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Evaluation of Reproductive Health Services at Jabalia and Al-Bureij Women's Health Centers

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~~**Thesis Approval**~~

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Dedication

My humble effort I dedicate to my mother who instilled the eagerness to learn and to be ambitious deeply inside me since childhood.

My sisters, brothers, extended family, friends, and my colleagues.

My sweet and lovely daughters

Dalia & Deema

My beloved husband

To the pure soul of my husband, Mahmoud El Ghirbawi

who always used to encourage and support me, despite he was the one who needs all the support at that time.

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Declaration

I certify that this thesis submitted for the degree of master is the result of my own research, except where otherwise acknowledged, and that this thesis or any of its parts has not been submitted for higher degree to any other university or institution.

Signed:

Maha Sabry El Akkad

Date: ……../ ……/ ……..

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Abstract

Worldwide, Reproductive Health problems are among the top leading causes of morbidity and mortality among women of reproductive age. In the Gaza Strip, programs that offer Reproductive Health services exist in most health service organizations; however, not all of these programs provide comprehensive services. Among the programs that provide comprehensive Reproductive Health services are the two Women Health Centers in Jabalia and Al-Bureij refugee Camps. The two Centers also provide legal, psychosocial, and physiotherapy services. The study aimed to evaluate the Reproductive Health services in the two women health Centers in order to improve the quality and effectiveness of the provided services.

This study is a mixed methods; it involves both quantitative and qualitative data. The quantitative were collected from beneficiaries of Reproductive Health clinics within the two Centers. In total, 375 randomly selected women participated in the quantitative study, with 89.3% response rate. The qualitative data were collected through nine in-depth interviews with senior managers and providers, and six focus group discussions with beneficiaries of two Centers' service, with participation of 38 women. The researcher insured reliability, validity and trustworthiness of the study tools. Different descriptive and inferential statistical tests were used to analysis the quantitative data while Open Coding Thematic analysis was used to analyze the qualitative data.

The quantitative study revealed that the participants were women aged between 16 and 65 years with average of 11.86 years of schooling. The majority of participants (96.8%) were married. Only 16% of the participants were employed and about 52% of them have monthly income of less than 1,000 ILS per month. Both quantitative and qualitative studies revealed that women's health status and their well-being have been improved as a result of utilizing the two center services. The vast majority of the participants (98.7%) have received the services they were supposed to, and these services met their health needs as indicated by 95.2% of participants. From beneficiaries' perspectives, the overall mean percentage of accessibility, affordability, and availability of selected services was 81.18%. And for providers' respect of privacy, confidentiality and dignity, the mean percentage was 87.68. It was 83.4% for the infrastructure and equipment, while it was 85.30% for skilled and competency of the health providers. General satisfaction of women related to the provided Reproductive Health services was 87.8%, congruently; the qualitative findings have shown high level of satisfaction with the provided legal, psychosocial, and physical therapy services. The study has showed that there is a limited financial sustainability of services as the two Centers are funded by external donors. To conclude, offering integrated reproductive services was very efficient and effective way of providing services; more efforts are needed to increase the utilization of postnatal care service and utilization of services by youth and single women.

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List of Abbreviations

AIDOS	Associazione italiana donne per to sviluppo Means the Italian Association for Women in Development.
CFTA	Culture and Free Thought Association
DHSSPS	Department of Health, Social Services and Public Safety
FSRH	Facility of Sexual and Reproductive Healthcare
GBV	Gender Based Violence
GS	Gaza Strip
IFC	International Finance Corporation
MCH	Mother and Child Health
MMR	Maternal Mortality Rate
MoH	Ministry of Health
NGOs	Non-governmental Organizations
PCBS	Palestinian Central Bureau of Statistics
RCS	Red Crescent Society
RH	Reproductive Health
SPSS	Statistical Package for Social Sciences
SRH	Sexual and Reproductive Health
STDs	Sexually Transmitted Diseases
NGOs	Non-governmental Organizations
UNEP	United Nations Environmental Program
UNFPA	United Nations Population Fund
UNPOPIN	United Nations Population Information Network
WHCs	Women's Health Centers
WHCJ	Woman's Health Center in Jabalia
WHO	World Health Organization

Chapter 1

Introduction

1.1 Background

Reproductive Health (RH) is of special importance due to its overall impacts on societal development. RH is a reflection of health during childhood, adolescence and adulthood. It sets the stage for health beyond the reproductive years for both women and men (United Nations Population Information Network, 2013).Currently, half of the world's 2.6 billion women are of reproductive age, 15-49 years of age, thus, without proper RH services, they are highly vulnerable to RH problems (Worku and Gebresilassie, 2008).

Worldwide, RH problems are among the top leading causes of morbidity and mortality among women of reproductive age. According to the World Health Organization (WHO), in 2013 some of 289,000 women died in perinatal period. Almost all of these deaths occurred in low-resource settings, and most deaths could have been prevented (WHO, 2014). A study conducted by United Nations Population Fund (UNFPA) showed that impoverished women, especially those living in developing countries, suffer from consequences of unintended pregnancies, maternal death and disability, STDs, and other problems related to their reproductive system and sexual behavior (UNFPA, 2013).

Maternal mortality is a prevalent problem in developing countries whereas 99% of maternal mortality cases occur in developing countries (WHO, 2009). Also, there is a wide range of differences between countries with regard to Maternal Mortality Rate (MMR). For instance, MMR ranges from 1 per 100,000 live births in Ireland to 2,100 per 100,000 live births in Sierra Leone. Such differences reveal major political, economic, and social differences across different countries (WHO, 2009). The

Ministry of Health (MoH) indicated that in the Gaza Strip (GS), the MMR during 2013 was 21.5 per 100,000 (MoH, 2014). According to Morse and colleagues (2011), MMR is an indicator that commonly used to assess the quality of health services provided, the overall level of health, and the socio-economic development of a particular population. Additionally, it is used to identify situations of inequality across and between countries (Morse et al., 2011).

In the GS, programs that offer RH services exist in most health service organizations; however, these programs do not provide comprehensive services. Most of these programs offer fragmented services, based on the organizations' interest. For instance, the objectives and design of most available family planning programs are largely driven by a demographic imperative, without taking into consideration important issues such as overall women's health and STDs treatment and prevention.

In the GS, there are two RH programs implemented at Woman's Health Centers (WHCs) serving women in Jabalia and Al-Bureij refugee Camps (Annex 11). The overall objectives of RH services provided at these WHCs are to improve the health status, the psychological and social well-being of the refugee women and adolescents of the GS. The two WHCs offer services which focus on reproductive age. The two WHCs focus on three areas; access to reproductive and sexual health services and products, counseling and empowerment support, and service quality and technical capacity building. The two WHCs are run and operate under the responsibility of two Palestinian Non-governmental Organizations (NGOs): the Red Crescent Society (RCS) and the Culture and Free Thought Association (CFTA). In this study, the researcher will evaluate these two programs in terms of input, process, and outcomes. Also, the researcher will assess the programs contribution to improving the status of women's health of the WHCs' beneficiaries.

1.2 Importance of the study

RH is an important component of public health that is necessary and needed for social, economic and human development. The highest attainable level of health is not only a fundamental human right, but it is also necessary to achieve social and economic development (United Nations Population Information Network, 2013).

The two WHCs in Jabalia and Al-BureijCamps offer a wide range of RH services (see Annex 11). Because of the importance of these services and consequently these Centers; it is important to evaluate the provided services.

This study is very important; it contributes to provide data, evaluation to improve the provided services in the two WHCs. It is an evaluative research study based on a model and contributes to the knowledge.

There are other studies related to the evaluation of WHCs services, but this study may be addressed in more holistic manner, the provided services.

Few studies have conducted to evaluate the provision of RH services, the effectiveness, or the impact of the program on women health status and well-being in the two WHCs. However, some studies were conducted to assess separate components of the provided services. In 2009, a study was conducted to assess the quality of RH services from clients' perspective in Jabalia WHC (Shaqura, 2009). Also, two studies were conducted in both WHCs; one of them was conducted to assess the adolescence counseling services in 2006.

1.3 Justification of the study

A high quality and comprehensive RH services are essential to improve health outcomes among women and their children. According to WHO, most of maternal mortality and morbidity cases that are attributed to pregnancy and childbirth related complications can be

avoided with improving women's access to quality care from a skilled birth attendant before, during and after pregnancy and childbirth (WHO, 2014).Currently, in the GS, many women face challenges to access care facilities that promote health, offer good quality care services, and provide much needed psychological counseling and support. To assess the quality and effectiveness of services, there is a need to conduct systematic evaluation for these services. Several studies were conducted in the GS to evaluate health care services, including RH services, most of these studies focused on the MoH and United Nations Relief and Works Agency for Palestine Refugees (UNRWA) health programs.

To the researcher's best knowledge; few studies were conducted to evaluate RH services in the NGOs and private sector, as mentioned earlier. This study will assess the effectiveness of RH services in the two WHCs. Findings of this evaluation study could be used in strategic planning and allocation of resources. Furthermore, this study will add to the body of knowledge in the field of healthcare services utilization and evaluation, particularly within NGO settings in the GS.

1.4. Aim of the study

The overall aim of this study is to evaluate the RH services in the two WHCs in Jabalia and Al-Bureij refugee Camps in order to improve the quality and effectiveness of the provided services.

1.5 Research Objectives

More specially, the study aims to:

1. Assess the effectiveness; the degree in which the program achieved its objectives and outcomes.

2. Appraise the beneficiaries' perspectives regarding the RH services they receive and its responsiveness to their needs.

3. Assess the accessibility, affordability and availability of the provided services, infrastructure and equipment of the clinics, skills and competency of the health providers. Furthermore, appraise the beneficiaries' perspectives regarding the communication, providers' respect of privacy, confidentiality and dignity.

4. Identify areas of strengths and weaknesses of the two programs.
5. Examine the beneficiaries' satisfaction with the RH services in the two WHCs.
6. Assess the effect of the programs on women's health.
7. Suggest recommendations according to the study findings.

1.6 Research questions

1. Did the two programs achieve their objectives and outcomes?
2. How do the beneficiaries perceive the RH services they receive? And to what extent these services are responsive to their needs?
3. What about the accessibility, affordability and availability of the provided services, infrastructure and equipment of the clinics, skills and competency of the health providers.
4. What about the communication between health providers and the beneficiaries. And to what extent the providers maintain and respect the privacy, confidentiality and dignity, according to the beneficiaries' perception .

5. What are the main factors that encourage women to utilize RH services?

6. What are the obstacles that may hinder women from utilizing WHCs services?
7. Do guide lines and protocols exist in the two WHCs?

8. Are the beneficiaries satisfied with the provided services?
9. What is the effect of these services on women's health status and well-being?

1.7 Context of the study

1.7.1 Demographic context

Palestine is located south-west Asia, on the south east coast of the Mediterranean Sea, to the west of Jordan and to the south of Lebanon. The total area of occupied Palestine is 27,009 square kilometers, the West Bank and GS amounts to 6,209 square kilometers and represent 22.95% of occupied Palestine as follows: West Bank 5,844 kilometers, and represents 21.6% of the total area of the land of historic Palestine. The Gaza Strip, an area of 365 square kilometers, and represents 1.35% (Palestinian News and Info Agency, 2011).

According to the Palestinian Central Bureau of Statistics (PCBS), the estimated population of Palestinians at the end of 2014 in the world was 12.10 million Palestinians, distributed according to place of residence by 4.62 million in the GS, West Bank, and Jerusalem. Distribution of population shows that the highest number of population is in Hebron with 15.0% of the total population, followed by GS with 13.3% of the total population (PCBS, 2013).The estimated population of the GS is 1.7 million, it constitutes 38.8% of the total population (PCBS, 2014).

The population of Palestine is considered a young population, as at the end of 2014, the percentage of individuals who are less than 15 years was 39.6% of the total population. The fertility rate in the GS is higher than in the West Bank and other surrounding countries. The total fertility rate is 3.7 births per woman in the West Bank and it is 4.5 births per woman in the GS (PCBS, 2014). The high fertility rate explains the high growth rate as it is 3.41% in the GS (PCBS, 2014).

The Gaza Strip is a small piece of land located in the southern area of Palestine (Annex 1) and is divided into five governorates: North Gaza, Gaza City, Mid Zone, Khan Younis, and Rafah. The population of the GS includes about one million of refugees who live in eight recognized camps. Jabalia is the largest of the GS's eight refugee camps, located north of Gaza City and covers an area of only 1.4 square kilometers. After the Arab-Israeli war in 1948, some of 35,000 refugees settled in this camp. In 2014, the total population of Jabalia camp was about 110,000 refugees (UNRWA, 2015). Regarding Al-Bureij camp, it is a comparatively small refugee camp located in the middle of the GS. Al-Bureij camp was built in the 1950s to host approximately 13,000 refugees. In 2014, the total population of Al-Bureij camp was slightly more than 34,000 refugees (UNRWA, 2015).The demand for health care services in the two camps is high mainly due to high population density, the high poverty rates, and harsh living conditions.

