a developing country like Palestine, many factors which inhibit prenatal care utilization, among which are; financial constraints, siege and political division, these play a fundamental role in the quality of prenatal care as well as the difficulties faced by the nurses during providing it.

More importantly, to the best of the researcher's knowledge; there have been no studies in the Gaza Strip which considered the "women's evaluation of prenatal care with the above mentioned components", women's opinions are considered very important and the ignorance of their opinions regarding these components will have adverse outcome in terms of pregnancy, delivery and health care system. Moreover, studies on prenatal care in low income countries such as Palestine have mainly focused on monitoring quantifiable data such as the number of antenatal visits during prenatal care and its effects on pregnancy outcome (Demographic Health Survey, 2013).

1.3. Justification of the Study

The success of any prenatal care depends on its policy formulation and implementation (Arthur, 2012). Prenatal care also depends on functional and operational continuum of care with high quality care (Ajayi & Osakinle, 2013). Also, for effective prenatal care, important components must be provided, so, coverage is not only the issue. Besides increase in coverage of prenatal care services, provision of quality of it will have the greatest impact on women accessing these services. This study will highlight the importance of women evaluation of the quality of prenatal care services, also the study will highlight that it is not sufficient for a pregnant woman to visit prenatal care facility; she must meet minimum requirements and be offered necessary components of prenatal care.

The components of prenatal care services that have been studied in this study are information sharing, anticipatory guidance, sufficient time, approachability, and availability of the provider. These components have not been studied elsewhere in the Gaza Strip, so it was necessary for the researcher to highlight the importance of these components for the policy makers at ministry of health and other providers in Gaza Strip. The study results might stimulate the health care system in Palestine to consider the quality of prenatal care and the above mentioned components to be implemented in it. Thus it might have its benefits on the pregnancy outcomes and later on the woman wellbeing.

More importantly, the results of this study might have its benefits on multi levels. Based on women's opinions, the study results may explore some shortfalls and gaps in providing prenatal care, thus it may stimulate the health care system and the key persons in the ministry of health to make some improvement in the overall system of prenatal care service. Also, the study results may give alarm saying that the prenatal care protocol in the Gaza Strip need to be improved. Moreover, the study results might have its benefits on the

nurses' level, it may explore some difficulties which have not been explored elsewhere in the Gaza Strip, detection of these difficulties will make easier opportunity for overcome some of it.

1.4. Main aim of the Study

The main aim of this study is to assess the prenatal care services in the Southern Gaza Governorates based on the women's perspectives.

1.5. Objectives of the Study

1. To assess the prenatal care services in the Southern Gaza Governorates in terms of sufficient time provided, availability of the service, information sharing, approachability, anticipatory guidance, and support and respect.
2. To compare the women's evaluation of the prenatal care between different governmental primary health care centres in Southern Governorates.
3. To determine the differences in the women's evaluation of the prenatal care with regard to different maternal socio-demographic characteristics.
4. To provide recommendations for the policy makers to improve the prenatal care and overcoming the difficulties during providing such care.

1.6. Research Questions

1. To what extent are the prenatal care approaches (sufficient time provided, availability of the service, information sharing, approachability, anticipatory guidance, and support and respect) are applied in the Southern Gaza Governorates?
2. Is there a significant difference in the women's evaluation of prenatal care among governmental primary health care centers in Southern Gaza Governorates?
3. Is there a significant difference in the women's evaluation of prenatal care with regard to their different maternal ages?
4. Is there a significant difference in the women's evaluation of prenatal care with regard to their residence?
5. Is there a significant difference in the women's evaluation of prenatal care with regard to their different educational levels?
6. Is there a significant difference in the women's evaluation of prenatal care with regard to their different levels of income?

7. Is there a significant difference in the women's evaluation of prenatal care with regard to their different body mass index?
8. Is there a significant difference in the women's evaluation of prenatal care with regard to maternal risk during pregnancy?
9. Is there a significant difference in the women's evaluation of prenatal care with regard to the presence of disease during pregnancy?

1.7. Context of the Study

The Palestinian territories consist of two politically separated areas West Bank and Gaza Strip. Gaza strip is a narrow zone of land bounded of the south by Egypt, on the west by the Mediterranean Sea, and on the east and north by the occupied territories in 1948. Gaza strip is very crowded place with 46 kilometers long and 5 –12 kilo-meters wide and with a total area of 365 km². Gaza strip is administratively divided into five governorates: North, Gaza, Mid-zone, Khanyounis and Rafah. It consists of four cities, fourteen villages and eight refugees' camps (Palestinian central bureau of statistics {PCBS}, 2016).

1.7.1. Gaza Strip

Gaza Strip has a population of 1,899,291 people. Population density is 5,154 inhabitants per sq. km². Gaza Strip has an extremely high population growth rate of over 3.3% and a fertility rate of 3.8, and as a result some 44.2% of the population is under the age of 15 (PCBS, 2017).

1.7.2. Palestinian Health Care System

The Palestinian Health Care System (PHCS) is consists of four major providers: Ministry of Health (MOH), United Nation Relief and Work Agency (United Nations Relief and Works Agency [UNRWA]), Non-Governmental Organizations (NGOs) and for profit private sector .The main provider MOH is operating 27 hospitals (14 in West Bank and 13 in Gaza Strip) and 743 PHC facilities (583 in WB and 160 in Gaza Strip). Another main component UNRWA is operating 65 PHC facilities (Health Annual report, 2018).

1.7.2.1. Primary Health Care Centres

Primary health care (PHC) is a major component of Palestinian health care system. PHC provides preventive, promotional, curative and rehabilitative health care to all Palestinian

people especially for children and other vulnerable groups through MOH, UNRWA, non-governmental and private centers. PHC centers try to offer accessible and affordable health services for all Palestinians regardless of geographical locations. According to MOH policy, PHC centers classified from level I to level IV according to health services they provided. The total number of governmental PHC centers in the Gaza Strip is 54, and there are 65 PHC centers operated by UNRWA, while the total number of military health centers is 20 (Health Annual report, 2018).

1.7.2.2. Mother and Child Health (MCH) Services

In 2017, the total number of pregnant visits to PHC centers was 154,251. The total number of pregnant women registered (first visit) in the PHC at MoH centers was 34,032, with coverage of 43.6% of pregnant women; the average visit rate for pregnant women to the centers during pregnancy was 4.5 visits (Health Annual report, 2018)

Moreover, in 2017, 5,597 pregnant women were referred to high risk pregnancy clinics which constituted 16.4% of total pregnant women registered in different MoH MCH clinics, while the total visits to high risk pregnancy centers amounted to 29,495 during the same period. Jericho & Al Aghwar Governorates recorded the highest rate of referral to HRP clinics, which reached 25.3% of the total number of registered pregnant women. While Al-Dhahiriya Center recorded the lowest rate of referral to HRP clinics, which amounted to 8.7% of all pregnant women registered (Health Annual report, 2018).

1.8. Operational definitions of terms

1.8.1. Prenatal care

It is a routine health care, which is provided for the woman during pregnancy and before labor, which is credited in the southern primary health care centers mainly at prenatal clinics.

1.8.2. Women's evaluation of prenatal care

The researcher defined and adopted the women's evaluation of prenatal care from Heaman et al. (2014) and Donabedian (2005) as the mother opinion toward the structure, process and outcome of the prenatal care provided, measured by the total score of their opinions

toward six domains in the questionnaire, including: sufficient time, availability, information sharing, approachability, anticipatory guidance, and support and respect.

1.8.3. Sufficient time

The time that the health care provider spends with the mother answering her questions and the actual length of the appointment in governmental prenatal clinics, it is measured by the participants' answers of their opinions toward this domain.

1.8.4. Availability

Is the knowledge of how to contact the mother's health care provider and the ease of communication and availability of governmental prenatal clinic staff, it is measured by the participants' answers of their opinions toward this domain.

1.8.5. Information sharing

Defined as ensuring confidentially and sharing of information with the mother to explain tests and results, it is measured by the participants' answers of their opinions toward this domain.

1.8.6. Approachability

The comfort with asking questions with the nurse and health care provider, it is measured by the participants' answers of their opinions toward this domain.

1.8.7. Anticipatory guidance

Defined as the extent to which the mother is prepared and feels to make decisions and knowledge of options. On other wards, the extent to which the health care provider discussed options with the mother for her labor and birth experience, it is measured by the participants' answers of their opinions toward this domain.

1.8.8. Support and respect

Defined as the mother's feeling of respect and support by the nurse and health care provider, it is measured by the participants' answers of their opinions toward this domain.

Chapter Two

Conceptual Framework and Literature Review

2.1. Conceptual Framework

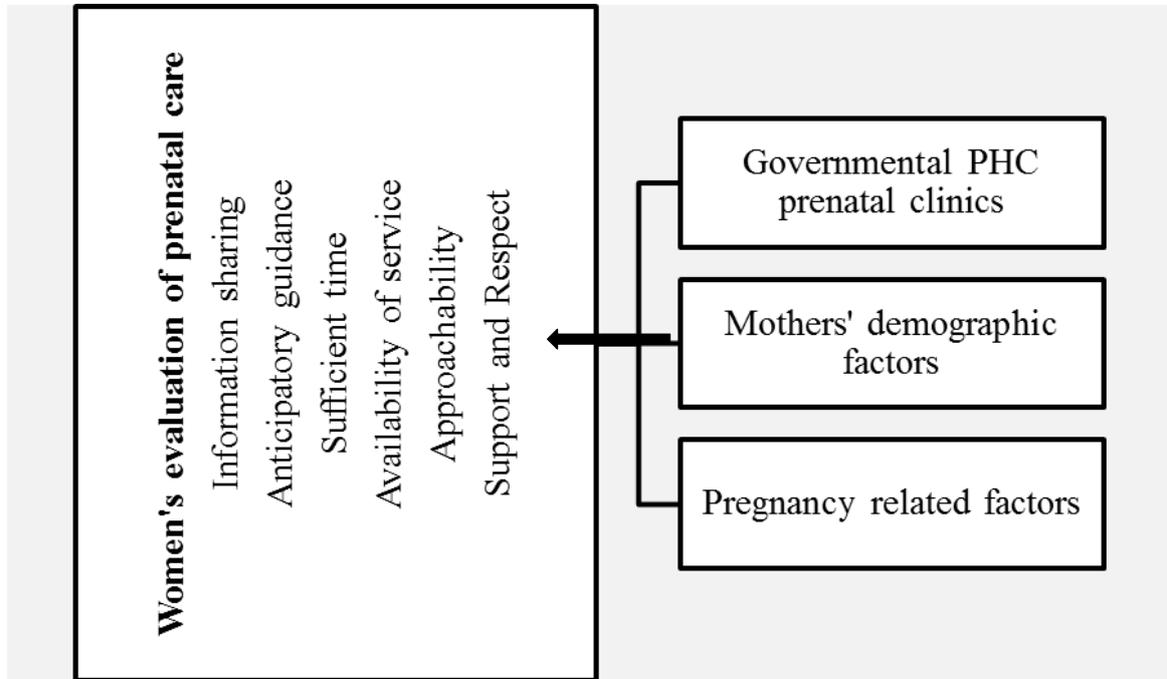


Figure 2.1: Conceptual Framework of the Study (self-developed)

Figure 2.1 clarifies the conceptual framework of the current study; the conceptual framework consists of four domains, the first 3 domains which are placed at the right of the figure; considered independent variables, they are: the governmental primary health care centres, mothers' demographic factors, and pregnancy related factors. The fourth domain which is placed at the left of the figure; is considered as the dependent variable which is the women's evaluation of prenatal care services (information sharing, anticipatory guidance, approachability, support and respect, availability of service, and sufficient time provided).

2.2. An Overview

Prenatal care is an important part of preventive medicine and professionals providing this service can reduce the risk of complications through education, counseling and various interventions (United Nations Population Fund [UNFPA], 2013). For many years, high standards of care were considered a luxury particularly in developing countries where

service coverage was largely inadequate (Nwaeze et al., 2013). Women's evaluation of prenatal care and its visits significantly influence their assessment of quality of services that are provided (Kamil and Khorshid, 2013). As a result of this new focus, measurement of customer satisfaction has become equally important in assessing system performance (Nwaeze et al., 2013).

Prenatal care can reduce maternal and perinatal morbidity and mortality directly through the detection and treatment of pregnancy-related illnesses, and indirectly through the identification of women at increased risk of delivery complications (Biza et al., 2015). Adesokan (2010) describes prenatal services as the attention, education, supervision and treatment given to the pregnant women from the time conception is confirmed until the beginning of labour, in order to ensure safe pregnancy, labour and puerperium. Also, prenatal care is also an opportunity to promote the use of skilled attendance at birth and healthy behaviours such as breastfeeding, early postnatal care, and planning for optimal pregnancy spacing (Idang et al., 2015).

According to de Jongh et al. (2016), integrated prenatal care service delivery results in improved uptake of essential health services for women, earlier initiation of treatment, and better health outcomes. Moreover, providing prenatal care has positive impact on the utilization of postnatal healthcare services and improves use of skilled birth attendance services (Anastasi et al., 2015). Therefore; prenatal care provides an entry for interventions which give health workers the opportunity to detect risky conditions that need further interventions and accordingly refer them for early management which will lead to better maternal and neonatal outcomes (Afulani, 2015).

Prenatal care provision and accessibility is generally good in Palestine (Yousef, 2016). This is also true for women living in the Gaza Strip, as antenatal care is provided free of charge at the primary health care centers that belong to the Palestinian Ministry of Health or UNRWA.

2.3. Prenatal Care

The prenatal care is the care of a woman during pregnancy and before labor is credited with the reduction of perinatal mortality over the last 50 years (Zolotor and Carlough, 2014). Prenatal care seeks to mitigate risks and promote positive maternal and neonatal outcomes (National Institute of Child Health and Human Development , 2017). The earlier

prenatal care is begun, the better (March of Dimes, 2014). This provides an opportunity for the health care provider to obtain baseline data on physical assessments and laboratory test results. Women who do not seek prenatal care in a timely fashion often have an underlying mental illness or substance abuse problem, or may be in denial of their pregnancy (Friedman et al., 2009).

This averages out to about 1 in 9 infants (11.3% of live births) born to women receiving inadequate prenatal care in the United States while 1 in 28 (3.6%) women received late or no prenatal care (March of Dimes, 2014). The goals of prenatal care are: 1) A healthy, prepared mother having minimal discomforts, 2) Identification of potential problems or complications as early as possible, 3) Safe delivery of a healthy infant, 4) A prepared father or partner who participates as much or as little as the couple desire and 5) Prepared siblings and grandparents (Simpson and Creehan, 2007).

National objectives and quality measures, such as Healthy People 2020 and the Healthcare Effectiveness Data and Information Set (HEDIS), feature similar goals for quality prenatal care. These goals include improved timeliness of care and adequate attendance to visits and postpartum care (Healthy People 2020, 2018). Furthermore, in 2017, UNRWA in the Gaza Strip registered over 28,000 new enrolments in its pre-conception care programme. This figure is higher compared to the year 2016 (20,000) and exceeds the Agency-wide target of 20,000 new enrolments, also 98.7% of pregnant women made four antenatal care visits to UNRWA Health centres and 99.9% of women attended post-natal care appointments within six weeks of delivery (UNRWA, 2018).

2.3.1. Initial Visit

The timing of initiation of the first antenatal care visit is paramount for ensuring optimal care and health outcomes for women and children. Globally, there has been a change in the pattern and type of obstetric outcomes, as a greater proportion of deaths and morbidities are related to complications of pre-existing medical conditions, namely indirect conditions, in a phenomenon described as the obstetric transition (Moller et al., 2017). An early antenatal care visit gives the opportunity to provide screening and tests that are most effective early in the pregnancy i.e., correct assessment of gestational age to allow for accurate treatment of preterm labor, screening for genetic and congenital disorders, provision of folic acid supplementation to reduce the risk of neural tube defects, and

screening and treatment for iron deficiency anemia and sexually transmitted infections (Souza et al., 2014).