1.7.2 Socio-economic context

The current political situation, the frequent Israeli wars, and the siege imposed on the GS have severely damaged the Palestinian economy. According to the PCBS, about 13% of the households in the GS and West Bank in 2011 suffered from deep poverty according to consumption patterns (7.8% in the West Bank, and 21.1% in the GS). High population density, limited land and sea access, continuing isolation, and strict internal and external security controls have degraded economic conditions in the GS. The unemployment rate in the GS continues to be at unprecedented levels, particularly among young people, it increased from 28.7% to 31.0% (PCBS, 2013). As mentioned earlier, the population of the GS has experienced a decline in living conditions due to the closures and blockade; the bad situation became worse after the last Israeli war on the GS in summer of 2014 that the level of destruction in the latest war far exceeded that which occurred in the two previous wars.

This terrible war affected the 1.7million as some of 490,000 became internally displaced in need for immediate need of food, water and health services. The frequent wars also affected the mental well-being of all Gaza's residents, particularly children and women (UNRWA, 2014).

1.7.3 Palestinian health care context

The political, social and economic situation in Palestine, particularly in the GS is challenging. The health providers, including the MoH are still struggling to provide high quality health services and to meet the high demand for health services. In the GS, the main health providers are the MoH, UNRWA, NGOs and private sector.

Ministry of Health (MoH)

The Ministry of Health provides primary, secondary and tertiary services. It provides free of charge services for mother and child. The Ministry of Health runs 54 primary health care centers in the GS (MoH, 2013). Out of the 54 centers, 26 clinics provide mother and child health (MCH) services (MoH, 2014). The MCH services include free of charge antenatal care, postnatal care for pregnant women. It also provides women with postnatal care services and family planning services (MoH, 2014).

United Nations Relief and Work Agency (UNRWA)

The United Nations Relief and Work Agency has been the main provider of comprehensive primary health care services for Palestinian refugees for the past 60 years. It promotes a comprehensive approach to health care from preconception to old age, with a strong focus on primary health care and prevention. UNRWA provides its services through 21 primary health clinics in the GS. In the GS, 82% of its refugees have access to UNRWA’s services (WHO, 2010).

Non-governmental organizations and private sector (NGOs)

The Non-governmental organizations manage 197 primary health care centers, including 57 in the GS. RH services constitute a major portion of health services offered in most of NGOs centers (MoH, 2013).

1.7.4 Red Crescent Society for Gaza Strip (RCS)

The Red Crescent Society for GS is an independent NGO concerned with democracy, development and relief work. It provides health, cultural, educational and humanitarian services to all needy citizens in the GS. The society was licensed in 1969 and permitted operating in the first of January 1972 (RCS, 2014).

The Red Crescent Society vision is to improve health, educational, cultural and human conditions of GS population and its mission is " t*o provide qualitative developmental services in fields of health, culture, education, and relief according to the societal needs mainly for those marginalized and low-income people; to participate in enhancing the role of the NGOs to positively influence the process of substantial and comprehensive development of the Palestinian society"* (RCS, 2014:5).The society has three centres which are Dr.Haider Abdul Shafi Centre, Abasan Medical Centre, and Woman's Health Centre in Jabalia Camp (RCS, 2014).

WHC in Jabalia Camp has been established in 1999 in Cooperation with the UNFPA and the Italian Association for Women in Development, Associazioneitalianadonne per to sviluppo (AIDOS), to meet women's need through providing Health Care, physical activities, psychological and legal counseling and community education via a unique center in the area (WHCJ, 2012). For more details, please see (Annex 11).

Objectives of WHC in Jabalia

The main objectives of WHC in Jabalia are: (1) improving women and men reproductive health, (2) reducing the incidence and complications of reproductive health diseases, (3) combating violence against women, (4) improving the physical health of women through physical activity and fitness, and (6) enhancing the women's culture and awareness regarding their roles and enable the women to be decision-makers (WHCJ, 2012).

1.7.5 Culture and Free Thought Association (CFTA)

The Culture and Free Thought Association established in 1991, it is an independent and secular knowledge-based organization playing a leading role in developing a Palestinian civil society.

According to CFTA strategic plan 2012-2014, CFTA aspires to be a leading contribute to a civil society organization working towards a society in which all Palestinian citizens enjoy freedom, equality, and human rights. While its mission is to develop a civil society that is based on promoting the rights of children, youth and women in the Middle and Southern Governorates of the Gaza Strip through community mobilization, child development, empowerment, youth engagement and advocacy initiatives. CFTA runs and financing, the WHC in Al-Bureij camp and other five centres in Khan Younis (CFTA, 2012).

Al-Bureij WHC is established in 1995 by two partner organizations, CFTA and AIDOS.

The two WHCs provide women comprehensive RH services. In addition to RH services which include antenatal care, postnatal care, family planning, outreach program, treatment and preventive care. It provides women with other services such as, physical therapy services, psychosocial assistance, legal counselling and community education in the north and middle governorate of Gaza, with technical support from AIDOS, and financial

support from the UNFPA, the European Union and others (CFTA, 2012). For more details, please see (Annex 11).

Objectives of WHC in Al-Bureij

The overall objective of the Al-Bureij WHC is to contribute to the improved RH, psychological and social well being of refugee women and adolescents of the Al-Bureij and middle area in the GS. By offering comprehensive quality services which focus on sexual health care, legal aid services, prevention of GBV and the protection of victimized women. In other words, the interventions of the Al-Bureij WHC program seek to:1) improve the health status of women and adolescents in Al-Bureij camp through greater outreach and enhanced range and quality of services and 2) investigate a positive change in attitudes and behaviours in relation to RH issues and choices amongst the beneficiaries (CFTA, 2012).

Outputs and results which both two WHCs work to achieve include, (1) better access to a comprehensive range of RH services for women and adolescents, (2) more victims and those at risk of gender-based and domestic violence receiving prevention and protection support, (3) greater awareness and better decision-making among the WHCs' service-users and communities towards reproductive and sexual health issue (CFTA, 2012).

1.7.6 **Situation of women's health in the Gaza Strip**

During its health annual report (March, 2015), the MoH in Gaza mentioned that the rate of women of child bearing age (15-49 year) was 23.8 out of total population. And the total fertility rate was 4 (MoH, 2015).

In the GS, the registered pregnant women attended MoH antenatal care centers was 18,187 and 39,546 woman in UNRWA clinics (MoH, 2015).

The percentage of high-risk pregnancy among new pregnant women in GS was 24.1 out of the total of new pregnant women (MoH, 2015).

In MoH centers, the average number of pregnancy visits was 7 visits. While it was 6.4 visits in UNRWA centers during 2014 (MoH, 2015).

Regarding the family planning, MoH reported that the common contraceptive method among new beneficiaries from its clinics (38 centers) in GS was the Intrauterine Device (IUD) that represented 36.9% while the tablets were represented 33.2% out of the total methods (MoH, 2015).

The MoH also mentioned that 25.6% of reported anemia was among pregnant women and 31.2% was among high-risk pregnant women (MoH, 2015b). The percentage of reported children under six months who received exclusively breastfeeding was 28.6 (MoH, 2015b). The MMR in the GS was 30.6/100,000 (MoH, 2015b).12.0 % of them were following up their pregnancy in private sector clinics, 35.0% in MoH centers and 53.0 were following up their pregnancy in UNRWA centers (MoH, 2015).

Sixteen pregnant women, out of (478) women, were passed away during the last war on Gaza in 2014 (MoH, 2015).

Finally, in the GS, the life expectancy among females during 2014 was 74.7 years (MoH, 2015b).

1.8 Operational definitions

Evaluation

Within the context of this study, the researcher is defining the evaluation as a process of collecting relevant information to determine the quality and effectiveness of the RH services in the two WHCs in Jabalia and Al-Bureij refugee Camps.

Quality of health care services

The definition which works with this study is that quality of health services mean, " The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Institute of Medicine, 2013).

Client's satisfaction

Client satisfaction is the level of satisfaction that clients experience having used a service. It therefore reflects the gap between the expected service and the experience of the service, from the client's point of view (Assefa et al., 2011).

Chapter 2

Literature review

2.1 Conceptual framework

The conceptual framework is the map that guides the design and the implementation of any research study. It is also a tool to summarize the study variables and it guides the research process through making research findings meaningful and applicable. The conceptual framework of the study was designed by the researcher based on the Donabedian Model, which is considered as a dominant paradigm for assessing the quality of care.

According to Donabedian Model, information about quality of care can be drawn from three dimensions: 1) structure (input) reflects the physical and organizational attributes where health care occurs. 2) process focuses on care delivered to clients, and 3) outcome, which reflects the effects of health services on the status of clients (Donabedian, 2005).This model is applied in the evaluation of health services and accreditation of health care providers and organizations. This model, structure (input)-process-outcomes, is universally accepted and used widely in the literature particularly in developing quality standards (Ibn El Haj et al., 2007).

The following (**Figure 2.1)** is showing the domains that were assessed in this study.

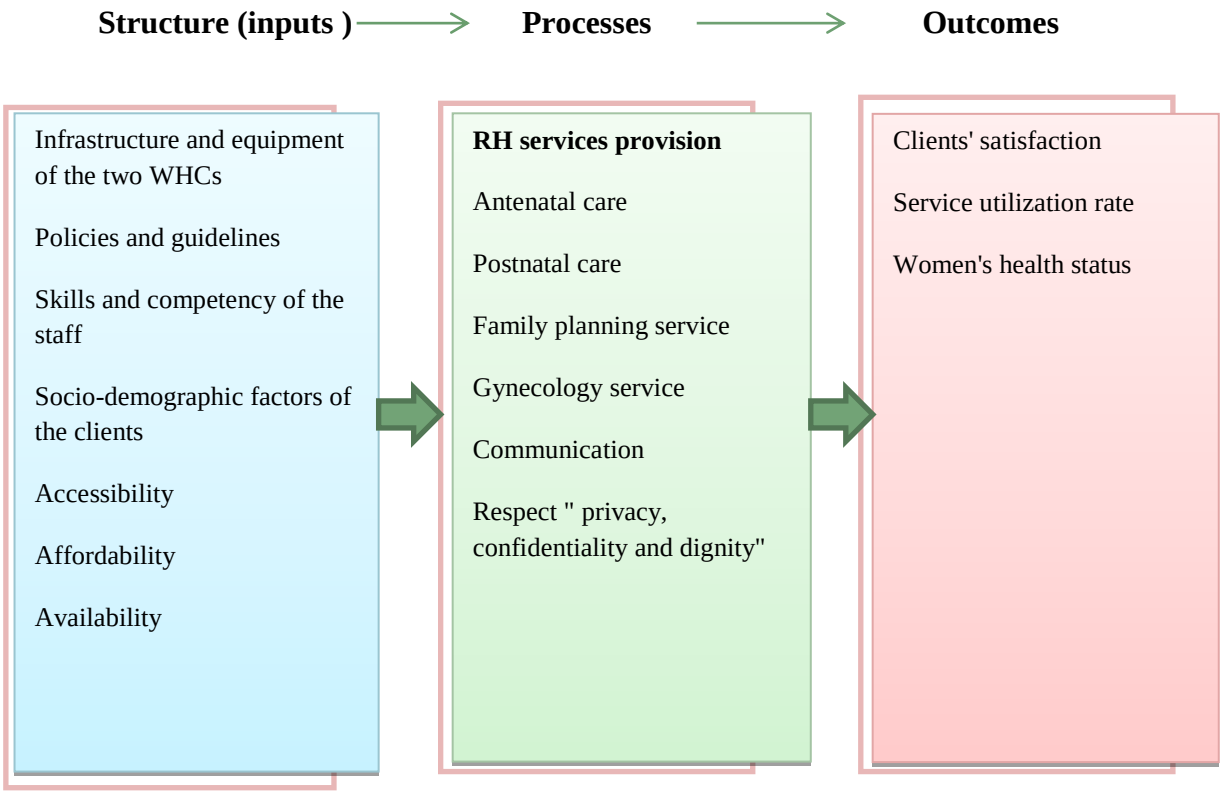

Figure (2.1): Diagram of conceptual frame work for the study-Self developed

The diagram above reflects the domains that affect the RH service provision and therefore clients' satisfaction, service utilization rate and women's health status. According to Donabedian Model, those domains could be categorized into three main groups;

1. Domains reflecting the structure (inputs): infrastructure and equipment of the two WHCs, policies and guidelines, socio-demographic factors of the clients, accessibility, affordability, availability, in addition to skills and competency of the staff.
2. Domains reflecting the process, RH services provision (antenatal care, postnatal care, family planning service, gynecology service). In addition to the communication (the interaction between providers and clients) and respect (privacy, confidentiality and dignity).

3. Domains reflecting the outcomes (clients' satisfaction, service utilization rate and women health status).

2.2 Literature review

2.2.1 Evaluation

Literature review shows that the evaluation utilizes many of the same methodologies used in traditional social research, but because the evaluation takes place within a political and organizational context, it requires group skills, management ability, political dexterity, sensitivity to multiple stakeholders and other skills that social research generally, does not depend on as much (Trochim, 2006.)

There are many definitions for the evaluation but the most frequently given definition is: "Evaluation is the systematic assessment of the worth or merit of some object" (Scriven, 1998; Trochim, 2006). Another definition sees evaluation as the systematic collection and analysis of the data needed to make decisions (Zinovieff, 2008). Also, one can define evaluation as: "Evaluation is the systematic acquisition and assessment of information to provide useful feedback about some object (Trochim, 2006.)

It is obvious that there is a similarity between the previous three definitions, but the latter definition emphasizes acquiring and assessing information rather than assessing worth or merit because all evaluation work depends on collecting data, making judgments about the validity of the information and of inferences we derive from it, whether or not an assessment of worth or merit results (Trochim, 2006).

Donabedian mentioned that the evaluation of health services is usually based on the collection data about the structure, process, outcome (Donabedian, 2005).

2.2.2 Types of evaluations

There are many different types of evaluations depending on the purpose of the evaluation and the object that will be evaluated, but the most important basic distinction in evaluation types according to the literature review is between formative and summative evaluation (Trochim, 2006). Formative evaluation improves the object being evaluated; it helps form it by examining the delivery of the program, the quality of its implementation, and the assessment of the organizational context, personnel, procedures, inputs, and so on. While summative evaluation examines the effects or outcomes of some object; it summarizes it by describing what happens subsequent to delivery of the program; assessing whether the object have caused the outcome; and estimating the relative costs associated with the object (Trochim, 2006).

2.2.3 Monitoring and evaluating the quality of RH programs

As 200 million women become pregnant every year, at least 30 million will develop life-threatening complications requiring emergency treatment (Kwast, 1998). It is a basic human right that pregnancy should be safe for all women as complications are mostly avoidable. This requires RH programs which are responsive to women's and their families' needs and expectations on the one hand and enhancement of community participation, high quality services, and both provider collaboration and satisfaction on the other. The Facility of Sexual and Reproductive Healthcare (2013) suggests all services should continually monitor and evaluate their selves in order to maintain and improve performance.

Monitoring and evaluation of these facets need to be an integral part of any safe motherhood program, not only to assess progress, but also to use this information for subsequent planning and implementation cycles of national programs. Lessons learned

from years' of implementation of Safe Motherhood programs indicate that process and outcome indicators are more feasible for short-term evaluation purposes than impact indicators, such as maternal mortality reduction (Kwast, 1998).

The MMR is difficult to use for monitoring short-term progress in safe motherhood programs. The WHO and UNFPA have proposed alternative process indicators to monitor the availability, the utilization, and the quality of RH services. There is little experience in the large-scale use of these indicators as part of routine health information systems in developing countries (WHO, 2006).

In this study, as mentioned earlier, the approach that the researcher used is structure (input), process, outcomes, which reflects Donabedian Model. Avedis Donabedian, a physician and health services researcher at the university of Michigan, developed the original model in 1966 (Donabedian, 2005). While there are other qualities of care frameworks, including the WHO-Recommended Quality of Care Framework and the Bamako Initiative, the Donabedian Model remains to be the dominant paradigm for assessing the quality of health care (Donabeian, 2005).

The following paragraphs will explain what are the determinants that shape this model (structure (inputs), process, outcomes).

1. **Structure (inputs**)

According to Donabedian's theory, structural characteristics are expected to affect both process and outcomes of the work. The structure of the resources in health care facilities and organizations is the foundation upon which quality health care services are provided (Steinwachs and Hughes, 2008).

a. Infrastructure and equipment of the two WHCs

Donabedian highlighted the main role of characteristics of health resources with regards to facilitating or hindering the use of services by the potential users (Donabedian, 1973).

A study conducted by International Finance Corporation (IFC) mentioned that clients everywhere, including in developing countries, have the right to receive services with high quality in a safe environment (IFC, 2010).

The environment of care is made up of three basic components, building, equipment, and people. Effective management of the physical environment aims to achieve the following goals: (1) reducing and controls environmental hazards and risks, (2) preventing accidents and injuries, (3) maintaining safe situations, and minimizing environmental stresses for patients, staff and others coming to the facility, and (4) maintaining the sensitivity of the environment to patient's needs such as: comfort, social interaction, and positive distraction (Levin and Joseph, 2009). The good state of infrastructure of health facilities and equipment is essential for effective health care.

b. Polices and guidelines

O'Donnell and Vogenberg (2012) mentioned that policies exist to serve the needs of all members of an organization and to help the organization comply with different regulatory and accreditation demands. They also added that descriptions of procedures and guidelines are usually created by a service provider within the practice setting as tools to assist individuals accomplish their work within the organization and to facilitate decision-making, and ensuring appropriate consistency.

The International Finance Corporation reported that quality standards assist the staff in looking at the different processes that affect the quality of care (IFC, 2010). According to

the standards that developed by Faculty of Sexual and Reproductive Health Care (FSRH) in UK, RH services provision should be evidence-based, which will include the use of national and local guidelines and policies. And all services should continually monitor, evaluate and improve performance. Hence, organizations need to ensure that they have a well-defined and well-implemented set of policies and procedures in place (FSRH, 2013). Good implemented policies and guidelines ensure: good practice, help to establish a professional and effective organization, provide consistency among staff and the beneficiaries, prevent any ambiguity about how particular situation should be handled in the service, promote harmony among staff, and it insures more efficient and effective delivery of services (IFC, 2010).

c. Skills and competency of the staff

Staff has an important role for implementation "work process" and outcomes. According to IFC (2010), each member of the staff has a role in providing quality care for the patient. Skills and competency, in addition to the communication are important factors that affect the effectiveness of the services and the outcomes (FSRH, 2013).

All staff members working in RH services field, should receive appropriate training and must maintain their skills (FSRH, 2013).

d. **Socio-demographic factors of the clients**

The literature reflects that socio-demographic factors have an influence on women utilization to health care services. A study was conducted by Dagne (2010) showed that the utilization of the services varied by characteristics of the participants. Utilization of maternal health services was very low among rural women in comparison with women living in urban areas. Study revealed also that educational status of the mother, household

wealth and place of residence, were found to be strong indicators of utilization in the study participants (Dagne, 2010)

Alrubaiee and Alkaa'ida (2011) found that social and demographic characteristics such as: age, educational level, marital status, and sex, nationality and hospital sector, affected the score of patient perception of health care quality, patient's satisfaction and patient's trust.Doku and his colleagues (2012) reported that there was high antenatal care utilization among women, but it was noticed that significant variables exist across the socio-demographic spectrum. Other researchers, Chubike and Constance (2013), insured this information, and reported that if the population was well informed and maternal health care was available, some demographic variables such as maternal age, and the number of living children affect the utilization of maternal health care services. Moreover, the study which conducted by Abeje and colleagues (2014) in Northwest Ethiopia indicated that among the socio-demographic variables, age, marital status, occupation and educational status of mothers were statistically associated with institutional delivery service use (Abeje et al., 2014). Consistently, Dibaba and Collogues found that household socio-economic status and women's employment are factors associated with the use of antenatal care services. Also, they found that women's pregnancy intention affects antenatal care utilization. Additionally, the researchers found that maternal education is significantly associated with use of antenatal care services (Dibaba et al., 2013). Furthermore, study conducted in the United States by Escarce and Kapur (2006) found that the low average income was a barrier to receiving timely and appropriate healthcare; even if the patients were have health insurance coverage. Also, in Al Bahrain, Mukhaimer (2010) found that perceived women's health status and well-being were affected by age and socio-economic status.

e. Accessibility, affordability and availability of RH services

Accessibility, affordability and availability are important factors; they affect achieving the outcomes. The term access is often used to describe factors or characteristics influencing the use of services. Within health care, access is always defined as access to service, provider or an institution. It is defined as the degree to which people are able to obtain appropriate care from the health care system in a timely manner (Escarce and Kapur, 2006). Consistently, Levesque and Colleagues (2013) defined access as the opportunity or ease with consumers or communities to use appropriate services according to their needs .

Access to health services is central in the performance of health care systems around the world. Measurement of the accessibility and utilization of health services is essential in any evaluation, and there should be easy and quick non-discriminatory access to RH services. In their report (2003), WHO and UNFPA reported that the access consists of at least five components of service provision: availability, affordability, acceptability, appropriateness and quality. Those components are applicable to the key elements of RH care (WHO, 2005).

Measuring access to health services is not straightforward as may be thought. Many indicators to measure access focus on physical characteristics such as the distance or travel time of health facilities and health care providers and often measured through geographical and health information systems. But the physical barriers are not the only barriers that may hinder the utilization of health services. There are other aspects that may hinder the utilization for the services, and should be measured to evaluate the accessibility. Affordability and cultural acceptability of the provided services, the availability of information and the client satisfaction must be considered. Also, quality of services and appropriateness of the provided services are important (WHO, 2005a).Additionally,

Dibaba and Colleagues (2013) found that accessibility, affordability and quality of health services are important factors in utilization of antenatal care services. On the same line, (Andaleeb, 1988; Shook, 2005; Mukhaimer, 2010; Ganle et al., 2014;Dibaba, 2013) found that the transportation is a barrier affects the utilization of health services.

Reviewing available literature in regard with waiting time and time spent with health provider showed that those factors affect utilization of health services. The researchers (Basaleem, 2012; Nwaeze et al., 2013; Ghafari et al., 2014; Ganle et al., 2014) found that the long waiting time is main barrier affected health services utilization; while Tavrow (2010) found that short waiting time encourage people to utilize health services. Additionally, Nwaeze and Colleagues (2013) reported that the views of the clients' about waiting time may be related to the hospital's location.

Concerning the time spent with health provider, Both and Colleagues (2006) found that the time spent with health provider affected the utilization to antenatal care in Tanzania. However, WHO (2002) recommended 30-40 minutes for the first visit, and 20 minutes for the sequent visits to carry out all the activities related to antenatal care.

2. Reproductive Health services provision

The World Health Organization (2013) defined the reproductive health services provision as the way in which inputs such as financial resources, qualified staff, equipment and drugs are combined to allow the delivery of health interventions. The organizations should focus on improving the structure and processes within it to create an environment that meets the needs of the staff and patients (IFC, 2010).

Health providers should provide clients with appropriate and high quality services in a safe environment. Health service providers should not only seek to "do the right thing", but should do it well and right every time (IFC, 2010).

FSRH (2013) and IFC (2010) reported that organizations must take into consideration some factors related to the clients such as, insuring good communication, clear patient information, information sharing, clients' involvement, continuity of service provision, and respect (confidentiality, clients' privacy and dignity).

Communication

Effective communication between health providers and clients improves the delivery of health services and contributes to improving health outcomes. Communication is one of Department of Health, Social Services and Public Safety (DHSSPS) standards "*All health and social care staff communicate in a way which is sensitive to the needs and preferences of patients and clients*" (DHSSPS, 2008:12). Ha and Longnecker (2010) mentioned that communication is a central component in the delivery process of health care, and good communication leads to good relationship between health provider and clients. This facilitates the exchange of information and involves patient in decision making. They mentioned also that good interpersonal between patient and health provider is an indicator for specialist competence from client's perception (Ha and Longnecker, 2010).

Arona(2003), Bredart and Collogues (2005) and Platt and Keating (2007), indicated that good patient-doctor communication helps and facilitates comprehension of medical information and result in better understanding for client needs, perceptions and expectations. Furthermore, several studies were conducted by (Henrdon and Pollick, 2002; Arona, 2003; Tongue et al., 2005; Kindler et al., 2005; Harmon et al., 2006) assess the impact of doctor- patient communication on health outcomes; findings of these studies found that patients who report good communication with their doctor are more likely to be satisfied with their care.

Respect (Privacy, confidentiality and dignity)

Privacy and confidentiality are important factors that affect clients' perception on the services provided. According to DHSSPS, clients have a right to experience respectful and professional care in supportive environment, where their privacy and dignity maintained. These principles should be supported by health organizations and professional staff to provide a quality service, and they should take clients' experience into consideration across all policy and strategy documents (DHSSPS, 2008). Maintaining clients' privacy and confidentiality is not only right for every patient, but also it enhances clients trust and increases their utilization. Clients who exposed to violations in privacy and confidentiality are more likely to drop out of services. Hence, all clients should be made aware that their right to confidentiality will be respected and maintained (FSRH, 2013). Snyder (2012) mentioned that at the beginning of and throughout the patient–physician relationship, the physician must respect the dignity of all persons and respect their uniqueness regardless of financial arrangements; the health care setting; or patient characteristics, such as decision-making capacity, behavior, or social status. Moreover, the physician must work to understand the patient's health problems, concerns, goals, and expectations. The physician also must be professionally competent, act responsibly, seek consultation when necessary, treat the patient with respect, and involve the patient in decision related to the care. WHO recommends that health providers, provide a private space for examinations, treatment, and counseling, and respect client confidentiality by not telling others what client revealed during the session or even whether the client received services (WHO, 2000b).

The literature illustrates how the lack of privacy and confidentiality affected the utilization to healthcare services. Results of qualitative study conducted in Ghana indicated that the lack of the privacy was one of the barriers that affected the accessibility and utilization of

maternal and newborn healthcare services (Ganleet al., 2014). In some situations, lack of privacy can violate women and make it more difficult for them to participate actively in selecting a family planning method. In a few places, using contraceptives can be a difficult and risky decision that can lead to violence, or divorce. In such situations, women need assurance of absolute confidentiality (Creel et al., 2002).

Satisfaction

Client satisfaction is a significant indicator of quality of care and quality services affect client satisfaction. To improve the quality of the provided services, health provider needs to recognize what factors influence client satisfaction (Johansson et al., 2002). Additionally, literature showed that health care quality can improve patient satisfaction and patient trust in healthcare provider (Alrubaiee and Alkaa'ida, 2011). Also, it showed that there is a link between patient's satisfaction and waiting time (Anderson et al., (2007; Awadallaet al., 2009; Assefaet al., 2011; Nwaezeet al., 2013).