Additionally, the visit can potentially capture non-communicable diseases such as diabetes and provide guidance on modifiable lifestyle risks such as smoking, alcohol consumption, drug abuse, obesity, malnutrition, and occupational exposures (European Board and College of Obstetrics and Gynecology “EBCOG” Scientific Committee, 2015). All these conditions can be detected and treated if early, timely, and high-quality antenatal care is provided, but beyond the content the antenatal care services need to be available, accessible, and acceptable (Zolotor and Carlough, 2014).

A comfortable environment, open communication, and the nurse’s attitude will help put the woman at ease during the initial antenatal visit. The first visit is often quite lengthy. A complete history is recorded to identify factors that may negatively affect the pregnancy and a physical examination is performed (White et al., 2011).

2.3.1.1. Comprehensive Health History

During the initial visit, a comprehensive health history is obtained, including age, menstrual history, prior obstetric history, past medical and surgical history, family history, genetic screening, lifestyle and health practices, medication or drug use, and history of exposure to sexual transmitted diseases (Jarvis, 2012). Often, use of a prenatal history form is the best way to document the data collected. The initial health history typically includes questions about three major areas: the reason for seeking care; the client’s past medical, surgical, and personal history, including that of the family and her partner; and the client’s reproductive history. During the history-taking process, the nurse and client establish the foundation of a trusting relationship and jointly develop a plan of care for the pregnancy. Tailor this plan to the client’s lifestyle as much as possible and focus primarily on education for overall wellness during the pregnancy. The ultimate goal for the first prenatal visit is to collect baseline data about the woman and her partner and to detect any risk factors that need to be addressed to facilitate a healthy pregnancy (Jarvis, 2012).

2.3.1.2. Physical Examination during Prenatal Care

The initial physical examination provides the baseline for evaluating changes during future visits. The physical examination begins with measuring the client’s height and weight and vital signs. A head-to-toe examination is performed by the health care provider. Special

attention is given to the assessment of the heart, lungs, pelvis, breasts, and nipples. The pelvic examination is performed last. The external genitalia are examined for scars, lesions, or infection. A Pap smear for cervical cancer and a specimen of cervical mucus for gonorrhoea are usually obtained. A bimanual examination is performed to determine uterine changes and pelvic size to estimate adequacy of the pelvic opening for delivery (White et al., 2011).

The pelvic examination provides information about the internal and external reproductive organs. In addition, it aids in assessing some of the presumptive and probable signs of pregnancy and allows for determination of pelvic adequacy (Chow et al., 2013). During the pelvic examination, the mother must remain in the examining room to assist the health care provider with any specimen collection, fixation, and labeling. Throughout the examination, explain what is happening and why, and answer any questions as necessary. Pelvic size is estimated by the examiner during the manual examination. The diagonal conjugate (distance from the lower border of the pubic symphysis to the sacral promontory) is an estimate of the pelvic inlet. It is generally 11.5 cm. The anteroposterior diameter (9.5 to 11.5 cm), measured from the lower border of the pubic symphysis to the tip of the sacrum, is an estimate of the pelvic outlet (Ricci et al., 2013).

2.3.1.3. Screening tests

During the first visit, screening tests are performed to determine the mother's health and to have baseline data with which to compare subsequent test results. Other screening tests are gestational age dependent and are ordered at a later time in antenatal pregnancy. Tests may vary for a specific client but generally include complete blood count, haemoglobin, blood type, Rh factor, urinalysis, blood glucose and other tests (Katorza and Achiron, 2012).

2.3.2. Return visits

Return visits for an uncomplicated pregnancy generally are: 1) Every 4 weeks for the first 28 weeks, 2) Every 2 weeks during weeks 29 to 36 and 3) Every week, after 36 weeks, until birth of infant (White et al., 2011).

2.4. World Health Organization's 2016 Prenatal Care Model

The 2016 WHO prenatal care model aims to provide pregnant women with respectful, individualized, person centred care at every contact and to ensure that each contact delivers

effective, integrated clinical practices (interventions and tests), provides relevant and timely information, and offers psychosocial and emotional support by practitioners with good clinical and interpersonal skills working in a well-functioning health system. Given evidence that perinatal deaths increase with only four prenatal care visits and that an increase in the number of prenatal care contacts, regardless of the country, is associated with an increase in maternal satisfaction, WHO recommends a minimum of eight contacts: five contacts in the third trimester, one contact in the first trimester, and two contacts in the second trimester (World Health organizations, 2016).

Table 2.1: 2016 WHO Prenatal Care Model

Trimester	Contacts
First trimester	Contact 1: up to 12 weeks
Second trimester	Contact 2: 20 weeks Contact 3: 26 weeks
Third trimester	Contact 4: 30 weeks Contact 5: 34 weeks Contact 6: 36 weeks Contact 7: 38 weeks Contact 8: 40 weeks
Return for delivery at 41 weeks if not given birth.	

Source: World Health organizations (2016)

WHO assumes each country will tailor the new model to its context based on the country's defined core package of prenatal care services and consensus on what care is provided at each contact, who provides prenatal care, where care is provided (which system level), and how care is provided (platforms) and coordinated across all eight prenatal care contacts (Blencowe et al., 2016).

2.5. The Importance of Prenatal Care

There are many causes of maternal death around the globe especially in developing countries. These causes include hypertensive disorders, anemia, hemorrhage, obstructed labor, unsafe abortion, ectopic pregnancy and specific chronic nutritional deficiencies (Chow et al., 2013). Routine monitoring of women during their pregnancy can prevent

death from these complications (Ekabua et al., 2011). For example, a pregnant woman's blood pressure can be monitored during her pregnancy through an ultrasound examination; severe anemia due to deficiencies in iron and foliate can be corrected by introducing iron and folic acid into the mother's diet; and dietary interventions during pregnancy can help to reduce the risk of gestational weight gain (Thangaratinam et al., 2012).

Parental care services therefore present opportunities to provide pregnant women with interventions that are essential to their health and their welfare (Ejigu et al., 2013). Parental care is also used as an opportunity to educate women about the hazards and symptoms that might place them at risk during their labour and delivery (Paudel et al., 2013). For example, pregnant women are usually advised about their deliveries based on their pregnancy situation (vaginal delivery vs caesarean section) (Pell et al., 2013). Women are advised of the importance of delivering with professional assistance and skilled health personnel, as well as the spacing of births, which improves their health and infant survival (Dowswell et al., 2010). On the other hand, tetanus immunization during pregnancy is very essential and parental care is used to protect pregnant women and infants from tetanus (Babalolf, 2014).

2.6. Nurses' Role during Prenatal Care

Nurses play a key role in providing a high quality of maternal services throughout the prenatal period and childbirth that contribute to reduce maternal and perinatal death (Zauderer, 2009). Trinh and colleagues (2007) stated that the prenatal care provider such as a nurse has a great impact on the quality of care. Nurses should have moral, ethical and professional responsibility to provide care to pregnant women (White et al., 2011). They are responsible for care giving, providing up-to date health education and listening to clients' suggestions about the services which women need (Ricci et al., 2013).

To identify those needs, the nursing process is the accepted framework used for assessing, analyzing, planning, implementing and evaluating nursing care (Zauderer, 2009). Nurses can take complete health history, perform physical examinations, order and interpret laboratory investigations, and provide primary care for health maintenance and promotion. Based on this framework, nurses' role in prenatal care is: (1) assessment, (2) analysis, (3) planning, (4) implementation and (5) evaluation (White et al., 2011).

2.7. Quality of Prenatal Care

In the health care system, quality is one criterion for good care. As well as quality of prenatal care, it reflects values and goals. Below standard quality contributes high maternal death especially among those who have easy access health care services (Fawole et al., 2008). Pregnant women should receive clear and complete information regarding their condition of pregnancy and care provision (Sword et al., 2012). At the prenatal clinic, nurses need to provide prenatal care based on the client-oriented personal holistic approach (Sword et al., 2013). Quality of prenatal care is the standard of care regularly monitored by trained health personnel. Pregnant women need to initiate prenatal consultation from the first trimester. At least four prenatal consultations are needed with a doctor or a nurse (Sword et al., 2013). Quality of prenatal care is focused on the nurse's role regarding two dimensions technical care and interpersonal care. Technical care in this study was focused on the nurse's assessment and provision of health education to the pregnant women; and interpersonal care focused on giving them a feeling of psychological well-being (Pajnkihar, 2009).

In light of this evidence that suggests the importance of quality of care and evidence that reducing the frequency of prenatal visits for low-risk healthy women does not adversely affect maternal or neonatal outcomes, the need for the usual 14 to 16 visits recommended by some professional organizations has been questioned (Sword et al., 2012). In fact, a recommended schedule of fewer visits for such women was proposed over 20 years ago by an expert panel of the United States (U.S) Public Health Service's Low Birth Weight Prevention Work Group. This recommendation was based on the assumption that high quality care is offered (Ricci et al., 2013).

There is no agreement, however, as to what constitutes quality prenatal care. The list of nine indicators of quality prenatal care developed by a working group of the Royal College of Obstetricians and Gynaecologists reflect very defined medical aspects of care for example: Rhesus antibody screening, detection of and use of external cephalic version for breech presentation, steroid administration in preterm delivery (Sword et al., 2012). Adherence to evidence-based clinical practice guidelines that are both applicable to the population of childbearing women and to midwifery practice has been suggested as a strategy to maintain quality in antenatal care delivered by midwives (Tillett, 2009).

Kirkham, Harris, and Grzybowski similarly proposed that prenatal care should be based on "the best available evidence" but added that this evidence should be integrated "into a model of informed, shared decision making" (Souza et al., 2014). While noting that medical procedures are important, Alexander and Kotelchuck suggested that parameters for assessing quality of prenatal care should take into account the provision of health education, assessment of the need for and referral to ancillary services (e.g., nutrition support, social services), and the nature of patient-provider-system interactions (Alexander and Kotelchuck, 2001).

Given the wide variation in opinions about the essential elements of quality prenatal care, the inconsistency in approaches to assessing quality of prenatal care in the published literature is not surprising. Research in this area has largely been a theoretical, few studies have considered women's perspectives, and much of the focus has been on medical or clinical aspects of care to the exclusion of interpersonal processes. Moreover, studies seeking to examine the relationships between quality of prenatal care and perinatal outcomes have been hindered by the lack of a theoretically-grounded and psychometrically-tested instrument (Sword et al., 2012).

As a first step in instrument development, semi-structured interviews were conducted with women and prenatal care providers to ascertain their views of quality care. Understanding what patients value is particularly critical in a prenatal care context as engagement of women in care is important for early initiation and continuation of care over a relatively short time period for health promotion, prevention of adverse outcomes, and early identification of and intervention for health risks (Wheatley et al., 2008). Additionally, there is evidence that engagement in prenatal care is predictive of future use of preventive health services, including well-child care (Sword et al., 2012).

2.8. Theoretical Framework of Prenatal Care for this Study

The theoretical framework of Donabedian's guides the quality of prenatal care developed in 1966. The quality of prenatal care has been utilized in various nursing research studies including one study focused on outcomes of preconception care and another on the quality of prenatal care questionnaire instrument development. Donabedian (2005) attests to the abstract nature of the concept of quality noting that quality may be almost anything anyone wishes it to be. Donabedian stated that in order for quality improvement to occur there must be a known connection between structure, process, and outcome (Donabedian, 2005).

The model focuses on a three-part approach to quality assessment that includes structure, process, and outcome. The first arm, titled structure, focuses on the particulars of the setting where the prenatal care occurs. Process, the second arm, is what actually occurs during the giving of care. Outcomes, the third arm of the quality of prenatal care, seek to identify the result of the care. The outcomes arm involves measurement of patient knowledge, behaviors, and patient satisfaction with care. This framework was chosen for the study as it was utilized in the development of one of the primary tools, which is the quality of prenatal care questionnaire (Heaman et al., 2014).

Structure was evaluated through collection of data on the health care system which, for this particular study, will focus on which method of prenatal care the participant has chosen as well as quality of prenatal care. The Quality of Prenatal Care Questionnaire (QPCA) was developed to measure the structure and process aspects of the framework as it related to the actual provision of care. The QPCQ has two factors which speak directly to structure of quality of care.

Sufficient time is defined as the time that the provider spends with the patient answering questions and the actual length of the appointment. Availability is considered structural and is defined as the knowledge of how to contact the patient's provider and the ease of communication and availability of office staff (Heaman et al., 2014).

Process was evaluated by measuring the interpersonal relationship between patient and provider, including clinical aspects of process such as health promotion and illness prevention, screening, shared information, continuity of care, non-medicalization of pregnancy, and women-centeredness (Sword et al., 2012). More specifically, the QPCQ has four factors that speak directly to measurement of the process of quality of care; information sharing, anticipatory guidance, approachability, and support and respect (Sword et al., 2013).

Information sharing and anticipatory guidance are both focused on clinical and technical processes. Information sharing is defined as ensuring confidentiality and sharing of information to explain tests and results. How prepared the patient feels to make decisions and knowledge of options are covered by anticipatory guidance. The interpersonal process aspect is covered by approachability and support and respect in the QPCQ. Approachability is defined within this study, as the comfort with asking questions of the

provider. Support and respect, which are addressed by the largest number of survey items, are defined as feeling respected and supported by the provider (Heaman et al., 2014).

2.9. Women's Evaluation of Prenatal Care Services

The content and quality of prenatal care have been measured in different ways. For example, Beeckman and colleagues recently developed the Content and Timing of Care in Pregnancy (CTP) tool to assess women's receipt of recommended content based on recommendations in national and international guidelines. Participants recorded the timing and content of prenatal care using diaries. These investigators concluded the content items need further refinement prior to larger scale testing of the new measure (Beeckman et al., 2008). Content has also been measured in studies that examined the effect of adherence to recommended prenatal care content, assessed from medical records, on pregnancy outcomes (Handler et al., 2012).

Other studies have investigated the impact of enhanced or augmented prenatal services or new models of care, such as group prenatal care, on outcomes (Ruiz-Mirazo et al., 2012). The quality of prenatal care has been evaluated using focus groups to explore quality as experienced by women (Goberna-Tricas et al., 2011), developing audit indicators of quality of prenatal care, or using checklists, observations and exit interviews (Goberna-Tricas et al., 2011). Wong and colleagues developed an instrument to measure the quality of interpersonal processes of care, but this instrument measures only one dimension of quality. To date, research on the effectiveness of prenatal care has been hindered by the lack of an instrument that comprehensively measures quality of prenatal care (Heaman et al., 2014).

Assessment of prenatal care has focused primarily on women's satisfaction, but often without clear distinction between the constructs of satisfaction and quality of care. Research to empirically test the relationships between these variables provides evidence that perceived quality affects satisfaction with health care, and that quality of care and consumer satisfaction are distinct constructs. Quality is defined as a judgment or evaluation of several dimensions specific to the service being delivered, whereas satisfaction is an affective or emotional response to a specific consumer experience (Vinagre and Neves, 2008).

Satisfaction measures tend to include components that are considered elements of quality, such as structure of service delivery (wait time, continuity of care, physical environment) and process of care (advice received, explanations given by care provider, technical quality of care). These instruments have limitations in that they do not discriminate between quantity and quality of care, generally lack psychometric evaluation, and do not adequately tap varying dimensions of the uniqueness of prenatal care (Handler et al., 2003). Finally, satisfaction measures are insensitive, as most women report high levels of satisfaction with prenatal care, particularly when measured after delivery (Heaman et al., 2014).