Reviewing of available literature reflected that most important influence on patient satisfaction was service providers' friendliness, competence, amount of time spent with the client, amount of information provided, and physical facility conditions. Other factors affect client's satisfaction include, service availability, continuity, confidence, efficiency, and outcomes (Ware et al., 1978).

Patient satisfaction enhances hospital or healthcare center image, which in turn translated into increasing access to the services (Andaleeb, 1988). Furthermore, the researchers highlighted the communication as other dimension affects client satisfaction (Andaleeb, 1988; Cleveret al., 2008). Andaleeb indicated also that staff behavior and degree of staff sensitivity to the patient's personal experience as important, the hospital or healthcare

center costs, and physical facilities; including cleanliness, modern equipment, and hospital are important factors that affect the patient satisfaction (Andaleeb, 1988).

2.2.4 Reproductive Health

Dibaba and colleagues in 2013 mentioned that the term of RH is mostly focused on one aspect of women's lives which is motherhood. Complications associated with different maternal issues are indeed major contributors to poor RH among millions of women worldwide. Thus, reproductive health care is important for better maternal, perinatal, and infant health outcomes. Inadequate and poor quality care including antenatal care, skilled attendance at birth and postnatal care, may lead to high maternal and neonatal mortality rates. Antenatal care is recognized as a key maternal service to improve health outcomes for women and children. Delay in using antenatal health services may result in missed opportunities to diagnose pregnancy induced hypertension, gestational diabetes, or sexually transmitted infections (Dibabaet al., 2013).

One of the United Nations Millennium Development Goals (MDGs) is to achieve universal access to RH by the end of 2015. This goal aimed also to reduce maternal mortality, improving maternal health, and reducing child mortality (United Nations General Assembly, 2005).

The reproductive health problems still the leading cause of ill-health and death for women of child bearing age worldwide. According to the WHO, reproductive and sexual ill-health accounts for 20% of the global burden of ill-health for women. Timely access to health facilities and services for women has been a priority for WHO for many years (WHO, 2009). Also, achieving the maternal health development goals remains an unfinished agenda for the UNFPA, which committed to achieving universal access to sexual and

reproductive health (SRH) and the protection of reproductive rights. From UNFPA point of view, every pregnancy should be wanted and every child should be safe. Consequently, these efforts will lead and improve the health and well-being of women and children, reduce poverty and contribute to sustainable development (UNFPA, 2014a).

Quality of reproductive health care

Providing high-quality health care based a client-centered approach is a basic human right. It has been emerged as a critical element of family planning and reproductive health programs, and affirmed at 1994 International Conference on Population and Development (ICPD). Providing high-quality services with reasonable cost increase the utilization to RH services and reduce the number of unintended pregnancies. It is also increase the use of family planning (Creel et al., 2002).

In previous study, the researchers mentioned that to improve quality of care for clients, providers should understand clients' cultural values, their previous experiences, and their perception in regard with the role of the healthcare system. They mentioned also that enhancing quality of care requires identifying providers' motivations and addressing their needs. And providing them with administrative support and help for better understands and addresses clients' concepts of quality. Identifying and addressing the needs of both clients and providers are needed. More research and ongoing evaluation, and improved infrastructure and facilities, affect client outcomes (Creel et al., 2002). Consistently, Alrubaiee and Alkaa'ida (2011) found that there is a significant association between healthcare quality and patient's satisfaction.

Assessing a quality in RH services means measuring the gap between services' quality as perceived by the providers and as preserved by women. Thus, quality services must give

special attention to women's experiences, expectations, and level of their satisfaction with the service to complement the views of the providers in regard with the care (Al-Qutobet al., 1998).

Reproductive Health rights

Worku and Gebresilassie (2008) mentioned that three rights in particular were identified in the ICPD, which held in 1994, couples and individuals have: 1) the right to decide freely and responsibly the number and spacing of children and to have the information and means to do so. 2) the right to attain the highest standards of SRH, and 3) the right to make decisions free of discrimination, pressure or violence.

A quick look at the development of RH

- Before 1978 Alma-Ata conference: underlined the importance of basic health services in clinics and health centers.
- Primary health care declaration 1978: underlined the importance of MCH services, focusing on family planning services.
- Save motherhood initiative in 1978: underlined the importance of maternal health and reducing of maternal mortality.
- Reproductive health, ICPD in 1994: underlined the importance of quality of services, availability and accessibility, social injustice and emphasis on individuals' women's needs and rights (Worku and Gebresilassie, 2008).

2.2.5 Components of reproductive health

The reproductive health care is defined as the constellation of methods, techniques and services that contribute to RH and well-being through preventing and solving RH problems. It also includes sexual health, the purpose of which is the enhancement of life

and personal relations, and not merely counseling and care related to reproduction and STDs (ICPD, 1994).

The reproductive health services in the context of primary health care include: family-planning counseling, information, education, communication and services; education and services for prenatal care, safe delivery, and post-natal care. Additionally, RH services cover, infant care and offering treatment of infertility, treatment of reproductive tract infections, STDs, education and counseling on SRH (UNFPA, 2013). Components of RH include also: active discouragement of harmful practices, such as female genital mutilation and violence related to sexuality and reproduction in addition to functional and accessible referral (Worku and Gebresilassie, 2008).

2.2.6 The importance of providing comprehensive integrated RH services

Comprehensive RH package is widely regarded as essential for meeting the need of women. The 1994 ICPD highlighted the importance of provision comprehensive SRH services to be delivered through integrated systems. More than 180 governments committed themselves to providing a comprehensive set of RH services for women, men, and adolescents in a best way and in a line with the declaration of Alma-Ata. This means that woman should receive care for a range of problems during one visit to a health facility. The commitment has been guided by a desire to improve equity in access to health care and to achieve gender equality and reproductive rights. Integration aims to improve the service in relation to efficiency, and quality. It reduces the costs of services and ensuring sustainability (Garner and Briggs, 2006). Providing a wider range of services, which can be offered through integration, may reduce the differences in access and utilization of health services between geographical and socio-economic groups, and leads to more quality. And this leads to increased satisfaction to the beneficiaries (WHO, 1996).

According to UNFPA (2008), the availability of SRH services should be complemented by comprehensive information and counseling to empower couples and individuals to be able to take decisions and choices related to their RH issues. It is important to insure that they receive the information and social support they need. This mechanism could lead to social and behavior changes (UNFPA, 2008)

2.2.7 The importance of going beyond health to other services such as psychosocial and legal services

At the Fourth World Conference on women, which held in Beijing (1995), governments recognized that entrenched patterns of social and cultural discrimination as a major contributors to sexual and reproductive ill health, in addition to the lack of information and services. So, SRH effort should coordinated with the interventions that address the patterns of social discrimination, gender inequalities and exclusion that hinder women, men, and adolescents getting their rights related to SRH services (UNFPA, 2008).

Physical and psychological abuse is linked to a number of medical health affects including RH, such as sexually transmitted infections, chronic pelvic pain. "*Six percent of all pregnant women are battered and pregnancy complications, including low weight gain, anemia, infections, first and second trimester bleeding, are significantly higher for abused women, as are maternal rates of depression, suicide attempts, and substance abuse* " (Centers for Disease Control and Prevention, 1994).

Worldwide, one in every three women has been beaten, coerced into sex, or abused mostly by someone she knows, including her husband or another male family member. And one woman in four has been abused during pregnancy (UNFPA, 2008).

According to Family Violence Prevention Fund (FVPF), women who are abused are less likely to engage in important preventive health care behaviors such as regular mammography (FVPF, 2004). Results of WHO Violence and Health Study (2005), revealed that the extent of physical or sexual violence, or both, by intimate partner reported over a lifetime, ranging from 15% in Japan city, to 71% in Ethiopia province, with prevalence estimates in most countries ranging from 30% to 60% (WHO, 2005b). Literature review indicated also that gender inequality and discrimination are behind why many women and adolescents girls are still unable to exercise one of the most crucial human rights for their quality of life: their reproductive rights (UNFPA, 2008).

2.2.8 The barriers of service utilization

Literature review reflected some barriers to utilization of RH services, Olayinkaet al., (2014) study, found that the barriers to utilization of maternal health care services that reproductive women in Amassoma community, Bayelsa State faced were, lack of knowledge about the existing services, previous bad obstetric history, attitude of health care provider, availability, accessibility and husband's acceptance of the maternal healthcare services (Olayinkaet al., 2014). While Abebe and Awoke (2014) found that the barriers to utilization youth RH services were, RH services working hours, which were inconvenient, participants' fear of being seen by parents or people, in addition to that services providers were judgmental and unfriendly. (Abebe and Awoke, 2014; Ganleet al., 2014) reported that the long waiting time is a main barrier affected health service utilization. Furthermore, unfriendly healthcare providers, cultural insensitivity, poor care quality, lack of privacy at healthcare facilities, were important health system barriers that affected access and utilization of services in Ghana (Ganleet al., 2014).

Also, Ghafari and Colleagues (2014) studied the main barriers of utilization of health services among post-secondary school Malaysian urban youths between the ages of 18 and 24 who are students in government and private colleges and universities; the researchers found that the barriers to utilization of health services were unsuitable service schedule, inconvenient office hours, long waiting time, work or study commitments, transportation problems, lack of information and awareness, and lack of friendly health services. Other factors are financial constraints, negative attitude of health care providers, and long distance needed to travel health service points. Finally, other barriers identified by these youths were limited referral services, lack of privacy, uncomfortable waiting place/area, fear of family knowing their health problems and lack of clear guiding signs on directions to services locations. While Malarcher (2010) highlighted other barriers related to social aspects and mentioned how it affects the utilization to SRH services. As mentioned previously, globally, women living in law- and middle - income countries experience higher levels of morbidity and mortality related to SRH than women living in wealthier countries (WHO, 2009). A woman living in sub- Saharan Africa is 15 times more likely to die from an unsafe abortion than a woman living Latin America, and 75 times than a woman living in developed country. Early detection and treatment have significantly improved a woman's chance of surviving cervical cancer, and this also has a relation with the income status of the country and related to inequity in health status (Malarcher, 2010). There is other social barrier affected the utilization of health services such as family obligations. In her study, Mukhaimer (2010) mentioned this factor as a main barrier affected Bahrani women to obtaining healthcare services. Women did not give a priority to their health status.

Review of some literature also indicates that women from the poorest households are less likely to use preventive and curative SRH services than women from the wealthiest households, including the use of modern contraceptive, antenatal care, skilled attendance at birth, and treatment of infection (Gwatkins, 2007).

There were other barriers related to SRH providers, according to Tavrow (2010), clients are more interested in obtaining the method or procedure they desire, being treated considerately and given encouragement, having their questions answered, and not waiting too long or paying much.

The other barriers related to service providers' including the attitudes and practices of some providers, such as delineating medical and administrative barriers that providers' biases, judgmental attitudes, misinforming and their refusal to offer services on certain time affect clients' utilization to the SRH services. Shelton and Collogues (1992) mentioned that there are 6 types of "medical barriers" that can lead providers to deny family planning services: The six types are: out dated contraceptive methods, eligibility restriction, process obstacles, limits on who can provide services, provider bias, and regulation.

Chapter 3

Methodology

Introduction

This chapter explores the methodologies utilized in this study and provides a full description of the quantitative survey and the qualitative data collection methods and tools. This mixed methods study involved primary quantitative and qualitative data collection. In this study, the combination of quantitative survey with qualitative data collection aimed at exploring the relevancy, outcomes, sustainability, accessibility, affordability, and the impact of the provided services within the two WHCs. This chapter highlights the data collection methods, sample size, data collection tools, reliability and validity of the study instruments, and ethical considerations of the study.

3.1 Study design

This study is a mixed methods; it involves both quantitative and qualitative data. In mixed methods studies, researchers triangulate quantitative and qualitative data rather than keeping them separate. Triangulated data have greater depth and breadth than either the qualitative research or the household survey alone. Additionally, triangulation of data collection and analysis help in maximizing the strengths and minimizing weaknesses of the collected data (Creswell and Plano Clark, 2011). The design of the quantitative data is cross sectional survey; the survey aimed to develop an in-depth assessment of health services including RH services. Quantitative data were collected from beneficiaries of the health clinics within the two WHCs, while the qualitative data were collected from service providers and from beneficiaries of RH centers' services.

The qualitative data aimed to examine the sustainability, accessibility, affordability, and the effect of the provided services from providers' and beneficiaries' perspectives. It also aimed to develop an in-depth assessment of RH services within the two WHCs. The use of in-depth interviews provides an opportunity to clarify ambiguous responses and to deeply explore respondents' perspectives on different issues at the same time (Kairuzet al., 2007). While, focus groups discussion generates rich deep information, particularly when the participants represent small groups of interest. Focus groups discussion is also used to collect sensitive data as the group coherence and dynamics motivate participants to express their opinion and feelings (Milena et al., 2008).

3.2 Study Population

Concerning quantitative data, the researcher collected the data from beneficiaries of the health clinic services, 240 cases from Al-Bureij WHC and 180 cases from Jabalia WHC. With regard to the qualitative data, data were collected from two-groups of participants: The first group consists of service providers, four specialists, specifically two midwifes, two gynecologists, two social workers, and two psychologists. In addition to one senior manager from each Center. The second group consists of beneficiaries of the RH services within the two WHCs, 38 women from the two WHCs.

3.3 Study settings

This study, both quantitative and qualitative, was carried out at the two WHCs in Jabalia and Al-Bureij camps.

3.4 Study Period

The study started in September 2013. The School of Public Health has approved the study proposal and sent administrative letters to the General Directors of RCS and CFTA in February 2014. Data collection tools have been developed, validated, revised, and finalized in March 2014.

The pilot studies were conducted in March 2014 while the data collection started in March 2014 and completed in May 2014. Quantitative data entry was conducted along the data collection and completed in June 2014. Transcription and coding of qualitative data were conducted alongside the data collection process and completed by June 2014. Data analyses, both quantitative and qualitative, were completed in November 2014. The study final report was completed in June 2015.

3.5 Eligibility criteria

3.5.1 Inclusion criteria: quantitative part

- Women who have been utilizing health services, including RH services for more than six months.

Inclusion criteria: qualitative part

- The specialists and key informants, in the two WHCs in Jabalia and Al-Bureij camps, who worked for at least one year.
- Women who utilized RH services of the WHCs for at least 6months.

3.5.2 Exclusion criteria: quantitative part

- Women who did not utilize health services or have been utilizing health services for less than six months during the time of data collection.
- Urgent cases.

Exclusion criteria: qualitative part

- New employees who have been working in the WHCs for less than a year, at the time of data collection.
- Women who did not utilize, or have been utilizing the WHC services for less than six months during the time of data collection.

3.6 Sampling

Sample size calculation and sampling process: quantitative part

The researcher calculated the sample size according to the number of women who utilized health services in the first 6 months of 2013, from January to June. According to the records of the two WHCs, the total number of women who have utilized health services from January to June 2013 was 4,000 women, distributed as 1,500 in Jabalia and 2,500 women in Al-Bureij.

Epi-info program was used to calculate the study sample size; the required sample size was estimated to be 400 women at 95% confidence level. The researcher increased the sample size to be 420, to cover the possibility of none respondents. To have a proportionate representative sample, the researcher allocated more weight to Al-Bureij center with 240 cases compared to 180 cases from Jabalia WHC (Annex 5). With regard to sampling process, simple random sample technique was used to select participants from beneficiaries of health clinics. The researcher and researcher assistants selected cases randomly from women who utilized health services. The simple random sample yielded unbiased representative sample.

Sample size and sampling process: qualitative part

With regard to the in-depth interviews, the researcher purposefully selected four specialists and a senior manager from each center. In addition to the two senior managers, in total, tin specialists were interviewed, specifically two midwifes, two gynecologists, two social workers, and two psychologists. All participants of in-depth interviews were purposefully selected based on their level of knowledge, availability, years of experience, and areas of expertise.

With regard to focus groups with women, the researcher conducted three focus groups in each center. In total, six focus groups were assembled. Two focus groups were conducted with beneficiaries of physical therapy services, pre-post natal- and four focus groups were conducted with beneficiaries of all the WHCs services.

All participants of focus groups discussions were purposefully selected according to the type of utilized services. Each focus group was assembled from different beneficiaries; all participants have in common the type of service utilized, but are different in age, type of experiences, and expectations. On average, each focus group assembled of six participants.

3.7 Instruments of the study: quantitative part

Semi-structured questionnaire (Annex 6) was developed by the researcher to collect data from beneficiaries of health services within the two WHCs. The questionnaire was designed to comprehensively cover the following areas:

1. Demographic background
2. RH issues, including pregnancy, perinatal history, family planning, and gynecology health issues.
3. Accessibility, affordability and availability of services
4. Responsiveness of medical team to clients health needs and non-health needs
5. Satisfaction with the provided services
6. Motivations and barriers affect health services utilization

Instruments of the study: qualitative part

1. In-depth interviews with health providers, the researcher developed standardized question guides (Annexes 8 and 9). The question guides have covered different areas such as strengths and weakness of the current programs, accessibility, appropriateness of

WHCs services, and the quality of WHCs services. Additionally, the question guides covered the availability of policies and guidelines, effect of WHCs services on women's health and well-being, and areas of potential improvement.

2. Focus groups with the beneficiaries, the researcher developed standardized question guides (Annex 7) that have covered different areas such as accessibility, affordability, satisfaction, and the effect of the provided services on women's health and well-being. It also included determinants and barriers to utilization of services.

3.8 Scientific rigor: quantitative part

3.8.1 Reliability

Test-retest was conducted in the first stage of piloting. To help in collecting data, the researcher hired two research assistants. The researcher assistants were trained by the researcher to ensure collecting reliable data. The researcher has trained the two assistants on how to ask questions, how to randomly select cases, and how to fill in the questionnaires. The researcher used to check and reviewed all the questionnaires that were completed by the research assistant day by day. In addition, the researcher re-entered 5% of the data.

The researcher used Cronbach's alpha to measure the internal consistency of the categorized questions. The categorized questions (domains) were tested twice; the first one was done during the pilot stage with 21 participants and the reliability score with Cronbach's Alpha, which was .794, reflected good reliability. The second one was conducted after collecting the study sample; the result ensured high degree of reliability with a .954 Cronbach's alpha. The Table (3.1) shows the breakdown of Cronbach's alpha by domains.

Table (3.1): The breakdown of Cronbach's alpha by domains

Domain	No. of questions	Chronbach's Alpha
Accessibility	10	.829
Centre's equipment	15	.770
Skills and professional	7	.875
Communication	12	.905
General satisfaction	12	.910
Total scale reliability	**0.954**	

3.8.2 Validity

Face validity

The questionnaire was structured in an organized way to allow easy smooth data collection and data entry. During the validation process, the questionnaire lay out was reviewed and formatted several times until a final version looked elegant.

Content validity

The questionnaire was evaluated by thirteen experts, including statisticians, researchers, and professionals working in the two WHCs, academics, and experts in different relevant fields. The evaluation aimed to assess the relevance of each domain, the importance of each particular item, and to check if the contents of the questionnaire seem appropriate to its intended purpose and overall aim. The researcher considered all the experts' feedback and comments; thus, the revised final version of the questionnaire incorporated all the experts' feedback. A pilot study was conducted before the actual data collection started.

Also, the researcher modified questionnaire according to feedback from the pilot study. Finally, as mentioned earlier, the two research assistants were trained well by the researcher to ensure the standardization of the data collection.

Scientific rigor: qualitative part

Trustworthiness

To assess reliability and validity of qualitative data, Guba and Lincoln (1981) substituted reliability and validity with the parallel concept of "trustworthiness", containing four aspects: credibility, transferability, dependability, and conformability. To ensure trustworthiness of the qualitative data, the researcher implemented the following actions:

1. The researcher ensured methodological coherences of the study through ensuring congruence between the research questions, objectives, and methods of data collection.
2. The researcher used variety of qualitative research techniques including in-depth-interviews and focus groups. The researcher recorded the interviews and focus group discussions and produced transcripts of the data.
3. Multiple methods of data collection and data analysis enhance the credibility of the research. The researcher applied triangulation research to control bias and to establish valid propositions and relationship.
4. The researcher has developed multiple data collection tools, which were reviewed and revised by experts. The researcher has developed different standardized guiding questions that were used to collect data through in-depth interviews and focus group discussions.

5. The researcher selected an appropriate sample, consisting of participants who best represent or have knowledge of the study topic.
6. The researcher collected and analyzed qualitative data concurrently. This enabled the researcher to link between what is known and what is needed to be known.
7. To ensure the integrity in data analysis, the researcher has used independent coding of the qualitative data, consistently recorded the observation, and used consensus discussions.

3.9 Ethical and administrative consideration

An official letter of approval to conduct the study has been obtained from Helsinki Committee in GS (Annex 2). Two official letters from the two organizations were obtained (Annex3, Annex 4). To guarantee participants' rights of privacy and confidentiality, a covering letter indicating that the participation is optional was provided and confidentiality was promised and maintained. All the study participants were asked for their approval to participate in the study. Respect for truth and academic honesty was also maintained during analysis, interpretation and writing up. Data analysis has been done at aggregate level without revealing any of participants' identities or any personal data.

3.10 Pilot study

With an aim of exploring the appropriateness and reliability of the questionnaire, the researcher has conducted a pilot study on a sample of 21 beneficiaries (10 from Jabalia and 11 from Al-Bureij). Minor modifications were done including rephrasing many questions, changing the order of some questions, adding new questions, and removing other irrelevant questions. The 21-piloted cases were included within the study sample, as no major modifications were made.

3.11 Data collection: quantitative part

The researcher and two research assistants collected the data. The two research assistants were trained on how to ask questions, specifically questions that have the non-prompted answers and the open ended questions. Along with receiving training on how to select participants and how to enter the data, the two researcher assistants also have received full information about the purpose, the objectives, and the methodology of the study.

The collection of quantitative data started on March 31, 2014 and ended on May 21 2014. All participants were selected randomly through simple random technique. After receiving full information about the study purposes and objectives, participants were informed that their participation is optional and they have the right not to answer any questions. After getting verbal approval, the researcher and the two research assistants conducted face-to-face interviews to fill in the questionnaires. On average, each questionnaire required from 30 to 45 minutes to be completed and reviewed to make sure of no missing answers.

Data collection: qualitative part

1. **In-depth interviews**

The researcher conducted all the in-depth interviews and facilitated all the focus groups discussion. The collection of qualitative data started on May 21, 2014 and ended on May 29, 2014. With regard to in-depth interviews, after receiving full information about the study purposes and objectives, participants were informed that their participation is optional and they have the right to refuse the participation in the study. On average, each in-depth interview lasted from 75 to 90 minutes. The researcher has recorded the interviews and took notes during the interview.

2. Focus groups discussion

After getting verbal approval from the WHCs' managers, the researcher with collaboration with the two WHCs' staff has identified cases to participate in the focus groups. The identified cases were invited to participate in the focus groups. The researcher assigned particular date and time for each group and asked participants to come to the WHC at the signed time and date. The researcher invited 48 women to participate in the six focus groups. In total, 38 women participated in the focus groups discussions, with an average of six participants per focus group. All participants have received full information about the study and were informed that their participation is optional. The researcher also informed participants that they have the right to answer the questions they want. On average, each focus group lasted about 90 minutes. The researcher has recorded the discussion and a research assistant took notes during the interview. All the recorder material, interviews and focus groups, were kept in a safe place and only the researcher has access to it.

3.12 Response rate

Concerning the quantitative study, the general response rate was 89.3% (375 out of 420). The response rate in Jabalia WHC was 90% (162 out of 180); while in Al-Bureij WHC was 88.8% (213 out of 240).

3.13 Data analysis

With regard to quantitative data, Statistical Package for Social Sciences (SPSS) version 20 was used for data analysis. The researcher has developed database for data entry. The data analysis included data cleaning, data coding, data recording, and data computing. The researcher conducted frequency distribution, cross tabulation, general scores, and mean

percentages. To detect differences and assess the significant relationships among variables, Chi-square test, spearman correlation test, and one way-ANOVA test were used at 95% confidence interval.

With regard to qualitative data, the researcher used open coding thematic analysis method. During the data collection, the researcher took field notes regarding the interviews and focus groups discussions and summarized the main findings immediately after the interviews and the focus group discussions. A research assistant was also taking notes during the qualitative data collection. All in-depth interviews and focus groups were recorded after getting verbal approval from participants.

Data analysis started by preparing verbatim transcription of the data, data coding, identification of main themes, data analysis, and writing the main findings. In addition to the main findings, the writing included interesting codes, similarities, and contradictions.

Chapter (4)

Quantitative results

This chapter highlights the main quantitative findings of the study. It begins with a brief description of the characteristics of study participants, and it then examines the relationship between the variables of interest and other selected covariates.

4.1 Descriptive analysis

Socio-demographic Characteristics

The results of the study have shown obvious variations among the study participants. The main variations are in the age, education level, marital status, working status, and monthly income. The below table summarizes the main variations with regard to selected variables.

Women's age

As shown in Table (4.1), the mean age of the study participants in general was 33.83 years with (SD 2.28, range 49). Table (4.1) also revealed that 11.2% from the participants were aged between 16 and 24 years, while 53.7% from them were aged between25 years and 35 years. And 35.1% were between 36 years and 65 years old.

The overall average of women's years schooling was 11.86 years (SD 2.76, range 20), about 40% of cases have completed less than 12 years of schooling and about 60% of the cases have completed at least 12 years of schooling (Table, 4.1).

Concerning the marital status, the vast majority of cases were married (96.8%); while 3.2% of cases were either divorced or widows, which means that the two WHCs give concern not only to the married women, but also to the divorced and widows. It is very interesting

to mention that none of cases were single women. With regard to employment status, at the time of data collection, 84% of cases were not employed and only 16% were employed.