Approaches to the assessment of quality of prenatal care have been largely a theoretical. Among the few studies that have based their selection of measures on a theoretical framework, the two frameworks most commonly used were Donabedian's model of quality and A day and Andersen's theoretical framework for the study of access to medical care. The latter model is primarily focused on health service utilization issues (Heaman et al., 2014). There is a need to develop a theoretically-grounded measure of prenatal care quality that is distinct from satisfaction measures in order to better evaluate the relationship between quality of prenatal care and pregnancy outcomes. The conceptual framework guiding the quality of antenatal care was done using Donabedian's systems-based model of quality health care. The framework encompasses a three-part approach to quality assessment, in which "good structure increases the likelihood of good process, and good process increases the likelihood of a good outcome" Structure includes attributes of the setting in which care is provided, such as material and human resources and organizational structure (Heaman et al., 2014)

The process component reflects the actual care given. There are two processes of care: clinical or technical, and interpersonal. According to Donabedian, the goodness of technical performance should be judged in comparison with best practice, while interpersonal process is the vehicle by which technical care is implemented and includes information exchange, privacy, informed choice, and sensitivity (Campbell et al., 2000).

In keeping with the findings of qualitative studies that demonstrated the value women place on the interpersonal processes of prenatal care (including communication, decision-making and interpersonal style), recent attention has been focused on the conceptualization of these processes, their measurement, and their impact on women's satisfaction and perception of quality of care. Research has demonstrated that ineffective communication is

a barrier to prenatal care utilization (Heaman et al., 2014). Care provider characteristics, such as lack of perceived concern and respect, being task focused and conveying an authoritarian approach, also deter use of prenatal care (Tandon et al., 2005). These characteristics also can be a barrier to women disclosing health concerns. Thus interpersonal processes are important in keeping women engaged in prenatal care and, ultimately, in enhancing outcomes (Chew-Graham et al., 2009).

The development of an instrument to measure quality of prenatal care can be informed by multiple sources, including the available research evidence regarding effective clinical practices and the perspectives of care providers and women (Heaman et al., 2014). Because quality of care is determined by the structure of service delivery and service-giving processes, it encompasses content dimensions through its attention to the technical (e.g., physical examinations and tests) and interpersonal (e.g., health promotion counseling) aspects of care. Care providers are best positioned to comment on clinical aspects of care, including that which is knowledge-based but does not necessarily have scientific evidence of effectiveness (Heaman et al., 2014).

Heaman et al. (2014) conducted a study to develop and test a new instrument, the QPCQ. Data were collected in five Canadian cities. Items for the QPCQ were generated through interviews with 40 pregnant women and 40 health care providers and a review of prenatal care guidelines, followed by assessment of content validity and rating of importance of items. The preliminary 100-item QPCQ was administered to 422 postpartum women to conduct item reduction using exploratory factor analysis. The final 46-item version of the QPCQ was then administered to another 422 postpartum women to establish its construct validity, and internal consistency and test-retest reliability.

The study results revealed that the exploratory factor analysis reduced the QPCQ to 46 items, factored into 6 subscales, which subsequently were validated by confirmatory factor analysis. Construct validity was also demonstrated using a hypothesis testing approach; there was a significant positive association between women's ratings of the quality of prenatal care and their satisfaction with care ($r=0.81$). Convergent validity was demonstrated by a significant positive correlation ($r=0.63$) between the "Support and Respect" subscale of the QPCQ and the "Respectfulness/Emotional Support" subscale of the Prenatal Interpersonal Processes of Care instrument.

Also, the overall QPCQ had acceptable internal consistency reliability (Cronbach's $\alpha = 0.96$), as did each of the subscales. The test-retest reliability result (Intra-class correlation coefficient = 0.88) indicated stability of the instrument on repeat administration approximately one week later. Temporal stability testing confirmed that women's ratings of their quality of prenatal care did not change as a result of giving birth or between the early postpartum period and 4 to 6 weeks postpartum (Heaman et al., 2014).

The study concluded that the QPCQ is a valid and reliable instrument that will be useful in future research as an outcome measure to compare quality of care across geographic regions, populations, and service delivery models, and to assess the relationship between quality of care and maternal and infant health outcomes (Heaman et al., 2014).

Sword et al. (2012) conducted a qualitative descriptive approach to explore women's and care providers' perspectives of quality prenatal care to inform the development of items for a new instrument, the quality of prenatal care questionnaire. Semi-structured interviews were conducted with 40 pregnant women and 40 prenatal care providers recruited from five urban centres across Canada. The study results revealed that the three main categories informed by Donabedian's model of quality health care were structure of care, clinical care processes, and interpersonal care processes. Structure of care themes included access, physical setting, and staff and care provider characteristics. Themes under clinical care processes were health promotion and illness prevention, screening and assessment, information sharing, continuity of care, non-medicalization of pregnancy, and women-centredness. Interpersonal care processes themes were respectful attitude, emotional support, approachable interaction style, and taking time. A recurrent theme woven throughout the data reflected the importance of a meaningful relationship between a woman and her prenatal care provider that was characterized by trust.

The study concluded that while certain aspects of structure of care were identified as being key dimensions of quality prenatal care, clinical and interpersonal care processes emerged as being most essential to quality care. These processes are important as they have a role in mitigating adverse outcomes, promoting involvement of women in their own care, and keeping women engaged in care. The findings suggest key considerations for the planning, delivery, and evaluation of prenatal care. Most notably, care should be woman-centred and embrace shared decision making as an essential element (Sword et al., 2012).

Nwaeze et al. (2013) evaluated clients' perception of antenatal care quality at the University College Hospital (UCH), Ibadan and determined levels of client satisfaction. Women presenting for antenatal care at the study center were interviewed in a cross-sectional design using a structured questionnaire. The study results revealed that the clinic services were regarded as good in 81.1% of respondents; the only significant association with clients' satisfaction was the desire to register in the same facility in the next pregnancy. The study concluded that there is a high overall level of satisfaction with antenatal services among pregnant women. Policy makers and health providers should however address improvement of amenities, reduction of waiting time and ensure that health interventions are available for all clients (Nwaeze et al., 2013)

Moreover, a study of Fagbamigbe and Idemudia (2013) was conducted to assess the timeliness of the commencement of the visits as well as the quality and relevance of prenatal care services in Nigeria. The researchers used information supplied by the 13410 respondents who claimed to have used the antenatal care (ANC) facilities at least once within five year preceding the 2013 Nigeria Demographic and Household Survey (NDHS).

The study results showed that the measurement of blood pressure and receiving iron supplementation were the most commonly offered antenatal care ANC component with 91.0 %. Only 4.6 % of women received good quality of ANC while nearly 1.0 % did not receive any of the components. Also, about 11.3 % of the attendees had minimum acceptable quality of ANC. Receipt of good quality ANC services was higher among users who initiated ANC early, had at least 4 ANC visits, attended to by skilled health workers, attended government and private hospitals and clinics. Moreover, higher odds of receiving good quality of ANC were found among users who live in urban areas, having higher educational attainment, belonging to households in upper wealth quintiles and attended to by skilled ANC provider.

The study concluded that the levels of desirable and minimum acceptable quality of ANC services were poor in Nigeria thereby jeopardizing efforts to achieve the Millennium Development Goals (MDGs). There is need for intensified commitment by national and state governments in Nigeria as well as other stakeholders to ensure that main components of ANC are received by the users (Nwaeze et al., 2013).

On the other hand Biza et al. (2015) conducted a qualitative study to identify the factors influencing provider uptake of the recommended package of ANC interventions in

Mozambique. This study utilized key informant interviews with stakeholders from the health sector and a total of five focus group discussions with women with experience with ANC or women from the community.

The study results showed that three main groups of factors were identified that hinder the implementation of the ANC package in the study setting: a) system or organizational: include chronic supply chain deficiencies, failures in the continuing education system, lack of regular audits and supervision, absence of an efficient patient record system and poor environmental conditions at the health center; b) health care provider factors: such as limited awareness of current clinical guidelines and a resistant attitude to adopting new recommendations; and c) Users: challenges with accessing ANC, poor recognition amongst women about the purpose and importance of the specific interventions provided through ANC, and widespread perception of an unfriendly environment at the health center. The study concluded that the ANC package in Mozambique is not being fully implemented in the three study facilities, and a major barrier is poor functioning of the supply chain system (Biza et al., 2015).

Also, Dotto et al. (2006) conducted a qualitative study to identify the difficulties nurses experience at the start of their professional life in prenatal care activities. Data were collected through interviews with 25 nurses who accompanied prenatal care in the basic health network in Brazil and were grouped according to the frequency and level of difficulty they mentioned. The researchers observed that the nurses did not demonstrate difficulties in a series of important prenatal care activities at the start of their professional life. However, they reported different levels of difficulties in other activities. Furthermore, the participants pointed out difficulties in activities that require knowledge (knowing) as well as abilities (know-how). This study also indicated flaws in undergraduate formation with respect to prenatal care, involving theoretical aspects as well as exclusively practical activities (Dotto et al., 2006).

Another quantitative cross-sectional study was conducted by Fatil et al. (2016) in Ondo State to evaluate the women and providers' perception, attitude and satisfaction with antenatal care using the new Focused Antenatal care (FANC) model as this information will improve quality of ANC provided for women in Ondo state. The study results revealed that there is a significant relationship between perception and attitude towards FANC among Nurses, and there is a significant difference in the perceived satisfaction among

women in FANC and traditional ANC indicating that the women in FANC are more satisfied.

The study concluded that the benefits of quality maternal health service especially antenatal care cannot be overemphasized. Focused antenatal care practice can be enhanced by establishing link between the community and the health facility in order to increase utilization of the services offered by the new WHO package. Therefore, there is need for the implementation of focused ante natal care at all levels of healthcare delivery system in Nigeria (Fatil et al., 2016).

Additionally, Rurangirwa et al. (2018) conducted a facility-based, cross-sectional study to investigate the ANC providers' current practices in relation to prevention, management and referral of maternal conditions as well as the information provided to pregnant women attending ANC services in Rwanda using an interviewer-administered questionnaire and a structured observation checklist.

The study results revealed that the nurses and midwives in ANC services failed to report a number of pregnancy-related conditions that would need urgent referral to a higher level of health care. Midwives did somewhat better than nurses in reporting these conditions. There was no statistically significant difference in how nurses and midwives informed pregnant women about pregnancy-related issues.

The study concluded that the providers in ANC clinics reported suboptimal practices on conditions of pregnancy that needed urgent referral for adequate management. Information to pregnant women on danger signs of pregnancy, recommended medicines and tests do not seem to be consistently provided. Midwifery training in Rwanda should be expanded so that most of staff at ANC clinics are trained as midwives to help lower maternal and child mortality and morbidity (Rurangirwa et al., 2018).

Furthermore, Edie et al. (2015) conducted an observational analytic cross-sectional study amongst pregnant women attending selected government health centres in the Buea Health District. The study results revealed that one third of respondents (30.1%) attended a health centre out of their catchment health area with Buea Town health centre receiving the highest proportion of women out of the health area (56.8% of attendees). Knowledge about antenatal care varied and majority of respondents (96.4%) were satisfied with the antenatal services received. However, there were elements of dissatisfaction with health centre

services, poor sitting facilities, amenities, few health education talks and poor nursing skills. High educational level (high school and university) and first time pregnancy were significantly associated with poor satisfaction. The study concluded that policy makers should implement changes in the health care delivery system taking into account the users' preferences, more so in the light of increasing female education in Cameroon (Eddie et al., 2015).

Doubova et al. (2014) also conducted a study to develop quality indicators for ANC and to evaluate the quality of ANC in family medicine clinics (FMCs) of Mexico City. The researchers have used a mixed methods approach including: (a) in-depth interviews with health professionals; (b) development of indicators; (c) a retrospective cohort study of quality of care provided to 5342 women aged 12–49 years who had completed their pregnancy in 2009 and attended to at least one ANC visit with their family doctor.

The study results revealed that 14 ANC quality indicators were developed. The evaluation showed that 40.6% of women began ANC in the first trimester; 63.5% with low-risk pregnancy attended four or more ANC visits; 4.4% were referred for routine obstetric ultrasound, and 41.1% with vaginal infection were prescribed metronidazole. On average, the percentage of recommended care that women received was 32.7%. The study concluded that it is feasible to develop quality indicators suitable for evaluating the quality of ANC using routine EHR data. The study identified the ANC areas that require improvement; which can guide future strategies aimed at improving ANC quality (Doubova et al., 2014).

Chapter Three

Methodology

3.1. Introduction

The chapter of methodology illustrates the issues related to methodologies used to answer the research questions, the chapter commences with study design, study population, study setting, period of the study, sample size, sampling, ethical considerations, and statistical methods that have been used.

3.2. Study design

The design of this study is a quantitative cross-sectional. This type of design is useful for describing and analyzing the study construct because it's suitable in term of people, resources and it is relatively practical and manageable.

3.3. Study Setting

This study was carried out at governmental primary health care centers in the southern governorates (Khanyounis and Rafah) mainly at prenatal care clinic services.

3.4. Study population

The target population of this study consisted of the pregnant women's who were attending the prenatal care services at governmental primary health care centers in the Southern governorate during their pregnancy. The total number of pregnant women in the Southern Gaza governorates is 1650 (MoH, 2018).

3.5. Sample size and sampling process

For prenatal care clinics were selected randomly from the governmental health care centers in the Southern Gaza governorates, two governmental health care centers were selected randomly from Rafah and two were selected from Khanyounis. The two which have been selected from Khanyounis are: Khanyounis primary health care center and Bani-Suhaila center, while the two which have been selected from Rafah Governorate are: Rafah primary health care center and Tal-Sultan center. After that, a non-probability convenience

sampling method was applied to select the women who attending the prenatal care services in the selected primary health care centers based on the inclusion and exclusion criteria.

Sample size was calculated by single population proportion formula for cross-sectional studies based on the previous studies and based on the number of study population (power=0.8, CI: 95.0, $\alpha=0.05$). After calculation, the sample was 312, Quota sampling method was applied to select the women from the four selected health care centers, in which 78 women were selected from each primary health care center. In the current study, 300 women have responded to participate in the study with a response rate 96.15%.

3.6. Eligibility Criteria

3.6.1. Inclusion criteria

- Received prenatal care in the PHC centers.
- Women after 20 weeks of their pregnancy.
- No previous prenatal care done outside the current pregnancy confirmation visit
- No prior fetal demise (death after 20 weeks' gestation)
- Carrying a singleton pregnancy.

3.6.2. Exclusion criteria

- Women who do not complete prenatal care with the same clinic for their entire pregnancy.
- Women who are not interested to participate in this study.
- Women with psychological problems.

3.7. Instrument of the study

An interview questionnaire was used in the current study. Quality of prenatal care questionnaire (QPCQ) adopted from Heaman et al. (2014) was used. The questionnaire measures quality of prenatal care on a 5 point Likert scale with 0 (strongly disagree) and 4 (strongly agree). The QPCQ measures the quality of prenatal care through six subscales: information sharing, anticipatory guidance, sufficient time, approachability, availability, and support and respect. The sum value of the QPCQ is computed as a total score and ranged from 0 - 180, the higher values indicating higher quality of prenatal care as

evaluated by the women. The instrument has reverse scores for some items to ensure that participants read the questions and do not merely respond based upon boredom or ease.

3.7.1. Questionnaire design and measurement

The first part of the questionnaire represented socio-demographic characteristics of the women and some questions related to their pregnancy such as her age, level of education, income, and etc.

The second part consisted of the questions related to the women's evaluation of prenatal care. The domain of anticipatory guidance has 11 items and focuses on providers sharing information, and educating patients on reasons for testing and results. Questions include: 2, 4, 10, 12, 15, 19, 23, 26, 30, 41, and 45. It was measured on a 5 point Likert scale with 0 (strongly disagree) and 4 (strongly agree), the total score for this domain is 44.

The domain of information sharing has 9 items which measure how the participants felt their provider discussed options with them for their labor and birth experience. Questions include: 3, 6, 11, 16, 21, 32, 38, 42, and 44. It was measured on a 5 point Likert scale with 0 (strongly disagree) and 4 (strongly agree), the total score for this domain is 36.

The domain of sufficient time has 5 items that measures how much time the provider spent talking with the participant and addressing any questions they may have. Questions include: 1, 8, 17, 29, and 43. It was measured on a 5 point Likert scale with 0 (strongly disagree) and 4 (strongly agree), the total score for this domain is 20.

The domain of approachability has 4 items. Questions include: 14, 22, 27, and 39. It was measured on a 5 point Likert scale with 0 (strongly disagree) and 4 (strongly agree), the total score for this domain is 16.

The domain of availability of the service has 4 items and included availability of the office staff and the health care provider to answer to questions or concerns. Questions include: 9, 31, 34, and 37. It was measured on a 5 point Likert scale with 0 (strongly disagree) and 4 (strongly agree), the total score for this domain is 16.

The domain of support and respect has 12 items. Questions include: 5, 7, 13, 40, 8, 20, 24, 25, 28, 33, 35, and 36. It was measured on a 5 point Likert scale with 0 (strongly disagree) and 4 (strongly agree), the total score for this domain is 48.

3.8. Pilot study

Pilot study was conducted on 30 women before the start of actual data collection, in order to provide feedback about the questionnaire and ensure validity and reliability of questionnaire.

3.9. Validity and Reliability

Although the instrument have been previously validated for construct validity and reliability, the questionnaire was submitted to experts panel with experience and knowledge about the adequacy of the instrument to evaluate and identify whether the questions agreed with the scope of the items and the extent to which these items reflect the concept of the research problem and to evaluate that the instrument used is statistically valid and that the questionnaire is designed well enough to provide relations and examined variables. Also, reliability coefficient was measured using Cronbach's coefficient alpha.

3.9.1. Cronbach's coefficient alpha

Techniques of measuring variables should be reliable to show the degree of stability and consistency of the questionnaire. As it gives the same results each time the factor is measured, it was reliable. This method is used to measure the reliability of the questionnaire between each field and the mean of the whole fields of the questionnaire. As shown in table 3.1 the results are in the range from 0.750 and 0.927. This range is considered good to excellent; the result ensures the reliability of the questionnaire, meaning that the instrument is reliable to measure the objectives of the study. Also, the total Cronbach's coefficient alpha for all questions is 0.853 which is very good, meaning that the questions with its scale are reliable enough to measure the purpose of the study.

Table 3.1: Cronbach's Alpha for reliability for all domains

Domains	No. of Items	Cronbach's coefficient alpha
Information sharing	9	0.927
Anticipatory guidance	11	0.903
Sufficient time provided	5	0.856
Approachability	4	0.750
Availability of the service	4	0.821
Support and respect	12	0.802
Total	45	0.853

3.9.2. Internal consistency

Internal consistency of the questionnaire was measured by a pilot sample, which consisted of thirty questionnaires, through measuring the correlation coefficients between each paragraph in one field and the whole field. The results showed that the *p*-Values for the majority of the questions are significant at 0.01 and 0.05 level, so it can be said that the paragraphs of these questions are consistent and valid to measure what it was set for.

Table 3.2: Correlation coefficient for the domain of sufficient time provided and total degree of the domain

No.	Sufficient Time Provided	Pearson correlation	<i>P</i> value
1.	I had as much time with my personal care provider(s) as I needed	0.658**	0.000
2.	My prenatal care provider (s) was rushed	0.334	0.072
3.	My prenatal care provider(s)always had time to answer my questions	0.570*	0.001
4.	My prenatal care provider(s) made time for me to talk	0.322	0.082
5.	My prenatal care provider(s) took time to listen	0.951**	0.000

**Correlation is significant at the 0.01 level (2-tailed)

*Correlation is significant at the 0.05 level (2-tailed)

Table 3.3: Correlation coefficient for the domain of availability of the service and total degree of the domain

No.	Availability of the Service	Pearson correlation	P value
6.	I knew how to get in touch with my prenatal care provider(s)	0.846**	0.000
7.	My prenatal care provider(s) was available when I had questions or concerns	0.725**	0.000
8.	I could always reach someone in the office clinic if I needed something	0.436*	0.016
9.	I could reach my prenatal care provider(s) by phone when necessary	0.772**	0.000

Table 3.4: Correlation coefficient for the domain of information sharing and total degree of the domain

No.	Information Sharing	Pearson correlation	P value
10.	I was given adequate information about prenatal tests and procedures	0.715**	0.000
11.	I was always given honest answers to my questions	0.383*	0.037
12.	Everyone involve in my prenatal care received the important information about me.	0.736**	0.000
13.	I was screened adequately for potential problems with my pregnancy	0.495*	0.005
14.	The results of tests were explained to me in a way I could understand	0.961**	0.000
15.	My prenatal care provider(s) gave straight forward answers to my questions	0.513*	0.004
16.	My prenatal care provider(s) gave me enough information to make decisions for myself	0.879**	0.000
17.	My prenatal care provider(s) kept my information confidential	-.079-	0.684
18.	I fully understood the reasons for blood work and other test my prenatal care provider(s) ordered for me	0.957**	0.000

Table 3.5: Correlation coefficient for the domain of approachability and total degree of the domain

No.	Approachability	Pearson correlation	P value
19.	My prenatal care provider (s) was abrupt with me	0.579*	0.001
20.	I was rushed during my prenatal care visits	0.762**	0.000
21.	My prenatal care provider(s) made me feel like I was wasting their time	0.621**	0.000
22.	I was afraid to ask my prenatal care provider(s) question	0.517*	0.003

**Correlation is significant at the 0.01 level (2-tailed)

*Correlation is significant at the 0.05 level (2-tailed)

Table 3.6: Correlation coefficient for the domain of anticipatory guidance and total degree of the domain

No.	Anticipatory Guidance	Pearson correlation	P value
23.	My prenatal care provider(s) gave me options for my birth experience	0.409*	0.025
24.	I was given enough information to meet my needs about breastfeeding	0.626**	0.000
25.	My prenatal care provider(s) prepared me for my birth experience	0.797**	0.000
26.	My prenatal care provider(s) spent time talking with me about my expectations for labor and delivery	0.768**	0.000
27.	I was given enough information about the safety of moderate exercise during pregnancy	0.722**	0.000
28.	I received adequate information about my diet during pregnancy	0.589*	0.001
29.	My prenatal care provider (s) was interested in how my pregnancy was affecting my life	0.583*	0.001
30.	I was linked to programs in the community that were helpful to me	0.788**	0.000
31.	I received adequate information about alcohol use during pregnancy	0.814**	0.000
32.	I was given adequate information about depression in pregnancy	0.698**	0.000
33.	My prenatal care provider(s) took time to ask about things that were important to me	0.613**	0.000

**Correlation is significant at the 0.01 level (2-tailed)

*Correlation is significant at the 0.05 level (2-tailed)

Table 3.7: Correlation coefficient for the domain of support and respect and total degree of the domain

No.	Support and Respect	Pearson correlation	P value
34.	My prenatal care provider(s) respected me	0.761**	0.000
35.	My prenatal care provider(s) respected my knowledge and experience	0.880**	0.000
36.	My prenatal care provider(s) was patient	0.725**	0.000
37.	I was supported by my prenatal care provider(s) in doing what I felt was right for me	0.637**	0.000
38.	My prenatal care provider(s) supported me	0.853**	0.000
39.	My prenatal care provider(s) paid close attention when I was speaking	0.868**	0.000
40.	My concerns were taken seriously	0.757**	0.000
41.	I was in control of the decisions being made about my prenatal care	0.476*	0.008
42.	My prenatal care provider(s) supported my decisions	0.456*	0.011
43.	I was at ease with my prenatal care provider(s).	0.676	0.000
44.	My values and beliefs were respected by my prenatal care provider(s)	0.868	0.000
45.	My decision were respected by my prenatal care provider(s)	0.756	0.003

**Correlation is significant at the 0.01 level (2-tailed)

*Correlation is significant at the 0.05 level (2-tailed)

3.10. Statistical Analysis

To achieve the goal of the study, the researcher used the statistical package for Social Science (SPSS version 22) for analyzing the data. Statistical procedure that have been used include: descriptive statistics such as frequencies and percentages, independent sample *t* test, and One-Way ANOVA.

3.11. Ethical Consideration

Ethical considerations were followed for conducting this study; ethical approval was obtained from Al-Quds University, Helsinki committee, and the ministry of health to visit and collect data from the primary healthcare centers. Informed consent was obtained from all women as well to participate in the study.

3.12. Period of the Study

The study was conducted during the period from May 2018 to February 2019.

Chapter Four

Results of the Study

4.1. Introduction

This chapter illustrates the results of statistical analysis of the data, including descriptive analysis that presents the socio-demographic characteristics of the study sample and answers to the study questions. The researcher used simple statistics including frequencies, means and percentages, also independent sample *t* test, and One-way ANOVA.

4.2. Descriptive Characteristics of the Sample

Table 4.1: Sample Distribution According to the Participants' Residence, Age groups, and Educational qualification (n=300)

Variables		Number	Percentage (%)
Residence	Rafah	150	50.0
	Khanyounis	150	50.0
Age groups	Less than 25 years	97	32.3
	25-30 years	99	33.0
	31-35 years	69	23.0
	More than 35 years	35	11.7
Educational qualification	Illiterate	10	3.3
	Primary / Elementary	19	6.3
	Secondary	143	47.7
	University	128	42.7

Table 4.1 shows the distribution of study participants' according to their residence, age groups, and educational qualifications. The table shows that half (50.0%) of the women included in the current study are from Khanyounis and half of them are from Rafah governorate. The table also shows that 33.0% of the study women are between 25 and 30 years, 32.3% are less than 25 years old, while 23.0% are between 31 and 35 years old. Moreover, the table shows that 47.7% of the women have secondary school, 42.7% have university, and 3.3% are illiterate.

4.3. Sample Distribution According to the Participants' Working Status and their Level of Income

Table 4.2 Sample Distribution According to the Participants' Working Status and their Level of Income (n=300)

Variables		Number	Percentage (%)
Working status	Working	7	2.3
	Not working	293	97.7
Income	Below 1000 Shekel	227	75.7
	1000- 1500	61	20.3
	More than 1500	12	4.0
	Total	300	100.0

Table 4.2 shows the distribution of study participants with regard to their working status and their income. The table shows that the vast majority (97.9%) of the women are not working, and only 2.3% of them are working. Also, 75.7% of the women have an average family income less than 1000 Shekel, 20.3% have income between 1000 – 1500 Shekel, while 4.0% have income of more than 1500 Shekel.

4.4. Sample Distribution According to the Health Care Centers Included in the Study

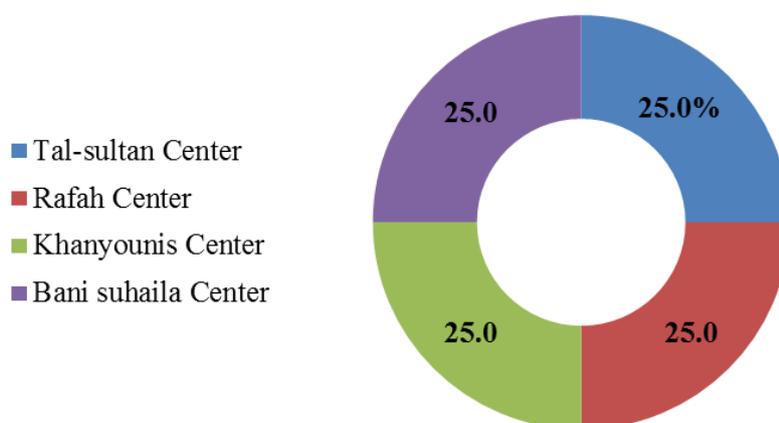


Figure 4.1: Health Care Centers Included in this Study

Figure 4.1 shows the distribution of the women based on health care centers they have had follow up. The figure shows that there are four primary health care centers distributed equally between Rafah and Khanyounis Governorate, in which there are the same number of women between each center (25.0% of the women each).

4.5. Sample Distribution According to the Participants' Number of Pregnancies

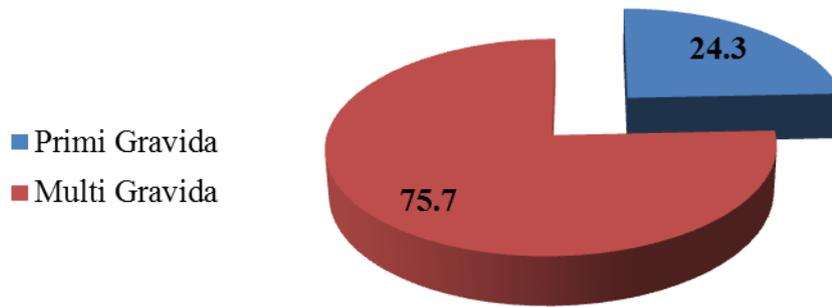


Figure 4.2: Participants' Number of Pregnancies

Figure 4.2 shows the distribution of the women based on the number of pregnancies. The figure shows that 75.7% of the women are multi gravida, while 24.3% are primi gravida.

4.6. Sample Distribution According to the Participants' Number of Deliveries

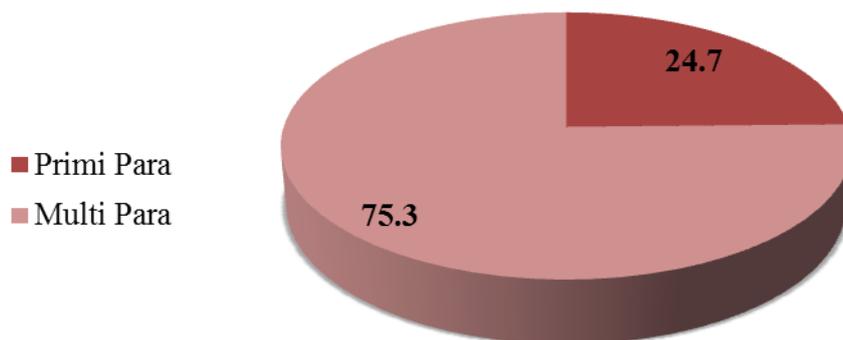


Figure 4.3: Participants' Number of Deliveries

Figure 4.3 shows the distribution of the women based on the number of deliveries. The figure shows that 75.3% of the women are multi para, while 24.7% are multi para.

4.7. Assessment of the prenatal care services in the Southern Gaza Governorates

Table 4.3: Assessment of the prenatal care services in the Southern Gaza Governorates

Domain	Number of items	Maximum score	Mean score	Mean% ^a
Sufficient time provided	5	20.0	13.13	65.65
Availability of the service	4	16.0	11.64	72.75
Information sharing	9	36.0	26.89	74.69
Approachability	4	16.0	8.04	50.25
Anticipatory guidance	11	44.0	30.19	68.61
Support and respect	12	48.0	35.71	74.39
Total	45	180.0	125.59	69.77

^a Calculated by dividing the mean score of the domain by the maximum score of the same domain

The table shows the assessment of the prenatal care services in the southern Gaza Governorates in the main six domains with mean and its mean percentage. The total number of items in each domain and the maximum score for each domain are illustrated. The highest mean domain of the women's evaluation of prenatal care services in the current study is information sharing (26.89 out of 36.0) with mean percentage 74.69%, followed by the domain of support and respect (35.71 out of 48.0) with mean percentage 74.39%. While the lowest mean is the domain of approachability (8.04 out of 16.0) with mean 50.25%. The table shows also that the total mean percentage of the women's evaluation of prenatal care services is 69.77%.

Table 4.4: Classification of Women's Evaluation of Prenatal Care

Classification	Frequency	Percentage
Not-satisfied (<126) ^a	144	48.0
Satisfied (≥126)	156	52.0

^a Median score (126.0) was considered as a cut of point

The table shows that 48.0% of the women have evaluated the prenatal care with score which is not-satisfactory, while the rest (52.0%) have evaluated it with a satisfactory score.