Table (4.1): Distribution of participants according to selected variables

	Demographic data	No.	%
	Women age groups		
	• 16 to24 years	42	11.2
	• 25 to 35years	202	53.9
	• 36 to 65 years	131	34.9
	Total	**376**	**100**
	Mean = 33.83, SD =7.32, Range=49		
	Education level		
	• Less than 12 years of schooling	152	40.5
	• 12 years of schooling	106	28.3
	• More than 12 years of schooling	117	31.2
	Total	**375**	**100**
	Mean = 11.86, SD =2.76, Range=20		
	Marital status		
	• Married	363	96.8
	• Divorced and widowed	12	3.2
	Total	**375**	**100**
	Employment status		
	• Unemployed	315	84.0
	• Employed	60	16.0
	Total	**375**	**100**
	Total monthly family income		
	• ≤ 1000 ILS*	193	51.5
	• 1001 to 2000 ILS	122	32.5
	• >2000 ILS	60	16.0
	Total	**375**	**100**
	Median =1000, range 6,300		
	Family size		
	• ≤6 members	158	42.1
	• 7 to 10 members	190	50.7
	• >11members	27	7.2
	Total	**375**	**100**
	Mean = 7.03 , SD= 2.59, Range= 19		

*ILS stands for Israeli new shekel

Concerning the total monthly family income, results of this study revealed that the median of monthly income was 1000 ILS. About 52% of the cases have monthly income of less than 1,000 ILS per month and only 16% of cases have monthly income of 2,000 ILS and more (Table, 4.1).

As shown in Table (4.1), the average family size of the study sample was 7.03 members with (SD 2.59, range19). The distribution of family size by groups revealed that (42.1%) had ≤ 6 members, while (50.7%) had 7 to 10 members. And (7.2%) had > 11 members.

4.2 Utilization of WHCs services and beneficiaries' perspective related the services they received

As showed in a Table (4.2), about 80% of the participants have been utilizing WHC services for more than 10 years and 20% of the participants have been utilizing WHC services for 5 years or less.

Concerning the reasons of visit during the data collection, as showed in the Table (4.2), about 37% of cases visited the two centers at the time of data collection to receive treatment for gynecological health issues. A bout 25% of women visited the two centers to receive antenatal care services, and 17.6% of women visited the two centers to receive family planning services. Only 3.2% of study participants visited the two centers to receive postnatal care services. The rest of women visited the two centers to utilize other services such as conducting laboratory investigations.

The vast majority of study participants (98.7%) indicated that they have received the services they were supposed to. As shown in Table (4.2), the services in the two centers met the health needs of the women, as indicated by more than 95% of the study participants.

Table (4.2): General information related to the two WHCs (all participants)

	Items	Jabalia Center		Al-Buraij Center		Total	
		No.	%	No.	%	No.	%
	Date of first visit /year						
	• Before 2005	79	48.8	87	40.8	166	44.2
	• From 2005 to 2010	50	30.9	86	40.4	136	36.3
	• After year 2010	33	20.4	40	18.8	73	19.5
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Reasons of visit						
	• Treatment of Gynecological issues	66	40.7	73	34.3	139	37.1
	• Antenatal care	28	17.3	67	31.5	95	25.3
	• Family planning service	40	24.7	26	12.2	66	17.6
	• Laboratory testing	19	11.7	23	10.8	42	11.1
	• Medicine & nutrition supplements	7	4.3	13	6.1	20	5.4
	• Postnatal care	2	1.2	10	4.7	12	3.2
	• Others	0	0.0	1	0.5	1	0.3
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Received the needed services						
	• Yes	160	98.8	210	98.6	370	98.7
	• No	2	1.2	3	1.4	5	1.3
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Received services met health needs						
	• Yes	150	92.6	207	97.2	357	95.2
	• To some extent	12	7.4	6	2.8	18	4.8
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Perceived quality of services: higher than other centers						
	• Strongly agree	115	71.9	119	55.9	234	62.7
	• Moderately agree	43	26.9	94	44.1	137	36.7
	• Disagree	2	1.2	0	0.0	2	0.6
	Total	**160**	**100.0**	**213**	**100.0**	**373**	**100.0**

Concerning the perceived quality of received services, the vast majority of women (99%) reported higher level of satisfaction with the provided quality compared to other health centers, as shown in Table (4.2).

Table (4.3): Frequency distribution of waiting time and time spent with health providers (all participants)

	Items	Jabalia Center		Al-Buraij Center		Total	
		No.	**%**	**No.**	**%**	**No.**	**%**
	Waiting time						
	• Up to 15 minutes	132	81.5	78	36.6	210	56.0
	• From 16 to 30 minutes	27	16.7	92	43.2	119	31.7
	• More than 30 minutes	3	1.9	43	20.2	46	12.3
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Jabalia: Mean = 13.66 minutes, SD = 11.38, Range=120 Al-Buraij: Mean = 26.41 minutes, SD =18.8, Range = 145 Total: Mean = 20.9 minutes, SD = 17.2, Range =150						
	Time spent with health provider						
	• Up to 15 minutes	123	75.9	133	62.4	256	68.3
	• More than 15 minutes	39	24.1	80	37.6	119	31.7
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Jabalia : Mean = 14.31, SD=7.04, Range= 26 Al-Buraj : Mean = 16.80, SD=7.8, Range= 55 Total : Mean = 15.7, SD=7.6, Range= 56						

The overall average of the study participants' waiting time was 20.9 minutes (SD 17.2, range 150). In Jabalia center, the overall average of women's waiting time was 13.66 minutes with (SD 11.38, range 120).While, in Al-Buraij center, the overall average of women's waiting time was 26.41 minutes with (SD 18.81, range 145). As shown in Table (4.3), of the total women, on one hand, about 88% of women waited up to 30 minutes to receive the required services; on the other hand, about 12% of women waited more than 30 minutes to receive the required services. The waiting time in Al-Buraij Center was clearly longer than in Jabalia Center.

With regard to time spent with the health provider, as shown in Table (4.3), the overall average of time that women spent with the health provider was 15.7 minutes (SD 7.6, range 56). In Jabalia Center, the overall average of time spent with the health provider was 14.31 (SD 7.04, Range 26) .While, in Al-Buraij Center, the overall average of time spent with the health provider was 16.80 (SD 7.8, range 55).

4.3 Pregnancy history and decisions on RH issues

Concerning the number of pregnancies that a woman had, the overall average of women's number of pregnancies was 5.4 pregnancies (SD 2.8, range 15). As shown in Table (4.4), about 38% of cases had up to 4 pregnancies, and about 41.4% of the cases had from 5 to 7 pregnancies, while 20.6% of the cases had more than seven pregnancies. With regard to the number of children ever born to a woman, the overall average number of children ever born to a woman was 4.7 children (SD 2.5, range 12). About 62.7% of cases had up to 5 children, and about 37.3% of the cases had more than 5 children as shown in Table (4.4).

Table (4.4): Frequency distribution of study participants by number of pregnancies and number of children ever born to a woman

	Items	Jabalia Center		Al-Bureij Center		Total	
		No.	**%**	**No.**	**%**	**No.**	**%**
	Number of pregnancies						
	• From 5 to 7 pregnancies	50	30.9	105	49.3	155	41.4
	• Up to 4 pregnancies	70	43.2	72	34.3	142	38.0
	• More than 7 pregnancies	42	25.9	35	16.4	77	20.6
	Total	**162**	**100.0**	**212**	**100.0**	**374**	**100.0**
	Mean = 5.4, SD=2.8, Range= 15						
	Number of children ever born to a woman						
	• Up to 5 children	102	63.0	133	62.4	235	62.7
	• More than 5 children	60	37.0	80	37.6	140	37.3
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Mean = 4.7, SD=2.5, Range= 12						
	Decision making about RH issue such as contraceptive use						
	• Shared decision, men and women	132	81.5	200	93.9	332	88.5
	• Sole decision, women only	16	9.9	9	4.2	25	6.7
	• Sole decision, men only	12	7.4	3	1.4	15	4.0
	• Others, like mothers-in-law	2	1.2	1	0.5	3	0.8
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**

Regarding decision-making about reproductive health issue, the majority of participants indicated that it is a shared decision between men and women (88.5%). Additionally, 6.7%

indicated that it is woman's decision and only 4% of the participants stated that it is a husband's decision.

Current pregnancy (95 participants)

During the data collection, out of the 375 women, a total of 95 women were pregnant (25.3%) and the rest, 279 women, were not pregnant (Figure, 4.1).

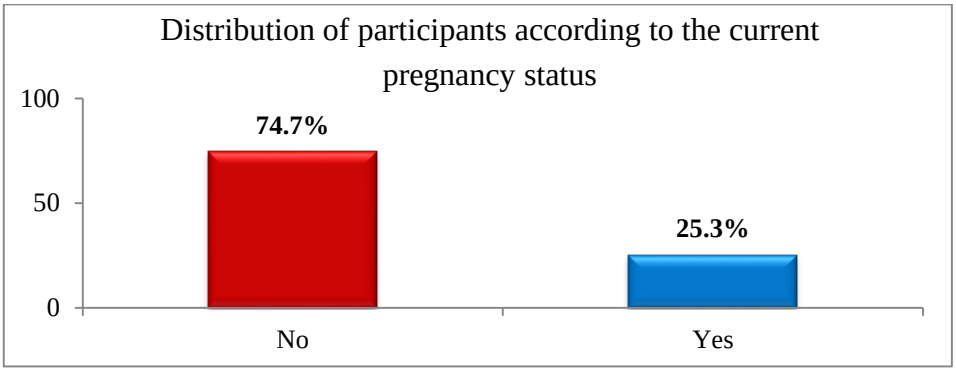

Figure (4.1): Distribution of participants according to the current pregnancy status

As shown in Figure (4.1), during the data collection time, 14% of pregnant women were pregnant in their first trimester, 46% were pregnant in second trimester, and 40% were pregnant in the third trimester.

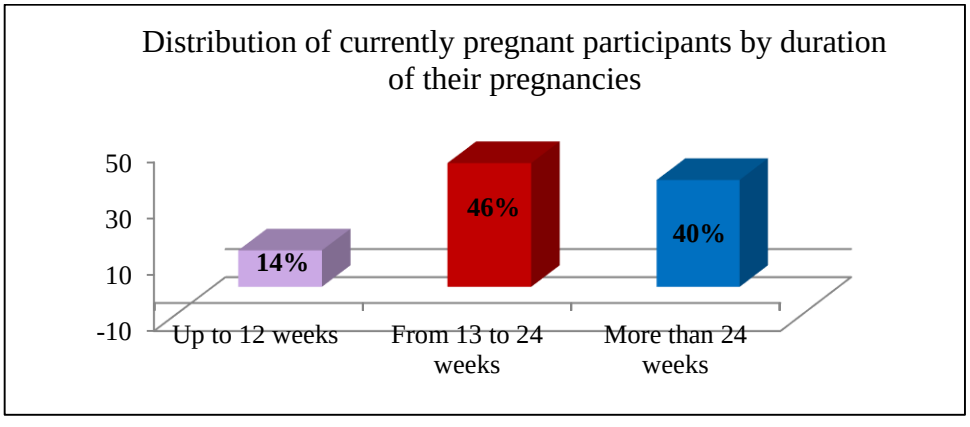

Figure (4.2): Distribution of currently pregnant participants by duration of their pregnancies

As shown in Figure (4.3), with regard to the time of utilizing antenatal care service, the majority of pregnant women (87.3%) indicated that they have started to utilize antenatal care services during the first trimester of their pregnancy, 12 weeks gestation or less, while only 12.7% were following up their pregnancy after the first trimester, more than 12 weeks of gestation.

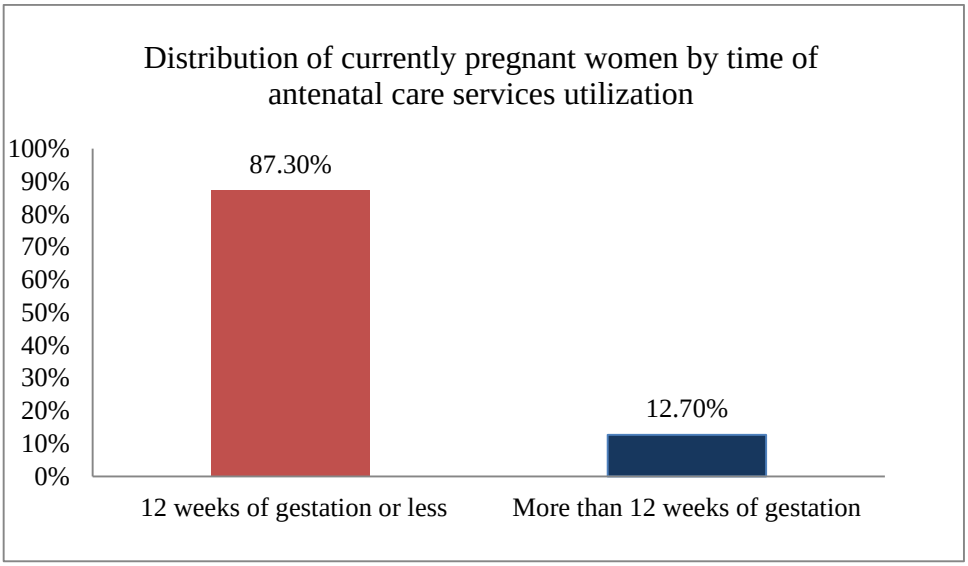

Figure (4.3): Frequency distribution of currently pregnant women by time of antenatal care services utilization

Current pregnancy and the last pregnancy in the past two years (161 participants)

During the data collection, a total of 161 women were pregnant either during the data collection or were pregnant in the past 2 years. Of the total of 95 women were pregnant at the time of data collection. The below sections explore utilization of antenatal care services of all the cases that were pregnant during the data collection or in the past two years.

Table (4.5): Frequency distribution of received antenatal care services by selected components (161 participants, Jabalia 69 and Al-Bureij 92)

	Items	Jabalia Center		Al-Bureij Center		Total*	
		No.	**%**	**No.**	**%**	**No.**	**%**
	Antenatal care components						
	Received health education about folic acid, iron and vitamins	59	85.5	91	98.9	150	93.2
	Received health education about nutrition during pregnancy	62	89.9	87	94.6	149	92.5
	Received health education about the exercises	46	66.7	78	84.8	124	77
	Received health education about family planning	37	53.6	79	85.9	116	72
	Received health education about breast feeding	41	59.4	57	62	98	60.9
	Received health education about delivery	33	47.8	32	34.8	65	40.4
	Visited by WHCs staff	27	39.1	37	40.2	64	39.8
	Received health education about neonatal care	30	43.5	27	29.3	57	35.4
	Received health education about weaning practices	12	17.4	30	32.6	42	26.1
	Knowledge about dangerous signs and symptoms during pregnancy						
	Vaginal bleeding	46	66.7	81	88	127	78.9
	Abdominal pain	14	20.3	45	48.9	59	36.6
	Edema	24	34.8	18	19.6	42	26.1
	Absence of fetal movement	11	15.9	19	20.7	30	18.6
	Others (Swelling, high blood pressure, back pain, and difficulty in breathing)	19	27.5	11.0	12.0	30	18.6
	Fever	7	10.1	3	3.3	10	6.2

As shown in Table (4.5), as part of antenatal care services, a total of 64 cases (39.8%) reported that the WHCs staff visited them at home. The majority of the participants (93.2%) have received health education about the importance of adherence in administering folic acid, iron, and vitamins. When it comes to health education on

nutrition, the majority of the participants (92.5%) reported that they received education about nutrition during the pregnancy. This education covered the importance and impact of good nutrition on pregnant women. Additionally, as in the Table (4.5), more than two third of study participants (77%) have received education about the importance of exercising during pregnancy, and about 60% have received health education about importance of breastfeeding. However, only 26.1% of the study participants have received health education about weaning practices. With regard to delivery process and care of the newborn, about 35% and 40% of the study participants received health education on delivery process and care of newborn, respectively. Finally, 72% of the study participants have received health education on family planning. This covered different areas such as side effects, indications, and general instructions on how to use both natural and artificial family planning methods.

Concerning the knowledge of dangerous signs and symptoms during pregnancy, pregnant women were asked a non-prompted question about signs and symptoms of risk pregnancy. It appears that women are fairly well informed about those symptoms as 78.9% from the participants mentioned vaginal bleeding, 36.6% mentioned abdominal pain, 26.1% mentioned edema, and 18.6% mentioned absence of fetus movement while 6.2% from the participants mentioned fever as one of dangerous signs during pregnancy. It is noticed that absence of fetal movement was mentioned by only 18.6% from the respondents, which gives alarm that pregnant women in both two centers need more education on this issue. Finally, 18.6% from the participants mentioned other signs and symptoms such as swelling, high blood pressure, back pain, and difficulty in breathing.

Table (4.6): Frequency distribution of the reported responses regarding the pre and post natal following up visits (95 participants)

	Items	Jabalia Center		Al-Bureij Center		Total	
		No.	**%**	**No.**	**%**	**No.**	**%**
	Number of antenatal visits						
	• Up to 3 visits	17	34.7	9	22.0	26	28.9
	• Four visits and more	32	65.3	32	78.0	64	71.1
	• Total	**49**	**100.0**	**41**	**100.0**	**90**	**100.0**
	Mean = 5.8, SD=4.03, Range= 27						
	Did you visit and follow up in WHC						
	• No	32	64.0	13	31.7	45	49.5
	• Yes	18	36.0	28	68.3	46	50.5
	Total	**50**	**100.0**	**41**	**100.0**	**91**	**100.0**
	Time of woman's postnatal visit/days after delivery						
	• Up to 6 days	0	0.0	1	3.6	1	2.2
	• Between7 to 40 days	9	50.0	11	39.3	20	43.5
	• > 40 days	9	50.0	16	57.1	25	54.3
	Total	**18**	**100.0**	**28**	**100.0**	**46**	**100.0**
	Mean = 58.4, SD=51.0 1, Range= 266						
	Received postnatal home visits by WHC staff						
	• No	27	56.2	28	68.3	55	61.8
	• Yes	21	43.8	13	31.7	34	38.2
	Total	**48**	**100.0**	**41**	**100.0**	**89**	**100.0**
	Time of WHC staff's postnatal visit/days after the delivery						
	• Up to 7 days	8	40.0	1	8.0	9	27.3
	• Between 8 to 21 days	10	50.0	5	38.8	15	45.4
	• More than 21 days	2	10.0	7	54	9	27.3
	Total	**20**	**100.0**	**13**	**100.0**	**33**	**100.0**

As shown in the above Table, more than two thirds of the study participants had conducted 4 antenatal care visits or more during their past pregnancy. While, 28.9% of the study participants had conducted 3 antenatal care visits during their past pregnancy. The overall average of the number of antenatal care visits is 5.8 visits (SD= 4.03, Range= 27).It worth mentioning that woman who could not pay the fees for antenatal care, is following up her pregnancy in UNRWA clinic (free services) and conducts only one or two visits to WHC clinic in order to insure that her pregnancy is going well.

As shown in Table (4.6), about 50.5% from the participants reported that they visited the WHCs for postnatal care, 45.7% from them visited WHCs during the first 40 days after delivery, and 54.3% visited the WHCs after 40 days after delivery. The overall mean number of days of postnatal care visit was 58.4 with (SD = 51.01, Range = 266). With regard to post natal home visits, about 38.2% were visited by WHCs staff, 27.3% from them were visited during the first 7 days after delivery, and 45.4% were visited by WHCs staff during the period between 8 to 21 days. While 27.3% were visited by WHCs staff after 21 days of delivery. The two WHCs provide post natal care during outreach programs (home visits). The field workers team visits women after delivery and provide them with the needed information related to breastfeeding, women's health after delivery and family planning. At the same time, the two WHCs encourage women to visit the clinic after delivery to make checkup and to use family planning method.

Postnatal care in the last pregnancy (91 participants)

Concerning postnatal care, about 91 women (50 from Jabalia and 41 from Al-Bureij), responded to the questions related post natal care. As shown in Table (4.7), 33% of them had exercises after delivery (post natal course). In regard with breast feeding, the majority of the respondents were committed to breastfeeding (93.4%). About 66.3% of them were committed to breastfeeding up to six months, while 33.7 % were committed to breastfeeding for more than 6 months. However, 60.4% of the respondents received health education about breastfeeding and family planning. The number of women who received education related to breastfeeding and family planning was clearly higher in Al-Buraij Center than in Jabalia Center (Table 4.7).

Table (4.7): Frequency distribution of the reported responses regarding selected postnatal components (95 participants)

	Items	Jabalia Center		Al-Bureij Center		Total	
		No.	**%**	**No.**	**%**	**No.**	**%**
	Received post natal exercise						
	• No	36	72.0	25	61.0	61.0	67.0
	• Yes	14	28.0	16	39.0	30.0	33.0
	Total	**50**	**100.0**	**41**	**100.0**	**91**	**100.0**
	Currently breast-feeding						
	• No	3	6.0	3	7.3	6	6.6
	• Yes	47	94.0	38	92.7	85	93.4
	Total	**50**	**100.0**	**41**	**100.0**	**91**	**100.0**
	Duration of exclusive breastfeeding						
	• Up to 6 months	32	64.0	27	69.2	59	66.3
	• More than 6 Months	18	36.0	12	30.8	30	33.7
	Total	**50**	**100**	**39**	**100**	**89**	**100**
	Receive health education about breastfeeding						
	• No	23	46.0	13	31.7	36	39.6
	• Yes	27	54.0	28	68.3	55	60.4
	Total	**50**	**100.0**	**41**	**100.0**	**91**	**100.0**
	Receive health education about family planning						
	• No	30	60.0	6	14.6	36	39.6
	• Yes	20	40.0	35	85.4	55	60.4
	Total	**50**	**100.0**	**41**	**100.0**	**91**	**100.0**

4.4 Utilization of family planning services (all participants)

Concerning the use of family planning methods, during the data collection, about 58% of the study participants were using family planning methods. Additionally, 36.6% of the study participants used family planning methods in the past two years. The overall mean of length of using family planning methods was 35.84 months (SD=30.80).

Table (4.8): Frequency distribution of the reported responses regarding family planning services (all married participants and not pregnant)

	Items	Jabalia Center		Al-Bureij Center		Total	
		No.	**%**	**No.**	**%**	**No.**	**%**
	Currently using family planning methods						
	• No	58	39.5	54	44.3	112	41.6
	• Yes	90	60.5	67	55.7	157	58.4
	Total	**148**	**100.0**	**121**	**100.0**	**269**	**100.0**
	Used family planning methods in the last two years (who were not use FP methods)						
	• No	29	50.0	42	77.8	71	63.4
	• Yes	29	50.0	12.0	22.2	41	36.6
	Total	**58**	**100.0**	**54.0**	**100.0**	**112**	**100.0**
	Who decide about using family planning method (currently FP users and during last two years)						
	• Sole decision, women only	45	38.8	45	63.4	90	48.1
	• Sole decision, men only	14	12.1	4	5.6	18	9.6
	• Shared decision, men and women	37	31.9	6	8.5	43	23.0
	• Health provider	19	16.4	16	22.5	35	18.7
	Total	**116**	**100.0**	**71**	**100.0**	**187**	**100.0**
	Received education about the currently used methods (current and last two years FP users)						
	• No	33	28.4	10	14.1	43	23.0
	• Yes	83	71.6	61	85.9	144	77.0
	Total	**116**	**100.0**	**71**	**100.0**	**187**	**100.0**

In regard with the planning to have more children, about 72% of the participants were planning to have more children, either sooner or later. While, 34% of women planned not to have more children.

Regarding decision-making about reproductive health issue, the majority of participants indicated that, it is a shared decision between men and women (88.5%). Additionally, 6.7% indicated that it is woman's decision and only 4% of participants stated that it is a husband's decision; statistics are not shown.

Concerning the decision of choosing family planning method, about 48.1%of the study participants indicated that it was woman's decision, 23% indicated that it was a shared

decision between men and women, and 9.6% indicated that it was a sole husband's decision. While 18.7% indicated that the decision was suggested by health provider.

As showed in Table (4.8), more than three-quarters of the participants (77%) received education about currently family planning method and its use.

With regard to availability of family planning methods in the WHCs, the vast majority of the participants (96.6%) reported that family planning methods were available in the WHCs (Statistics are not shown).

As shown in Figure (4.4), Intrauterine Device (IUD) was the most commonly used contraceptive method among the family planning users (64.9%), followed by pills (17.8%) and male condom (11.4%). Other methods were used, including injectable hormones and natural methods that represented (5.4%).The MoH reported that the common contraceptive method among new beneficiaries from its clinics (38 centers) in GS during 2014 was the Intrauterine Device (IUD) that represented 36.9% while the tablets were represented 33.2% out of the total methods (MoH, 2015).

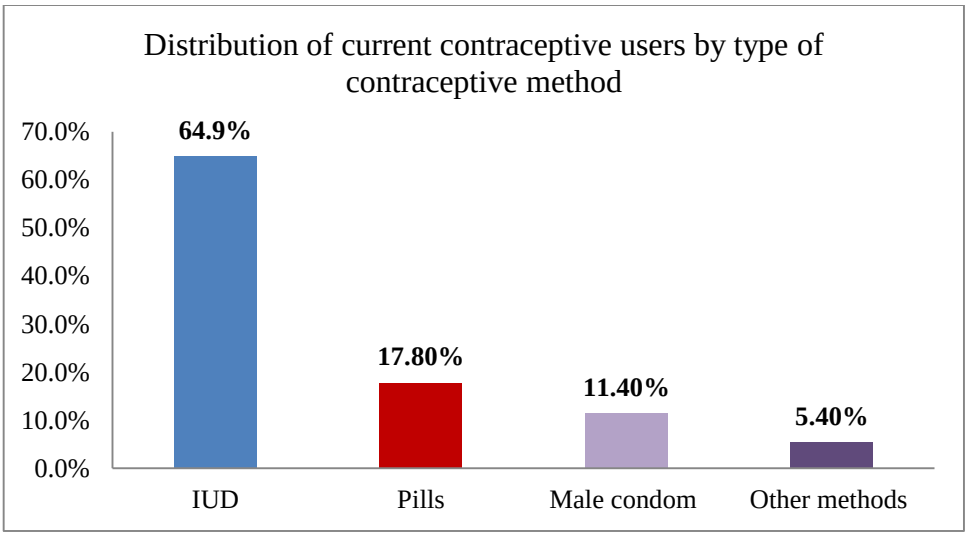

Figure (4.4): Frequently distribution of current contraceptive users by type of the contraceptive method

4.5 Utilization of gynecology service of the two WHCs (all participants)

As shown in Table (4.9), the majority of the participants (78.9%) had received treatment for of gynecology issues or infertility problems in WHCs. The level of satisfaction was very high as some of 290 cases out of 297 (97.6%) have reported that the treatment they received was effective. The differences between the two Centers were not significant.