4.8. Assessment of the prenatal care services in the Southern Gaza Governorates in terms of sufficient time provided

Table 4.5: Mean and Mean Percentage of sufficient time provided for the Pregnant Women

No	Sufficient Time Provided	Mean	SD	Mean % ^a
1	I had as much time with my personal care provider(s) as I needed	3.34	0.68	83.5
2	My prenatal care provider (s) was rushed	1.51	1.05	37.75
3	My prenatal care provider(s)always had time to answer my questions	2.94	0.77	73.5
4	My prenatal care provider(s) made time for me to talk	2.88	0.81	72.0
5	My prenatal care provider(s) took time to listen	2.47	1.06	61.75
	Total	13.13	2.25	65.65

^a Calculated by dividing the mean score on 4 (maximum score for each item)

The table shows the mean and mean percentage of sufficient time provided for the pregnant women during prenatal care. The maximum score for each item is 4, and the lowest one is 0. The highest mean score in this domain is the item “I had as much time with my personal care provider(s) as I needed” with mean percentage 83.50%, followed by “My prenatal care provider(s)always had time to answer my questions” with mean percentage 73.50%. While the lowest mean score is “My prenatal care provider(s) took time to listen” with mean percentage 61.75%.

4.9. Assessment of the prenatal care services in the Southern Gaza Governorates in terms of availability of the service

Table 4.6: Mean and Mean Percentage of availability of the services in the Governmental health Centers

No	Availability of the Service	Mean	SD	Mean %
1	I knew how to get in touch with my prenatal care provider(s)	2.73	0.71	68.25
2	My prenatal care provider(s) was available when I had questions or concerns	3.00	0.86	75.0
3	I could always reach someone in the office clinic if I needed something	2.91	0.90	72.75
4	I could reach my prenatal care provider(s) by phone when necessary	3.01	0.91	75.25
	Total	11.64	2.29	72.75

The table shows the mean and mean percentage of availability of the services in the Governmental primary health care centers. The highest mean score in this domain is the item “I could reach my prenatal care provider(s) by phone when necessary” with mean percentage 75.25%, followed by “My prenatal care provider(s) was available when I had questions or concerns” with mean percentage 75.0%. While the lowest mean score is “I knew how to get in touch with my prenatal care provider(s)” with mean percentage 68.25%.

4.10. Assessment of the prenatal care services in the Southern Gaza Governorates in terms of information sharing

Table 4.7: Mean and Mean percentage of information sharing

No	Information Sharing	Mean	SD	Mean %
1	I was given adequate information about prenatal tests and procedures	3.12	0.80	78.0
2	I was always given honest answers to my questions	3.09	0.70	77.25
3	Everyone involve in my prenatal care received the important information about me.	3.06	0.71	76.5
4	I was screened adequately for potential problems with my pregnancy	2.97	0.65	74.25
5	The results of tests were explained to me in a way I could understand	2.91	0.86	72.75
6	My prenatal care provider(s) gave straight forward answers to my questions	3.13	0.70	78.25
7	My prenatal care provider(s) gave me enough information to make decisions for myself	2.98	0.78	74.5
8	My prenatal care provider(s) kept my information confidential	3.08	0.78	77.0
9	I fully understood the reasons for blood work and other test my prenatal care provider(s) ordered for me	2.54	1.02	63.5
	Total	26.89	3.43	74.69

The table shows the mean and mean percentage of availability of information sharing. The highest mean score in this domain is the item “My prenatal care provider(s) gave straight forward answers to my questions” with mean percentage 78.25%, followed by “I was

given adequate information about prenatal tests and procedures” with mean percentage 78.0%. While the lowest mean score is “I fully understood the reasons for blood work and other test my prenatal care provider(s) ordered for me” with mean percentage 63.5%.

4.11. Assessment of the prenatal care services in the Southern Gaza Governorates in terms of approachability

Table 4.8: Mean and Mean Percentage of Approachability

No	Approachability	Mean	SD	Mean %
1	My prenatal care provider (s) was abrupt with me	1.53	1.07	38.25
2	I was rushed during my prenatal care visits	1.99	1.22	49.75
3	My prenatal care provider(s) made me feel like I was wasting their time	2.47	1.09	61.75
4	I was afraid to ask my prenatal care provider(s) question	2.06	1.18	51.5
	Total	8.04	3.03	50.25

The table shows the mean and mean percentage of availability of approachability. The highest mean score in this domain is the item “My prenatal care provider(s) made me feel like I was wasting their time” with mean percentage 61.75%, and “My prenatal care provider (s) was abrupt with me” with mean percentage 38.25%, in which this item is reverse coded and the real mean percentage is 61.75 (100 – 38.25). While the lowest mean score is “I was rushed during my prenatal care visits” with mean percentage 49.75%.

4.12. Assessment of the prenatal care services in the Southern Gaza Governorates in terms of anticipatory guidance

Table 4.9: Mean and Mean Percentage of Anticipatory Guidance

No	Anticipatory Guidance	Mean	SD	Mean %
1	My prenatal care provider(s) gave me options for my birth experience	3.06	0.86	76.5
2	I was given enough information to meet my needs about breastfeeding	3.02	0.90	75.5
3	My prenatal care provider(s) prepared me for my birth experience	2.59	0.81	64.75
4	My prenatal care provider(s) spent time talking with me about my expectations for labor and delivery	2.92	0.76	73.0
5	I was given enough information about the safety of moderate exercise during pregnancy	2.57	0.96	64.25
6	I received adequate information about my diet during pregnancy	3.05	0.80	76.25
7	My prenatal care provider (s) was interested in how my pregnancy was affecting my life	2.95	0.85	73.75
8	I was linked to programs in the community that were helpful to me	2.27	1.16	56.75
9	I received adequate information about alcohol use during pregnancy	2.88	0.93	72.0
10	I was given adequate information about depression in pregnancy	2.67	1.02	66.75
11	My prenatal care provider(s) took time to ask about things that were important to me	2.21	1.19	55.25
	Total	30.19	5.87	68.61

The table shows the mean and mean percentage of anticipatory guidance. The highest mean score in this domain is the item “My prenatal care provider(s) gave me options for my birth experience” with mean percentage 76.50%, followed by “I received adequate information about my diet during pregnancy” with mean percentage 76.25%. While the lowest mean score is “My prenatal care provider(s) took time to ask about things that were important to me” with mean percentage 55.25%.

4.13. Assessment of the prenatal care services in the Southern Gaza Governorates in terms of Support and Respect

Table 4.10: Mean and Mean Percentage of Support and Respect Given by Prenatal Health Care Providers

No	Support and Respect	Mean	SD	Mean %
1	My prenatal care provider(s) respected me	3.08	0.84	77.0
2	My prenatal care provider(s) respected my knowledge and experience	2.93	0.76	73.25
3	My prenatal care provider(s) was patient	2.59	0.81	64.75
4	I was supported by my prenatal care provider(s) in doing what I felt was right for me	2.86	0.91	71.5
5	My prenatal care provider(s) supported me	3.08	0.81	77.0
6	My prenatal care provider(s) paid close attention when I was speaking	3.00	0.61	75.0
7	My concerns were taken seriously	2.87	0.79	71.75
8	I was in control of the decisions being made about my prenatal care	2.89	0.81	72.25
9	My prenatal care provider(s) supported my decisions	3.09	0.71	77.25
10	I was at ease with my prenatal care provider(s).	3.02	0.74	75.5
11	My values and beliefs were respected by my prenatal care provider(s)	3.13	0.75	78.25
12	My decision were respected by my prenatal care provider(s)	2.96	0.80	74.0
	Total	35.71	5.26	73.95

The table shows the mean and mean percentage of support and respect. The highest mean score in this domain is the item “My values and beliefs were respected by my prenatal care provider(s)” with mean percentage 78.25%, followed by “My prenatal care provider(s) supported my decisions” with mean percentage 77.25%. While the lowest mean score is “My prenatal care provider(s) was patient” with mean percentage 64.75%.

4.14. Women's Evaluation of Prenatal Care and Age Groups of the Mothers

Table 4.11: Differences in the Women's Evaluation of Prenatal Care with Regard to Age Groups of the Mothers

Variable	N	Mean (SD)	F (df)	P value*
Sufficient time provided				
< 25 years	97	13.12 (2.31)	0.736 (3, 296)	0.531
25 – 30 years	99	13.21 (2.40)		
31 – 35 years	69	13.28 (2.14)		
>35 years	35	12.62 (1.81)		
Availability of the service				
< 25 years	97	11.47 (2.64)	2.458 (3.296)	0.063
25 – 30 years	99	11.31 (2.29)		
31 – 35 years	69	12.02 (2.03)		
>35 years	35	12.28 (1.38)		
Information sharing				
< 25 years	97	26.77 (3.99)	1.795 (3.296)	0.148
25 – 30 years	99	26.39 (3.59)		
31 – 35 years	69	27.49 (2.63)		
>35 years	35	27.48 (2.46)		
Approachability				
< 25 years	97	8.17 (3.26)	0.508 (3.296)	0.677
25 – 30 years	99	8.15 (3.14)		
31 – 35 years	69	7.97 (2.87)		
>35 years	35	7.48 (2.31)		
Anticipatory guidance				
< 25 years	97	30.77 (5.64)	2.166 (3.296)	0.092
25 – 30 years	99	29.00 (6.77)		
31 – 35 years	69	30.55 (5.12)		
>35 years	35	31.25 (4.74)		
Support and respect				
< 25 years	97	35.71 (5.86)	1.481 (3.296)	0.220
25 – 30 years	99	34.91 (5.75)		
31 – 35 years	69	36.43 (3.94)		
>35 years	35	36.54 (4.00)		
Total Women's evaluation of prenatal care				
< 25 years	97	126.19 (18.91)	1.325 (3.296)	0.266
25 – 30 years	99	122.91 (18.13)		
31 – 35 years	69	127.59 (14.69)		
>35 years	35	127.57 (11.91)		

*One way ANOVA

The table shows that there are no significant differences in the mean score of women's evaluation of prenatal care services in all domain (sufficient time provided, availability of the service, information sharing, approachability, anticipatory guidance, and support and

respect) with regard to women's age groups ($p>0.05$). Also, there are no significant differences in the total mean score of women's evaluation of prenatal care services with regard to their age groups ($p>0.05$).

4.15. Women's Evaluation of Prenatal Care and Mothers' Level of Income

Table 4.12: Differences in the Women's Evaluation of Prenatal Care with Regard to Mothers' Level of Income

Variable	N	Mean (SD)	F (df)	P value*
Sufficient time provided				
Below 1000 Shekel	227	13.07 (2.13)	2.198 (2, 297)	0.113
1000 – 1500 Shekel	61	13.54(2.52)		
More than 1500 Shekel	12	12.16 (2.69)		
Availability of the service				
Below 1000 Shekel	227	11.63 (2.34)	5.266 (2, 297)	0.006
1000 – 1500 Shekel	61	12.06 (1.87)		
More than 1500 Shekel	12	9.75 (2.49)		
Information sharing				
Below 1000 Shekel	227	27.01 (3.54)	2.506 (2, 297)	0.083
1000 – 1500 Shekel	61	26.86 (2.97)		
More than 1500 Shekel	12	24.75 (3.01)		
Approachability				
Below 1000 Shekel	227	8.04 (2.92)	0.154 (2, 297)	0.857
1000 – 1500 Shekel	61	8.11 (3.35)		
More than 1500 Shekel	12	7.58 (3.62)		
Anticipatory guidance				
Below 1000 Shekel	227	30.48 (5.42)	2.071 (2, 297)	0.128
1000 – 1500 Shekel	61	29.72 (7.36)		
More than 1500 Shekel	12	27.16 (5.07)		
Support and respect				
Below 1000 Shekel	227	35.78 (5.24)	3.788 (2, 297)	0.024
1000 – 1500 Shekel	61	36.22 (5.13)		
More than 1500 Shekel	12	31.75 (4.99)		
Total prenatal quality				
Below 1000 Shekel	227	126.03 (16.66)	3.281 (2, 297)	0.039
1000 – 1500 Shekel	61	126.39 (18.06)		
More than 1500 Shekel	12	113.33 (16.46)		

*One way ANOVA

The table shows that there is a significant difference in the mean score of women's evaluation of availability of the service domain with regard to the women's level of income ($p<0.05$). Post hoc test using Tukey test was done and revealed that the difference is significant between the women who have income below 1000 and those who have income more than 1500 Shekel in favor to those who have income below 1000 Shekel, also the

difference is between the mothers who have income 1000 – 1500 and those who have more than 1500 Shekel in favor to those who have income between 1000 and 1500 Shekel.

The table also shows that there are significant differences in the mean score of women's evaluation of support and respect domain with regard to the women's level of income ($p < 0.05$). Post hoc test using Tukey test was done and revealed that the difference is between the women who have income below 1000 and those who have income more than 1500 Shekel in favor to those who have income below 1000 Shekel, also the difference is between those who have income 1000 – 1500 and those who have more than 1500 Shekel in favor to those who have income between 1000 and 1500 Shekel.

Moreover, there are significant differences in the total mean score of women's evaluation of prenatal care services with regard to their level of income ($p < 0.05$). Post hoc test using Tukey test was done and revealed that the difference is between the women who have income below 1000 and those who have income more than 1500 Shekel in favor to those who have income below 1000 Shekel, also the difference is between those who have income 1000 – 1500 and those who have more than 1500 Shekel in favor to those who have income between 1000 and 1500 Shekel.

On the other hand, there are no significant differences in the women's evaluation of sufficient time provided, information sharing, anticipatory guidance, and approachability with regard to their level of income.

4.16. Women's Evaluation of Prenatal Care among Different PHC Centers

Table 4.13: Differences in the Women's Evaluation of Prenatal Care with Regard to PHC Centers

Variable	N	Mean (SD)	F (df)	P value*
Sufficient time provided				
Tal-Sultan Center	75	13.09 (2.33)	11.554 (3.296)	<0.001
Rafah Center	75	12.08 (1.99)		
KhanyounisCenetr	75	13.22 (2.42)		
Bani-Suhaila Center	75	14.13 (1.74)		
Availability of the service				
Tal-Sultan Center	75	11.72 (2.24)	5.650 (3.296)	0.001
Rafah Center	75	11.52 (1.92)		
KhanyounisCenetr	75	10.92 (2.83)		
Bani-Suhaila Center	75	12.41 (1.82)		
Information sharing				
Tal-Sultan Center	75	26.57 (2.54)	11.645 (3.296)	<0.001
Rafah Center	75	26.13 (2.91)		
KhanyounisCenetr	75	26.08 (4.47)		
Bani-Suhaila Center	75	28.80 (2.77)		
Approachability				
Tal-Sultan Center	75	7.24 (3.48)	4.107 (3.296)	0.007
Rafah Center	75	7.74 (2.76)		
KhanyounisCenetr	75	8.32 (2.94)		
Bani-Suhaila Center	75	8.85 (2.69)		
Anticipatory guidance				
Tal-Sultan Center	75	30.34 (4.12)	11.607 (3.296)	<0.001
Rafah Center	75	28.28 (6.73)		
KhanyounisCenetr	75	28.92 (6.82)		
Bani-Suhaila Center	75	33.22 (3.99)		
Support and respect				
Tal-Sultan Center	75	36.06 (5.33)	7.142 (3.296)	<0.001
Rafah Center	75	34.93 (4.96)		
KhanyounisCenetr	75	34.10 (6.40)		
Bani-Suhaila Center	75	37.74 (3.19)		
Total Women's evaluation of prenatal care				
Tal-Sultan Center	75	125.10 (14.54)	13.054 (3.296)	<0.001
Rafah Center	75	120.38 (15.26)		
KhanyounisCenetr	75	121.65 (21.35)		
Bani-Suhaila Center	75	135.24 (11.86)		

*One way ANOVA

The table shows that there are significant differences in the mean score of the women's evaluation of sufficient time provided with regard to different primary healthcare centers ($p < 0.05$). Post hoc test using Tukey test was done and revealed that the difference is between Tal-sultan and Bani-Suhaila center in favor of Bani-Suhaila healthcare center.

Also post hoc test revealed that the difference is between Tal-sultan and Rafah center in favor to Tal-sultan center.

The table also shows that there is a significant difference in the mean score of women's evaluation of availability of the service with regard to different primary healthcare center ($p < 0.05$). Post hoc test using Tamhane's test was done and revealed that the difference is between Rafah center and Bani-Suhaila center in favor to Bani-Suhaila healthcare center. Also post hoc test revealed that the difference is between Khanyounis center and Bani-Suhaila center in favor to Bani-Suhaila healthcare center.

Moreover, there are significant differences in the mean score of women's evaluation of prenatal care services with regard to different primary healthcare centers ($p < 0.05$). Post hoc test using Tamhane's test was done and revealed that the difference is between Tal-sultan center and Bani-Suhaila center in favor to Bani-Suhaila healthcare center. Also post hoc test revealed that the difference is between Rafah center and Bani-Suhaila center in favor to Bani-Suhaila healthcare center.

Additionally, there are significant differences in the mean score of women's evaluation of approachability with regard to different primary healthcare centers ($p < 0.05$). Post hoc test using Tukey test was done and revealed that the difference is between Tal-sultan center and Bani-Suhaila center in favor to Bani-Suhaila healthcare center.

There are also significant differences in the mean score of women's evaluation of anticipatory guidance with regard to different primary healthcare center ($p < 0.05$). Post hoc test using Tamhane's test was done and revealed that the difference is between Tal-sultan center and Bani-Suhaila center in favor to Bani-Suhaila healthcare center. Also, the difference is between Rafah center and Bani-Suhaila center in favor to Bani-Suhaila healthcare center.

Furthermore, there are significant differences in the mean score of women's evaluation of support and respect with regard to different primary healthcare center ($p < 0.05$). Post hoc test using Tamhane's test was done and revealed that the difference is between Rafah center and Bani-Suhaila center in favor to Bani-Suhaila healthcare center. Also post hoc test revealed that the difference is between Khanyounis center and Bani-Suhaila center in favor to Bani-Suhaila healthcare center.

On the other hand, there are significant differences in the total mean score of the women's evaluation of prenatal care services with regard to the primary healthcare center ($p < 0.05$). Post hoc test using Tamhane's test was done and revealed that the difference is between

Tal-sultan center and Bani-Suhaila center in favor to Bani-Suhaila healthcare center. Also post hoc test revealed that the difference is between Rafah center and Bani-Suhaila center in favor to Bani-Suhaila healthcare center.

4.17. Women's Evaluation of Prenatal Care and their Educational Level of Mothers

Table 4.14: Differences in the Women's Evaluation of Prenatal with Regard to Educational Level of Mothers

Variable	N	Mean (SD)	F (df)	P value*
Sufficient time provided				
Illiterate	10	13.20 (2.14)	0.019 (3.296)	0.996
Below secondary	19	13.10 (2.30)		
Secondary	143	13.16 (2.14)		
University	128	13.10 (2.38)		
Availability of the service				
Illiterate	10	11.30 (2.90)	0.182 (3.296)	0.909
Below secondary	19	11.68 (1.70)		
Secondary	143	11.72 (2.08)		
University	128	11.57 (2.55)		
Information sharing				
Illiterate	10	26.80 (4.02)	0.283 (3.296)	0.838
Below secondary	19	26.26 (3.73)		
Secondary	143	27.02 (3.30)		
University	128	26.85 (3.52)		
Approachability				
Illiterate	10	10.00 (3.33)	1.984 (3.296)	0.116
Below secondary	19	8.63 (2.45)		
Secondary	143	8.06 (2.92)		
University	128	7.77 (3.16)		
Anticipatory guidance				
Illiterate	10	29.30 (5.92)	0.118 (3.296)	0.949
Below secondary	19	29.94 (3.92)		
Secondary	143	30.33 (5.03)		
University	128	30.14 (6.95)		
Support and respect				
Illiterate	10	35.30 (4.98)	0.240 (3.296)	0.868
Below secondary	19	35.63 (5.44)		
Secondary	143	35.48 (5.09)		
University	128	36.00 (5.48)		
Total Women's evaluation of prenatal care				
Illiterate	10	126.10 (18.30)	0.014 (3.296)	0.998
Below secondary	19	125.42 (15.44)		
Secondary	143	125.76 (15.09)		
University	128	125.39 (19.35)		

*One way ANOVA

The table shows that there are no significant differences in the mean score of women's evaluation of sufficient time provided, availability of the service, information sharing, approachability, anticipatory guidance, and support and respect with regard to their educational qualifications ($p>0.05$). also, there are no significant differences in the total mean score of women's evaluation of prenatal care services with regard to their educational qualifications ($p>0.05$).

4.18. Women's Evaluation of Prenatal Care with Regard to BMI of the Mothers

Table 4.15: Differences in the Women's Evaluation of Prenatal Care with Regard to BMI of the Mothers

Variable	N	Mean (SD)	F (df)	P value*
Sufficient time provided				
18.5 - 24.9 (Normal)	91	13.28 (2.70)	0.961 (2.297)	0.384
25 - 29.9 (Over weight)	171	12.98 (2.01)		
30 and above (Obese)	38	13.44 (2.04)		
Availability of the service				
18.5 - 24.9 (Normal)	91	11.45 (2.60)	0.625 (2.297)	0.536
25 - 29.9 (Over weight)	171	11.68 (2.23)		
30 and above (Obese)	38	11.92 (1.74)		
Information sharing				
18.5 - 24.9 (Normal)	91	26.95 (4.07)	1.079 (2.297)	0.341
25 - 29.9 (Over weight)	171	26.70 (3.07)		
30 and above (Obese)	38	27.60 (3.32)		
Approachability				
18.5 - 24.9 (Normal)	91	8.68 (3.26)	4.840 (2.297)	0.009
25 - 29.9 (Over weight)	171	7.57 (2.73)		
30 and above (Obese)	38	8.60 (3.42)		
Anticipatory guidance				
18.5 - 24.9 (Normal)	91	30.89 (5.91)	1.025 (2.297)	0.360
25.0 - 29.9 (Over weight)	171	29.80 (6.20)		
30 and above (Obese)	38	30.28 (3.95)		
Support and respect				
18.5 - 24.9 (Normal)	91	35.48 (5.69)	0.129 (2.279)	0.879
25 - 29.9 (Over weight)	171	35.79 (4.86)		
30 and above (Obese)	38	35.89 (5.97)		
Total Women's evaluation of prenatal care				
18.5 - 24.9 (Normal)	91	126.86 (19.97)	0.928 (2.297)	0.397
25 - 29.9 (Over weight)	171	124.45 (15.90)		
30 and above (Obese)	38	127.71 (14.53)		

*One way ANOVA

The table shows that there are no significant differences in the mean score of women's evaluation of sufficient time provided, availability of the service, information sharing, anticipatory guidance, and support and respect with regard to women's educational qualifications ($p>0.05$). also, there are no significant differences in women's evaluation of

the quality of prenatal healthcare services with regard to their educational qualifications ($p>0.05$). On the other hand, there are significant differences in the mean score of women's evaluation of approachability with regard to the different BMI of the mothers ($p<0.05$). Post hoc test using Tukey test was done and revealed that the difference is between the women who have normal BMI (18.5 - 24.9) and those who have BMI (25.0 – 29.9) in favor to the women who have normal BMI (18.5 - 24.9).

4.19. Differences in the Women's evaluation of prenatal care with regard to different residence areas

Table 4.16: Differences in the Women's evaluation of prenatal care with regard to different residence areas

Variable	Mean (SD)		<i>t</i> statistics (df)	<i>p</i> value*
	Refah	Khanyounis		
Sufficient time provided	13.68 (2.15)	12.58 (2.22)	4.327 (298)	<0.001
Availability of the service	11.66 (2.49)	11.62 (2.08)	0.176 (298)	0.861
Information sharing	68.50 (3.63)	68.21 (2.71)	0.792 (276.01)	0.429
Approachability	8.58 (2.82)	7.49 (3.14)	3.168 (298)	0.002
Anticipatory guidance	31.07 (5.97)	29.31 (5.66)	2.618 (298)	0.009
Support and respect	35.92 (5.36)	35.50 (5.16)	0.702 (298)	0.483
Total Women's evaluation of prenatal care	128.44 (18.51)	122.74 (15.04)	2.926 (298)	0.004

*Independent sample *t* test

Table 4.4 shows that the women's evaluation of "sufficient time provided" in Rafah governorate is significantly higher than in Khanyounis ($p<0.05$). Also, the process of approachability and anticipatory guidance in Rafah governorate is significantly higher than in Khanyounis ($p<0.05$). Moreover, the mean score of total women's evaluation of prenatal care services in Rafah governorate is significantly higher than in Khanyounis ($p<0.05$).

On the other hand, there are no significant differences in the mean score of the women's evaluation of availability of the service, Information sharing, and Support and respect between Rafah and Khanyounis.

4.20. Differences in the women’s evaluation of prenatal care with regard to the number of pregnancies

Table 4.17: Differences in the women’s evaluation of prenatal care with regard to the number of pregnancies

Variable	Mean (SD)		<i>t</i> statistics (df)	<i>p</i> value*
	Primi Gravida	Multi Gravida		
Sufficient time provided	13.24 (2.27)	13.09 (2.24)	0.493 (298)	0.622
Availability of the service	11.57(2.30)	11.66(2.29)	0.291 (298)	0.772
Information sharing	26.69 (3.65)	26.96 (3.37)	-0.565 (298)	0.572
Approachability	8.39(2.85)	7.92(3.08)	1.157 (298)	0.248
Anticipatory guidance	30.68(5.11)	30.3(6.10)	0.821 (298)	0.412
Support and respect	35.94(5.08)	35.63(5.32)	0.432 (298)	0.666
Total Women’s evaluation of prenatal care	126.54(16.57)	125.29(17.26)	0.546 (298)	0.585

*Independent sample *t* test

The table shows that there are no significant differences in the mean score of women’s evaluation of sufficient time provided, availability of the service, information sharing, approachability, anticipatory guidance, and support and respect with regard to women’s gravida status ($p>0.05$). also, there are no significant differences in the total mean score of women’s evaluation of prenatal healthcare services with regard to their gravida status ($p>0.05$).

4.21. Differences in the Women's evaluation of prenatal care with regard to the number of deliveries

Table 4.18: Differences in the Women's evaluation of prenatal care with regard to the number of deliveries

Variable	Mean (SD)		<i>t</i> statistics (df)	<i>p</i> value*
	Primi Para	Multi Para		
Sufficient time provided	13.27 (2.26)	13.08 (2.25)	0.602 (289)	0.548
Availability of the service	11.58(2.29)	11.66(2.30)	0.268 (289)	0.789
Information sharing	26.66 (3.64)	26.97 (3.37)	-0.675 (298)	0.500
Approachability	68.45(3.12)	7.91(3.09)	1.239 (298)	0.216
Anticipatory guidance	30.66 (5.08)	30.03 (6.11)	0.790 (298)	0.430
Support and respect	35.66 (5.32)	35..66 (5.32)	0.285 (298)	0.776
Total Women's evaluation of prenatal care	126.48 (16.46)	125.30 (17.30)	0.529 (298)	0.606

*Independent sample *t* test

The table shows that there are no significant differences in the mean score of women's evaluation of sufficient time provided, availability of the service, information sharing, approachability, anticipatory guidance, and support and respect with regard to the number of deliveries ($p>0.05$). also, there are no significant differences in the total mean score of the women's evaluation of prenatal care services with regard to the number of deliveries ($p>0.05$).

4.22. Differences in the Women's evaluation of prenatal care with regard to pregnancy risk

Table 4.19: Differences in the Women's evaluation of prenatal care with regard to pregnancy risk

Variable	Mean (SD)		<i>t</i> statistics (df)	<i>p</i> value*
	Risk	No		
Sufficient time provided	13.03 (2.23)	14.76 (1.98)	3.120 (298)	0.002
Availability of the service	11.61 (2.29)	12.11 (2.28)	0.877 (298)	0.381
Information sharing	27.44 (3.95)	26.35 (2.73)	2.767 (265.2)	0.006
Approachability	8.05 (2.98)	7.76 (3.81)	0.358 (298)	0.701
Anticipatory guidance	30.10 (5.89)	31.70 (5.47)	1.092 (298)	0.276
Support and respect	35.57 (5.29)	37.94 (4.23)	1.804 (298)	0.072
Total Women's evaluation of prenatal care	125.17 (16.94)	132.64 (18.29)	1.758 (298)	0.080

*Independent sample *t* test

The table shows that there are no significant differences in the mean score of women's evaluation of sufficient time provided, availability of the service, approachability, anticipatory guidance, and support and respect with regard to the pregnancy risk ($p > 0.05$). Also, there are no significant differences in the total mean score of women's evaluation of prenatal care services domains with regard to their risk in pregnancy ($p > 0.05$). On the other hand, there is a significant difference in the women's evaluation of information sharing between the women who have risk and those who did not, the women who have had risk during pregnancy have significantly higher mean score of information sharing than the women who did not have risk.

4.23. Differences in the Women's evaluation of prenatal care with regard to Gestational HTN

Table 4.20: Differences in the Women's evaluation of prenatal care with regard to Gestational HTN

Variable	Mean (SD)		<i>t</i> statistics (df)	<i>p</i> value*
	Gestational HTN	No		
Sufficient time provided	13.22 (1.87)	13.12 (2.30)	-0.241 (298)	0.810
Availability of the service	12.35 (1.81)	11.56 (2.33)	-1.830 (298)	0.068
Information sharing	27.77 (2.12)	26.79 (3.54)	-1.504 (51.78)	0.030
Approachability	6.93 (2.82)	8.16 (3.03)	2.154 (298)	0.032
Anticipatory guidance	32.03 (3.22)	29.98 (6.07)	-2.979 (298)	0.004
Support and respect	37.09 (3.62)	35.55 (5.40)	-1.550 (298)	0.122
Total Women's evaluation of prenatal care	129.16 (17.64)	125.18 (10.56)	-1.823 (298)	0.074

*Independent sample *t* test

The table shows that there are no significant differences in the mean score of women's evaluation of sufficient time provided, availability of the service, approachability, anticipatory guidance, and support and respect with regard to their status of gestational HTN and those who do not ($p > 0.05$). Also, there is no significant difference in the total mean score of the women's evaluation of prenatal healthcare services with regard to the women who have gestational HTN and those who do not ($p > 0.05$).

On the other hand, there is a significant difference in the mean score of the women's evaluation of information sharing, approachability and anticipatory guidance between the women who have gestational HTN and those who do not, the women who have gestational HTN have significantly higher mean score of information sharing and anticipatory guidance than the women who did not. Also, the women who do not have gestational HTN have significantly higher mean score of evaluation of approachability than the women who did.

4.24. Differences in the women's evaluation of prenatal care with regard to Gestational DM

Table 4.21: Differences in the women's evaluation of prenatal care with regard to Gestational DM

Variable	Mean (SD)		<i>t</i> statistics (df)	<i>p</i> value*
	Gestational DM	No		
Sufficient time provided	12.89 (1.83)	13.16 (2.30)	0.696 (298)	0.487
Availability of the service	11.94 (1.59)	11.60 (2.37)	1.148 (61.075)	0.256
Information sharing	26.94 (2.80)	26.88 (3.52)	0.969 (298)	0.333
Approachability	7.64 (3.11)	8.09 (3.02)	0.838 (298)	0.403
Anticipatory guidance	30.16 (5.32)	30.19 (5.96)	0.034 (298)	0.973
Support and respect	36.40 (3.94)	35.61 (5.42)	0.854 (298)	0.394
Total Women's evaluation of prenatal care	125.94 (13.32)	125.54 (17.56)	0.133 (298)	0.895

*Independent sample *t* test

The table shows that there are no significant differences in the mean score of women's evaluation of sufficient time provided, availability of the service, information sharing, approachability, anticipatory guidance, and support and respect between the women who have gestational DM and those who do not ($p > 0.05$). Also, there is no significant difference in the total mean score of the women's evaluation of prenatal care services between the women who have gestational DM and those who do not ($p > 0.05$).

4.25. Discussion of the Study Results

4.25.1. Introduction

The following sections illustrates the discussion of the study results in all domains of the study results, they include the women's evaluation of prenatal care services and the factors affecting their evaluation of prenatal care in Southern governorates. The current study

results are compared to the previous studies; also the personal opinion of the researcher is illustrated based on her experience in the field.

4.25.2. Assessment of the quality of prenatal care services in the Southern Gaza Governorates

Measurement of the quality of prenatal care is an essential step in more fully evaluating its effectiveness. In the current study, the quality of prenatal care questionnaire through a rigorous process of item generation and psychometric testing was used. The quality of prenatal care questionnaire was designed to be completed by the women who have received prenatal care in southern governmental primary healthcare centers, it is consistent with growing acknowledgement of the value of the consumer's viewpoint in evaluating quality of health care (Lees, 2011). The six subscales of the quality of prenatal care questionnaire measure both structure and process attributes of Donabedian's model, with more emphasis on clinical and interpersonal processes of care.

There is a need for more awareness on prenatal care among the women attending antenatal clinic. The goal of prenatal care is to prepare for birth and parenthood as well as prevent, detect, alleviate, or manage the three types of health problems during pregnancy that affect mother and newborn. The study results revealed that the highest mean domain of the quality of prenatal healthcare services in the current study is information sharing (26.89 out of 36.0) with mean percentage 74.69%, followed by the domain of support and respect (35.71 out of 48.0) with mean percentage 74.39%. While the lowest mean is the domain of approachability (8.04 out of 16.0) with mean 50.25%. The study results also showed that the total mean percentage of the quality of prenatal health care services is 69.77%

The study results are not consistent with the results of Nwaeze et al. (2013) which revealed that the total quality of antenatal care services were regarded as good in 81.1% among the respondents. Also, these results are not consistent with the results of Fagbamigbe and Idemudia (2013) which showed that the levels quality of antenatal care services were poor in Nigeria.

On the other hand, these results are not consistent with the results of Muchie (2017), which showed that 54.3% women lived in a community with a low level quality of received of antenatal care services, while 45.7% lived in a community with high community level quality of received antenatal care services, and 45.9% of women living in a community

with high quality of received antenatal care services, whereas only 25.6% of those in a community with low quality of received antenatal care services.

The current study results indicate that the mean score of the quality of health care services in Southern Governorates was not satisfactory, in which it was 69.77%, this could be explained by the fact that there are severe shortage in the governmental primary health care centers in the Gaza Strip due to strict siege over the Gaza Strip over the last years, there are a lot of needed medical supplies which are not available in these centers, thus this issue could affect the quality and satisfaction of the mother who conduct her prenatal care follow up in these primary healthcare centers. More importantly, this evaluation is subjective and considers the point of view of the mothers, and it may be not efficient as it could be. Moreover, the quality of prenatal care which have been considered in the current study like sufficient time provided, availability of the service, information sharing, approachability, anticipatory guidance, and support and respect were not considered in the previous studies, this create some difficulties to make comparisons with other studies. The highest quality of prenatal health care domain is information sharing with mean percentage 47.69%, followed by the domain of support and respect, and the lowest one is approachability with mean percentage 50.25%.

In the current study, information sharing is defined as ensuring confidentially and sharing of information with the mother to explain tests and results, this approach is very important for the mother, and of course; the issue of keeping privacy is considered as top priority for the mother during her follow up in the prenatal care clinics. Also, the approach of support and respect, in which the majority of doctors and nurses in the prenatal clinics provide respect for the pregnant women, this could be attributed to our culture in the Gaza Strip, in which the client receive good respect from health care providers.

The issue of approachability achieved the lowest mean score in the current study, which is the comfort with asking questions with the nurse and health care providers. This could be explained by the increase in the number of pregnant women who make their follow up in the prenatal health care clinics, which may prevent the mother to freely ask questions, this indicates that there is a problem within the issue of listening among healthcare providers, in which they do not care about the mothers as well as they do not listen carefully to the mothers; and this is approved from what has been revealed from the current study results in which the issue of “listening” took the lowest mean percentage (61.75%).

The results of the current study are also not consistent with the results of Fatile et al. (2016) which revealed that the majority (81.0%) of respondents agreed that prenatal care is good and will encourage compliance while 71.1% respondents feels there was no need to reduce prenatal care visits however 64.6% believed that focused antenatal care (FANC) can result in quality care. Also, Fatile et al. (2016) revealed that with respect to quality of examination and treatment received, the majority (64%) of the respondents were not satisfied with the quality of examination and treatment received while 32% are fairly satisfied. With regards to the respondents' level of satisfaction with next appointment, a large proportion (81%) were satisfied with the date for their next appointment, 24% are fairly satisfied and only 5% are not satisfied.

4.25.3. Mothers' Demographic Factors and the Women's Evaluation of Prenatal Care

In the current study, the age as a factor; was not considered has an effect on the mothers' evaluation of prenatal health care services. This result is not consistent with the result of Muchie (2017), which showed that the age groups especially the early age period and the late one have a significant effect on the mothers' evaluation of the quality of prenatal health care services. The current study result could be attributed to the current system in the ministry of health in the Gaza Strip which providers' health care services to all of age groups of the clients regardless of their ages.

Also, it could be attributed to the distribution of the age groups over the study, in which the first two age groups (less than 25 years and the group 25 – 30 years) have nearly the same numbers, this could create some difficulties in detecting any differences by SPSS. More importantly, the age of pregnant mothers do not have major differences in general; hence there will be no differences in their evaluation since they receive the same prenatal health care services.

The study results also revealed that there are significant differences in the total mean score of the women's valuation of the prenatal healthcare services with regard to the women's level of income in favor to those who have income below 1000 Shekel and those who have income between 1000 and 1500 Shekel. This result could be explained by the fact that the majority of the mothers included in the current study are among the poor class, who have their monthly income of less than 1000 shekel, this issue prevent them from conducting prenatal care in private clinics, hence they may be more satisfied more than who have better monthly income who may go to private doctors and make their follow up there,

those women can make comparison between the governmental and private clinics, the issue which is not present among those who have low monthly income because they cannot pay for the private clinic.

Regarding the differences in the quality of prenatal healthcare with regard to different primary health care centers in southern governorate, the current study results revealed that there are significant differences in the total mean score of the women's evaluation of prenatal health care services with regard to the primary healthcare center in favor to Bani-Suhaila healthcare center. This result is not consistent with the results of Muchie (2017), which revealed that the region has an effect on the quality of prenatal care services. In the current study, Bani-Suhaila healthcare center is the smallest one in terms of the number of pregnant women who make their visits to this center, this can create a sense of organization and low level of workload from the clients and the mothers who conduct their visits, which make health care providers more comfortable in providing healthcare service, the issue which may lead to increase the level of the quality of care provided to the mothers.

In comparison to Khanyounis and Rafah center, they have huge number of clients and the mothers who conduct their follow up, thus the health care providers have a lot of workload and they may cannot find enough time to give the mother the needed time to advise her and conduct other investigations.

Moreover, there are no significant differences in the mean score of all domain of women's evaluation of prenatal healthcare services (sufficient time provided, availability of the service, information sharing, approachability, anticipatory guidance, and support and respect) with regard to women's educational qualifications and there are no significant differences in the total mean score of the quality of prenatal healthcare services with regard to women's educational qualifications. These results are not consistent with the results of Muchie (2017).

The current study result could be attributed to the nature of the study sample in which more than half of the mothers have secondary education or less, this may led to make some difficulties among them in making judgement about the evaluation of the quality of prenatal care services; hence the differences were not observed. It could be reasonable to say that educated women as compared to uneducated, have better access to information, possess a level of health literacy that could empower them to exercise their choice, and

able to overcome cultural barriers of prenatal care service utilization (Babalola and Fatusi, 2009) ; Greenaway et al., 2012).

Furthermore, education changes attitude and expectation of a woman and her significant others towards the quality of health care, thus lack of education leads to poor quality interactions between a pregnant woman and healthcare providers; consequently discouraging utilization of prenatal care services (Adamson et al., 2012).

Additionally, the current study results are not consistent with the results of Edie et al. (2015) which revealed that there were significant differences between the mothers' educational levels on the aspect of the comprehensiveness of prenatal care, the differences between both findings could be explained by the type of the sample, women culture, and differences in the place of the study. Women attending prenatal care for their subsequent pregnancies probably had a notion of what health topics were discussed during clinic sessions and so their objectives at prenatal care were not only aimed at acquiring knowledge about diet, danger signs and other topics but also in the state of their babies.

The absence of the effect of the educational level of the mothers on their evaluation of prenatal healthcare services is predominant here as it is noticed that in the previous studies those at a high educational level are more likely to be critical about care received and defer a positive evaluation. This issue was also revealed in Fawole et al study (Fawole et al., 2008) where they hypothesized that as the level of education in the community steadily increases, pregnant women may become more and more critical of health care. Hence there is a need to mobilize efforts for a better quality assessment in our health care provision with the aim of improving quality in terms of provision of health care services. Improvement must be made to attain a desired change and amelioration in our health care delivery package.

Additionally, in the current study results, factors such as gravida, para, risk during pregnancy, gestational DM and gestational HTN do not have significant effect on the mothers' evaluation of prenatal care in the Southern Governorate. This could be explained by that the mothers receive the same prenatal care services regardless of the presence of the factor which were mentioned above. Also, it could be attributed to the current study sample, in which the total number of primi gravida and primi para in the current study are less than multi ones, which can lead to make some statistical variations in calculating the

test statistics and p value. Also, the total number of mothers who have gestational DM and HTN are less than those who do not.

The current study results are not consistent with the results of Edie et al. (2015) which revealed that there were significant differences between primigravida or multigravida on the aspect of the comprehensiveness of prenatal care. Primigravida on the contrary expected vital information from the health talks to help them cope well with their.

Chapter Five

Conclusion and Recommendations

5.1. Summary of the Study

The main aim of this study was to assess the prenatal care services in the Southern Gaza Governorates based on the women perspectives. The design of this study was a quantitative cross-sectional. This study was carried out at governmental primary health care centers in the southern governorates (Khanyounis and Rafah) mainly at prenatal care clinic services. The target population of this study consisted of the women who have received prenatal care services during their pregnancy in the primary health care centres at Southern governorates in the governmental health care centers.

Two governmental health care centers were selected randomly from Rafah (Rafah primary health care center and Tal-Sultan center) and two were selected from Khanyounis (Khanyounis primary health care center and Bani-Suhaila center). After that, a convenience sampling method was applied to select the women who have received prenatal care services in the selected primary health care centers, in which 300 out of 312 women agreed to participate in the current study. An interview questionnaire was used in this study. Which is Quality of prenatal care questionnaire.

The study results revealed that the highest mean domain of the quality of prenatal healthcare services in the current study is information sharing (26.89 out of 36.0) with mean percentage 74.69%, followed by the domain of support and respect (35.71 out of 48.0) with mean percentage 74.39%. While the lowest mean is the domain of approachability (8.04 out of 16.0) with mean 50.25%. The study results showed also that the total mean percentage of the women's evaluation of prenatal health care services is 69.77%

Moreover, significant factors which affected the women's evaluation of prenatal care include: the level of income in favor to those who have income below 1000 Shekel and those who have income between 1000 and 1500 Shekel. Also, the name of primary health care centers in favor to Bani-Suhaila center. Other factors include: body mass index, the presence of risk, the presence of gestational hypertension, and residence.

5.2. Conclusion

The women's evaluation of prenatal care services in the southern governorates was not satisfactory. Some of the mean percentage of the domains of women's evaluation were low, which indicate that there are substantial problem in providing the prenatal care services in some areas like information sharing and approachability

5.3. Recommendations

- Conducting workshops at the ministry of health level to increase the level of the quality of prenatal care services in the Southern governorates and other governorates.
- The ministry of health should work on the domains which have been included in the questionnaire in order to include it in the daily work of the prenatal care in the primary healthcare centers.
- Application of evidence-based practice by the nurses and other healthcare proviers should be considered and encouraged.
- Modification of nursing and midwifery curriculum to meet the current and updated challenges which face the quality of prenatal healthcare services.
- In-service training for healthcare providers for prenatal care and the current issues and practices, stressing on giving the mother sufficient time and approachability of care.
- Encouraging healthcare providers to be more patient and good and active listeners for the clients and the mothers.
- Informing and educating the mothers about their status during pregnancy, discussing with them about the important issues which they do not understand it.
- Further studies should be conducted to reveal other factors which affect the quality of prenatal care services.

5.4. Limitations of the Study

Very limited previous studies especially the studies considering the study tool which have been used in the current study; which make huge difficulties in making comparisons with other previous studies. Also, the absence of the factors of healthcare providers may affect the women's evaluation, some of these factors were not considered in the present study.

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Annexes

Annex 1: The Questionnaire

الرقم التسلسلي

أختي الفاضلة .. حفظكي الله

السلام عليكم ورحمة الله وبركاته

تقوم الباحثة أدناه بإعداد رسالة ماجستير بعنوان

تقييم السيدات الحوامل للرعاية المقدمة لهن قبل فترة الولادة في مراكز الرعاية الصحية

الحكومية في محافظات قطاع غزة الجنوبية

إن هذا البحث يشكل جزء ضروري من دراستي كمتطلب أساسي للتخرج من جامعة القدس تخصص ماجستير تمريض صحة الأم والطفل - وقد تم اختياركم ضمن مجموعة الأخوات المشاركات في هذه الدراسة للإجابة على العبارات الواردة فيها.

إذا كنتي توافقين على المشاركة في هذه الدراسة، يرجى التكرم بقراءة العبارات التالية بدقة والإجابة عنها بموضوعية لما في ذلك من أثر كبير على صحة النتائج والتوصيات التي سوف تتوصل إليها الباحثة مع التأكيد بأن هذه البيانات سوف تستخدم لأغراض البحث العلمي فقط، وسيتم التعامل معها بسرية تامة.

أوافق لا أوافق

ملاحظة / الوقت اللازم لتعبئة الإستبانة كاملة لا يستغرق أكثر من 20 دقيقة.

نشكركم على حسن تعاونكم معنا

الباحثة

أسماء عيسى عبدالهادي

الجزء الأول: البيانات الخاصة بالأم والحمل

سنة		1. العمر
<input type="checkbox"/> رفح	<input type="checkbox"/> خانيونس	السكن
.....		اسم المركز الصحي
<input type="checkbox"/> ثانوية	<input type="checkbox"/> ابتدائي/إعدادي	2. المؤهل العلمي
	<input type="checkbox"/> لست متعلمة	<input type="checkbox"/> جامعية
	<input type="checkbox"/> دراسات عليا	
	<input type="checkbox"/> لا أعمل	3. المهنة
	<input type="checkbox"/> أعمل	
..... شيكل شهريا		4. معدل الدخل

الجزء الثاني: معلومات عن الحمل / مشاكل ومخاطر خلال فترة الحمل

<input type="checkbox"/> أول مرة	<input type="checkbox"/> متعددة	5. الحمل
<input type="checkbox"/> أول مرة	<input type="checkbox"/> متعددة الولادات	6. الولادة
..... أسبوع		7. عمر الحمل
..... كجم		8. الوزن
..... متر		9. الطول
<input type="checkbox"/> لا	<input type="checkbox"/> نعم	10. هل تعرضت لمخاطر خلال الحمل الحالي
<input type="checkbox"/> لا	<input type="checkbox"/> نعم	11. هل تعانين من ارتفاع في ضغط الدم
<input type="checkbox"/> لا	<input type="checkbox"/> نعم	12. هل تعانين من السكري
<input type="checkbox"/> لا	<input type="checkbox"/> نعم	13. هل تعانين من مشاكل في القلب
<input type="checkbox"/> لا	<input type="checkbox"/> نعم	14. هل تعانين من أمراض في الكلى
<input type="checkbox"/> لا	<input type="checkbox"/> نعم	15. هل تعانين من مرض الربو/مشاكل تنفسية
.....		16. هل تعانين من أمراض أخرى

Section (2): Assessment of Quality of Prenatal Care

تقييم جودة الرعاية الصحية المقدمة قبل فترة الولادة

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. I had as much time with my personal care provider(s) as I needed قضيت الوقت الكافي الذي أحتاجه مع مقدم الرعاية الصحية	4	3	2	1	0
2. My prenatal care provider(s) gave me options for my birth experience. قدم لي مقدم الرعاية خيارات لعملية الولادة مستقبلاً	4	3	2	1	0
3. I was given adequate information about prenatal tests and procedures. تم إعطائي معلومات كافية عن الاختبارات والفحوصات اللازمة لرعاية ما قبل الولادة.	4	3	2	1	0
4. I was given enough information to meet my needs about breastfeeding. تم إعطائي معلومات كافية حول الرضاعة الطبيعية.	4	3	2	1	0
5. My prenatal care provider(s) respected me. يحترمني / تحترمني مقدم/ة الرعاية الصحية	4	3	2	1	0
6. I was always given honest answers to my questions. يتم إعطائي دائماً إجابات صحيحة على أسئلتني	4	3	2	1	0
7. My prenatal care provider(s) respected my knowledge and experience. يحترم مقدمي الرعاية الصحية معرفتي وخبراتي .	4	3	2	1	0
8. My prenatal care provider(s) was rushed. مقدمي الرعاية الصحية متسرع	4	3	2	1	0

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
9. I knew how to get in touch with my prenatal care provider(s). أعرف كيف أتواصل مع مقدم الرعاية قبل الولادة	4	3	2	1	0
10. My prenatal care provider(s) prepared me for my birth experience. قام مقدم الرعاية الصحية بتجهيزي للخوض في تجربة الولادة	4	3	2	1	0
11. Everyone involve in my prenatal care received the important information about me. تم إعطاء المعلومات الهامة لكل شخص شارك في الرعاية الخاصة لما قبل الولادة	4	3	2	1	0
12. My prenatal care provider(s) spent time talking with me about my expectations for labor and delivery. تحدث مقدم الرعاية معي بخصوص توقعاتي للولادة	4	3	2	1	0
13. My decision were respected by my prenatal care provider(s). يتم احترام قراراتي من قبل مقدم الرعاية الصحية قبل فترة الولادة	4	3	2	1	0
14. My prenatal care provider (s) was abrupt with me. مقدمي الرعاية الصحية كان حادا معي.	4	3	2	1	0
15. I was given enough information about the safety of moderate exercise during pregnancy. تم إعطائي معلومات كافية تتعلق بالتمارين الخفيفة خلال الحمل.	4	3	2	1	0

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
16. I was screened adequately for potential problems with my pregnancy. تم فحصي بشكل كامل للتحقق من المشاكل المحتملة أثناء الحمل.	4	3	2	1	0
17. My prenatal care provider(s) always had time to answer my questions. مقدم الرعاية الصحية لديه الوقت دائما للإجابة على أسئلتني	4	3	2	1	0
18. My prenatal care provider(s) was patient. يتسم مقدم الرعاية الصحية بالصبر	4	3	2	1	0
19. I received adequate information about my diet during pregnancy. تم إعطائي معلومات كافية عن النظام الغذائي السليم أثناء الحمل.	4	3	2	1	0
20. I was supported by my prenatal care provider(s) in doing what I felt was right for me. أتلقي دعم من مقدم الرعاية الصحية عندما أخبره عن فعلي لما هو مفيد وجيد بالنسبة لي	4	3	2	1	0
21. The results of tests were explained to me in a way I could understand. يتم شرح نتائج الفحوصات الخاصة بي بطريقة أستطيع فهمها.	4	3	2	1	0
22. I was rushed during my prenatal care visits. أكون متسرعة وعجولة خلال زيارتي لتلقي الرعاية الصحية الخاصة بفترة ما قبل الولادة.	4	3	2	1	0
23. My prenatal care provider (s) was	4	3	2	1	0

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
interested in how my pregnancy was affecting my life. يهتم مقدم الرعاية الصحية بقضية تأثير الحمل على حياتي اليومية.					
24. My prenatal care provider(s) supported me يوفر مقدم الرعاية الصحية الدعم اللازم لي.	4	3	2	1	0
25. My prenatal care provider(s) paid close attention when I was speaking. مقدم الرعاية الصحية يعيرني الاهتمام عندما أتحدث معه	4	3	2	1	0
26. I was linked to programs in the community that were helpful to me. أشارك في برامج المجتمعية مفيدة جدا لي.	4	3	2	1	0
27. My prenatal care provider(s) made me feel like I was wasting their time. يشعرنني مقدم الرعاية الصحية أنني قمت بإضاعة وقته.	4	3	2	1	0
28. My concerns were taken seriously. يتم أخذ اهتماماتي واعتباراتي على محمل الجد.	4	3	2	1	0
29. My prenatal care provider(s) made time for me to talk. يمنحني مقدم الرعاية الصحية الوقت الكافي لأتحدث بحرية.	4	3	2	1	0
30. I received adequate information about alcohol use during pregnancy. أعطيت معلومات كافية عن أضرار التدخين أثناء الحمل.	4	3	2	1	0
31. My prenatal care provider(s) was available when I had questions or concerns.	4	3	2	1	0

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
يكون مقدم الرعاية الصحية متاحاً عندما يكون لدي استفسارات وأسئلة					
32. My prenatal care provider(s) gave straight forward answers to my questions. مقدم الرعاية الصحية يقوم بالإجابة مباشرة على أسئلتي .	4	3	2	1	0
33. I was in control of the decisions being made about my prenatal care. أستطيع التحكم بالقرارات التي تم أخذها بشأن الرعاية الصحية قبل فترة الولادة.	4	3	2	1	0
34. I could always reach someone in the office clinic if I needed something. أستطيع الوصول للشخص الذي أريده عند احتياجي لأمر ما.	4	3	2	1	0
35. My prenatal care provider(s) supported my decisions. مقدم الرعاية الصحية يدعم قراراتتي .	4	3	2	1	0
36. I was at ease with my prenatal care provider(s). أشعر بالراحة مع مقدم الرعاية الصحية.	4	3	2	1	0
37. I could reach my prenatal care provider(s) by phone when necessary. أستطيع التواصل مع مقدمي الرعاية الصحية عن طريق الهاتف للضرورة.	4	3	2	1	0
38. My prenatal care provider(s) gave me enough information to make decisions for myself. أعطاني مقدم الرعاية الصحية المعلومات الكافية لعملية	4	3	2	1	0

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
اتخاذ القرارات الخاصة بي.					
39. I was afraid to ask my prenatal care provider(s) question. أشعر بالخوف عندما أسأل مقدم الرعاية الصحية عن أي أمر ما.	4	3	2	1	0
40. My values and beliefs were respected by my prenatal care provider(s). يحترم مقدم الرعاية الصحية معتقداتي وقيمي	4	3	2	1	0
41. I was given adequate information about depression in pregnancy. أتم إعطائي معلومات كافية عن الاكتئاب أثناء فترة الحمل.	4	3	2	1	0
42. My prenatal care provider(s) kept my information confidential. يحافظ مقدم الرعاية الصحية على سرية المعلومات الخاصة بي.	4	3	2	1	0
43. My prenatal care provider(s) took time to listen. استغرق مقدم الرعاية الصحية وقتاً كافياً للاستماع لي.	4	3	2	1	0
44. I fully understood the reasons for blood work and other test my prenatal care provider(s) ordered for me. أفهم جيداً أسباب طلب التحاليل والفحوصات خلال فترة الحمل	4	3	2	1	0
45. My prenatal care provider(s) took time to ask about things that were important to me. استغرق مقدم الرعاية الصحية وقتاً ليسأل عن الأمور الهامة بالنسبة لي	4	3	2	1	0

Annex 2: Approval from Helsinki



المجلس الفلسطيني للبحوث الصحية Palestinian Health Research Council

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

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

Helsinki Committee For Ethical Approval

Date: 05/02/2018

Number: PHRC/HC/328/18

Name: ASMAA E. ABDALHADI

الاسم:

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

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم

حول:

Women's Evaluation of Prenatal Care in the Southern Gaza Governorates: A Comparative Study between UNRWA and Governmental Health Centers.

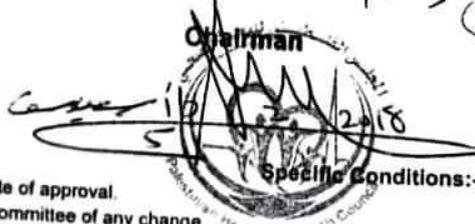
The committee has decided to approve the above mentioned research. Approval number PHRC/HC/328/18 in its meeting on 05/02/2018

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

Signature

Member
Nak Mahan

Member
د. نائل أبو حسان
5/2/2018



General Conditions:-

Valid for 2 years from the date of approval.
It is necessary to notify the committee of any change in the approved study protocol.

The committee appreciates receiving a copy of your final research when completed.

Annex 3: Approval of MOH

State of Palestine
Ministry of health



دولة فلسطين
وزارة الصحة

التاريخ: 30/04/2018
رقم المراسلة: 213140

السيد : المحترم

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

السلام عليكم ،،،

الموضوع/ تسهيل مهمة الباحثة/ أسماء عبد الهادي

التفاصيل //

بخصوص الموضوع أعلاه، يرجى تسهيل مهمة الباحثة/ أسماء عيسى عبد الهادي
الملتحنة ببرنامج ماجستير التمريض - كلية الصحة العامة- جامعة القدس أبوديس في إجراء بحث بعنوان:-
"Women's Evaluation of Prenatal Care in the Governmental Health Centers at Southern
"Gaza Governorates"

حيث الباحثة بحاجة لتعبئة استبانة من عدد من النساء الحوامل المراجعات لعيادات الحوامل في مراكز الرعاية الأولية في
محافظة رفح وخانيونس.
نأمل توجيهاتكم لذوي الاختصاص بضرورة الحصول على الموافقة المستنيرة من النساء اللاتي هن على استعداد
 للمشاركة في الدراسة ومن ثم تمكين الباحثة من التواصل معهن، بما لا يتعارض مع مصلحة العمل وضمن أخلاقيات
 البحث العلمي، ودون تحمل الوزارة أي أعباء أو مسئولية.
وتفضلوا بقبول التحية والتقدير،،،
ملاحظة/ البحث حصل على موافقة لجنة أخلاقيات البحث الصحي.
ملاحظة / تسهيل المهمة الخاص بالدراسة أعلاه صالح لمدة 6 شهر من تاريخه.

محمد إبراهيم محمد السرساوي

مدير دائرة/الإدارة العامة لتنمية القوى البشرية -



التمويلات

إجراءتكم بالخصوص(30/04/2018)	← رامي عبد سليمان العبداله(مدير عام بالوزارة)	■ محمد إبراهيم محمد السرساوي(مدير دائرة)
إجراءتكم بالخصوص(30/04/2018)	← عبد اللطيف محمد محمد الحاج(مدير عام بالوزارة)	■ رامي عبد سليمان العبداله(مدير عام بالوزارة)
إجراءتكم بالخصوص(30/04/2018)	← ماهر محمود عبد الهادي شامية(مدير عام بالوزارة)	■ رامي عبد سليمان العبداله(مدير عام بالوزارة)
لعمل اللازم(30/04/2018)	← نهله صقر سليمان الأعرج(مدير دائرة)	■ ماهر محمود عبد الهادي شامية(مدير عام بالوزارة)
لعمل اللازم(30/04/2018)	← فواز ادريس محمد ابو زياده(طبيب مدير)	■ ماهر محمود عبد الهادي شامية(مدير عام بالوزارة)
لعمل اللازم(30/04/2018)	← صلاح الدين علي عبد الحفيظ الرنتيسي(مدير دائرة)	■ ماهر محمود عبد الهادي شامية(مدير عام بالوزارة)

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غزة

Annex 4: Control Panel

No	Name	Affiliation
1	Dr. Hamza Abdel-jawwad	Al-Quds University
2	Dr. Ahmad Nejm	Al-Azhar University
3	Dr. Waleed Abu-hatab	Obstetrics and Gynecology -Nasser Medical Complex
4	Dr. Ali Alkhateeb	University College of Applied Sciences
5	Dr. Hani Mahdi	Obstetrics and Gynecology -Shifa Medical Complex

عنوان الدراسة: تقييم السيدات الحوامل للرعاية المقدمة لهن قبل فترة الولادة في مراكز الرعاية الصحية الحكومية في محافظات قطاع غزة الجنوبية

إعداد: أسماء عيسى عبدالهادي

إشراف: د. سامر خضر النواجحة

ملخص:

إعداد النساء لمرحلة الولادة ومنع المضاعفات تعد من الأمور المهمة والجوهرية التي تحدث للنساء، والتي من الممكن أن تحدث للنساء الحوامل والرضع من خلال الاكتشاف المبكر والتخفيف من حدة هذه المضاعفات. لقد هدفت هذه الدراسة إلى تقييم خدمات رعاية ما قبل الولادة من قبل الأمهات المراجعات في محافظات جنوب قطاع غزة، حيث بلغت عينة الدراسة 300 تم اختيارهم بطريقة العينة الملائمة من أربع عيادات تم اختيارهم بطريقة عشوائية بسيطة من عيادات الرعاية الأولية الحكومية في محافظتي خانينونس ورفح، وقد استخدمت الباحثة الاستبانة كأداة لجمع البيانات، حيث تم استخدام الأساليب الإحصائية مثل النسب المئوية والمتوسط الحسابي، واختبار ت لعينتين مستقلتين، واختبار التباين الأحادي.

كشفت نتائج الدراسة أن أعلى متوسط نسبي لمجال تقييم النساء الحوامل للرعاية ما قبل الولادة هو "تبادل المعلومات" (74.69%)، يليها مجال الدعم والاحترام (74.39%)، بينما كان أقل متوسط هو مجال "المنهجية في التعامل وسهولة الوصول" (50.25%)، علاوة على ذلك فقد كشفت نتائج الدراسة أن العوامل التي أثرت على تقييم النساء الحوامل للرعاية ما قبل الولادة شملت: مستوى الدخل، عيادة الرعاية الأولية، مؤشر كتلة الجسم، ووجود خطر خلال فترة الحمل، ووجود ارتفاع ضغط الدم أثناء الحمل.

خلصت الدراسة إلى أن تقييم النساء الحوامل لخدمات الرعاية ما قبل الولادة في محافظات قطاع غزة الجنوبية لم يكن مرضياً وخاصة في مجالين: توفير الوقت الكافي للأم الحامل خلال وقت المراجعة، والمنهجية في التعامل وسهولة الوصول، وقد أوصت الباحثة بضرورة إجراء ورش عمل على مستوى وزارة الصحة لرفع مستوى جودة خدمات رعاية ما قبل الولادة في محافظات قطاع غزة الجنوبية والمحافظات الأخرى، إلى جانب تنفيذ المجالات الستة التي قد تم ذكرها مسبقاً في أداة الدراسة الحالية، علاوة على ذلك ينبغي إجراء مزيد من الدراسات للكشف عن المزيد من العوامل التي قد تؤثر على جودة خدمات الرعاية ما قبل الولادة.