Table (4.9): Frequency distribution of the reported responses regarding the utilization of gynecology service

	Items	Jabalia Center		Al-Bureij Center		Total	
		No.	**%**	**No.**	**%**	**No.**	**%**
	Received treatment for gynecological issues and/or infertility problems						
	• No	24	14.8	55	25.8	79	21.1
	• Yes	138	85.2	158	74.2	296	78.9
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Effectiveness of treatment						
	• No	3	2.2	4	2.5	7	2.4
	• Yes	136	97.8	154	97.5	290	97.6
	Total	**139**	**100.0**	**158**	**100.0**	**297**	**100.0**

Utilization of none health service of the two WHCs (all participants)

As shown in Table (4.10), the results revealed that only 27.7% of the study participants have utilized social services of the two WHCs. This percentage reflects only the number of women who utilized RH services in the clinics (pilot of the study) that the women who need counseling or any none health services go directly to these departments.

Among cases that utilized social services in addition to RH services, interestingly, the majority of them (95%) were satisfied with the provided services. In regard with the psychological service, about 27.2% of the participants utilized psychological service of the two WHCs. Among cases that utilized psychological services, the vast majority of them (97%) were satisfied, while 3% of them were not.

Table (4.10): Frequency distribution of the reported responses regarding the social, psychological, legal, and physiotherapy services

	Items	Jabalia Center		Al-Bureij Center		Total	
		No.	**%**	**No.**	**%**	**No.**	**%**
	Utilized social service						
	• No	113	69.8	158	74.2	271	72.3
	• Yes	49	30.2	55	25.8	104	27.7
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Satisfied with received social service (only cases who utilized social services)						
	• No	5	10.2	0	0	5	4.8
	• To some extent	8	16.3	8	14.5	16	15.4
	• Yes	36	73.5	47	85.5	83	79.8
	Total	**49**	**100**	**55**	**100**	**104**	**100.00**
	Utilized psychological service						
	• No	105	64.8	168	78.9	273	72.8
	• Yes	57	35.2	45	21.1	102	27.2
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Satisfied with received psychological service						
	• No	3	5.3	0	0.0	3	3
	• To some extent	6	10.5	3	6.7	9	8.8
	• Yes	48	84.2	42	93.3	90	88.2
	Total	**57**	**100.0**	**45**	**100.0**	**102**	**100.0**
	Utilized legal service						
	• No	135	83.3	178	83.6	313	83.5
	• Yes	27	16.7	35	16.4	62	16.5
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Satisfied with received legal service						
	• No	1	3.7	0	0.0	1	1.6
	• To some extent	3	11.1	2	5.6	5	7.9
	• Yes	23	85.2	34	94.4	57	90.5
	Total	**27**	**100.0**	**36**	**100.0**	**63**	**100.0**
	Utilized physiotherapy service						
	• No	78	48.1	105	49.3	183	48.8
	• Yes	84	51.9	108	50.7	192	51.2
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Satisfied with received gym/physiotherapy service						
	• No	2	2.4	1	0.9	3	1.6
	• To some extent	3	3.6	5	4.7	8	4.2
	• Yes	79	94.0	101	94.4	180	94.2
	Total	**84**	**100.0**	**107**	**100.0**	**191**	**100.0**

Concerning legal service, the results showed that 16.5% of the study participants have utilized legal service of the two WHCs. Among cases that utilized legal service, the vast majority of cases (98.4%) were satisfied with the provided services.

Along with the above services, the two WHCs provide women with other services such as physiotherapy services; the results of the study revealed that 51.2% of the study participants have utilized services from this department. As shown in Table (4.10), among cases that utilized physiotherapy services, the vast majority of the study participants (98.4%) were satisfied with the received service. It is worth mentioning that there were no significant differences between the two centers with regard to rate of utilization and satisfaction with the provided services.

Table (4.11): Availability of reproductive health services (all participants)

	Items	Jabalia Center		Al-Bureij Center		Total	
		No.	**%**	**No.**	**%**	**No.**	**%**
	Want other RH services that not existing in the Center						
	• No	110	67.9	185	86.9	295	78.7
	• Yes	52	32.1	28	13.1	80	21.3
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Other RH services wish to be in the Center						
	• Delivery department	33	63.5	17	58.6	50	61.7
	• Child care	7	13.5	5	17.2	12	14.8
	• Others	12	23	7	24.1	19	23.5
	Total	**52**	**100.0**	**29**	**100.0**	**81**	**100.0**
	Unavailability service during last six months?						
	• No	147	90.7	182	85.4	329	87.7
	• Yes	15	9.3	31	14.6	46	12.3
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**

As shown in Table (4.11), more than two thirds of the study participants (78.7%) have indicated that all RH services are available in the two WHCs. While 21.3% of the study participants have reported that they wish if there are other services such as, delivery

department (61.7%), child care department (14.8%), and other services (23.5%) such as: library, department for infertility, and in vitro fertilization.

Concerning the unavailability of any RH services, the majority of the participants (87.7%) have reported that all the services were available during the last six months. While 12.3% reported that they sometimes returned back home without getting the service they need. The first most reported reason for returning home (56.5%) was unavailable gynecologist, the second reported reason (28.3%) was the lack of medicine, and too many cases in the WHCs were the third reported reason (8.7%). Additionally, there were other reported reasons (6.5%) such as: long waiting time and unaffordable of service.

4.6 Accessibility, affordability, and availability of reproductive health services

In this study, accessibility, affordability, and availability of selected reproductive health services dimension included ten items (Table 4.12). As shown in Table (4.12), easy access to WHCs has the highest mean percentage with 86%. Physical location of the two WHCs is suitable as indicated by most women; as 83.8% of women expressed satisfaction with the physical location of the two centers. With regard to the cost of transportation, most women agreed that the cost of transportation is reasonable, as expressed by a high mean percentage (84.2%). In contrary, fewer women have agreed that the fee of services is reasonable, with a mean percentage of 77.6%. However, this mean percentage still reflects financial affordability of the services as only 6.1% of the study cases indicated that the cost is not affordable. Regarding the availability of health providers, most women expressed high level satisfaction as reflected by the high mean percentage with 85.2%. Also, health providers' respects women's time through high level of compliance with the centers appointment system, this was reflected by a mean percentage of 84.6%.

Table (4.12): Frequency distribution of the reported responses regarding the accessibility, affordability, and availability of selected reproductive health services

Items	WHCs No. / %	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree	Mean / Mean %
Easy access of the WHCs	**No.**	1	8	2	232	132	4.30
	%	0.3	2.1	0.5	61.9	35.2	86.0
Physical location of WHCs is suitable	**No.**	1	20	9	223	122	4.19
	%	0.3	5.3	2.4	59.5	32.5	83.8
Cost of transportation is reasonable	**No.**	1	5	24	231	114	4.21
	%	0.3	1.3	6.4	61.6	30.4	84.2
Fee for service is reasonable	**No.**	0	23	94	162	96	3.88
	%	0.0	6.1	25.1	43.2	25.6	77.6
Health providers are available in the two WHCs	**No.**	1	1	11	248	114	4.26
	%	0.3	0.3	2.9	66.1	30.4	85.2
Health providers respect the appointment system	**No.**	1	1	23	236	114	4.23
	%	0.3	0.3	6.1	62.9	30.4	84.6
Waiting time is suitable	**No.**	0	5	12	253	105	4.22
	%	0.0	1.3	3.2	67.5	28.0	84.4
Working hours & days are suitable	**No.**	2	8	22	238	105	4.16
	%	0.5	2.1	5.9	63.5	28.0	83.2
Medicine is available all the time	**No.**	0	52	188	86	49	3.35
	%	0.0	13.9	50.1	22.9	13.1	67.0
Folic acid & vitamins are available all the time	**No.**	1	7	116	196	55	3.79
	%	0.3	1.9	30.9	52.3	14.7	75.8
Total Mean %	**Jabalia**	**Mean = 87.36, SD = 8.77**					
	Al-Bureij	**Mean = 76.48 , SD = 4.80**					
	Total	**Mean = 81.18, SD = 8.68**					

Also, Table (4.12) showed that about two-thirds of women agreed that drugs are always available at the two centers and that Folic acid & vitamins are also available all the time. The mean percentages were 67% and 75.8%, respectively. Finally, most women agreed that the waiting time is reasonable and that the centers' working hours and days are suitable. The mean percentages were 84.4% and 83.2%, respectively. The overall mean

percentage of accessibility, affordability, and availability of selected reproductive health services was 81.18 (SD= 8.68).

4.7 Infrastructure and equipment of the two WHCs

To assess the suitability of infrastructure and equipment of the two WHCs from study participants' perspectives, the researcher proposed ten items, as in Table (4.13).

With regard to WHCs physical buildings and space, as shown in Table (4.13), more than two thirds of participants agreed that the physical space is suitable, with a mean percentage of 71%. Among the assessed items, the researcher examined whether the clinic space is suitable and whether the examination room has enough space; most participants expressed satisfaction with the two items with a mean percentage of 74.4% and 81%, respectively. Also, the researcher examined the availability of medical bed in the examination room and the adequacy of the light, most study participant expressed higher level of satisfaction as the mean percentages were 84% and 86%, respectively.

Regarding the availability of entertainment materials in the waiting area such as books and TV, the mean percentage was 79.8%. Additional items that were assessed were availability of electricity and availability of clean water for drinking. Most participants expressed high level of satisfaction with the availability of clean water and electricity as reflected by high mean percentages, 86.2% and 84.4%, respectively (Table, 4.13).

Finally, with regard to the cleanliness of the two centers and the cleanliness of the toilets, the mean percentages were the highest among the other items, with 88.8% and 88.4%, respectively. To sum, the overall mean percentage for infrastructure and equipment of the two centers was 83.4% (Table, 4.13).

Table (4.13): Frequency distribution of the reported responses regarding the infrastructure and equipment

Items	Two WHCs	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree	Mean / Mean %
WHC physical buildings and space are suitable for the services	**No.**	6	78	28	230	33	3.55
	%	1.6	20.8	7.5	61.3	8.8	71.0
WHC clinic space is suitable to the services	**No.**	5	52	28	248	42	3.72
	%	1.3	13.9	7.5	66.1	11.2	74.4
Examination rooms have enough space	**No.**	2	20	8	271	74	4.05
	%	0.5	5.3	2.1	72.3	19.7	81.0
There is adequate light in the examination rooms	**No.**	0	4	7	273	91	4.20
	%	0.0	1.1	1.9	72.8	24.3	84.0
There are bed for medical examination in the examination rooms	**No.**	0	1	3	254	117	4.30
	%	0.0	0.3	0.8	67.7	31.2	86.0
There is an entertainment material in the waiting room	**No.**	1	22	31	246	75	3.99
	%	0.3	5.9	8.3	65.6	20.0	79.8
Electricity is always available	**No.**	0	1	8	238	128	4.31
	%	0.0	0.3	2.1	63.5	34.1	86.2
Clean water for drinking is always available	**No.**	1	2	29	216	127	4.24
	%	0.3	0.5	7.7	57.6	33.9	84.8
Toilets are clean	**No.**	0	0	11	197	167	4.42
	%	0.0	0.0	2.9	52.5	44.5	88.4
The centers are always clean	**No.**	0	3	3	237	132	4.43
	%	0.0	0.0	0.5	55.5	44.0	88.6
Total Mean %	**Jabalia**	**Mean = 85.89, SD= 9.21**					
	Al-Bureij	**Mean = 81.62, SD = 4.43**					
	Total	**Mean = 83.47, SD = 7.23**					

4.8 Skills and competency of the health providers

To assess providers' skills and competency, the researcher included seven items as in Table (4.14). Results showed that the highest mean percentages were for the two items that directly related to provider's knowledge, information and skills to understand and to deal with women health condition and concerns. The mean percentages were 87.4%, and 87.2%, respectively.

Table (4.14): Frequency distribution of the reported responses regarding skills and competency of the health providers

Items	Two WHCs	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree	Mean / Mean%
Health provider makes necessary procedures to diagnose my health status	**No.**	0	1	7	227	140	4.35
	%	0.0	0.3	1.9	60.5	37.3	87.0
Health provider prescribes treatment and instruct me about my health	**No.**	0	1	3	236	135	4.35
	%	0.0	0.3	0.8	62.9	36.0	87.0
Health provider involves you in your treatment plan	**No.**	2	4	6	242	121	4.27
	%	0.5	1.1	1.6	64.5	32.3	85.4
Health provider gives another appointment if it is needed	**No.**	0	3	2	246	124	4.31
	%	0.0	0.8	0.5	65.6	33.1	86.2
In case of non-available service, health provider refers client to other medical centers	**No.**	3	26	85	169	92	3.86
	%	0.8	6.9	22.7	45.1	24.5	77.2
Health provider has sufficient knowledge &information to understand your health condition	**No.**	0	2	7	218	148	4.37
	%	0.0	0.5	1.9	58.1	39.5	87.4
Health provider has sufficient skills qualify him to deal with your cases	**No.**	0	4	8	212	151	4.36
	%	0.0	1.1	2.1	56.5	40.3	87.2
Total Mean %	**Jabalia**	**Mean = 89.47, SD= 10.42**					
	Al-Bureij	**Mean = 82.13, SD= 6.68**					
	Total	**Mean = 85.30, SD= 9.24**					

With regard to the providers' ability to prescribe treatment and educate women about the prescribed drugs, most women have expressed high level of satisfaction as manifest by high mean percentage (87%). Interestingly, women also expressed that providers involve them in their treatment plan. The mean percentage of involving clients in the treatment plan was 85.4%. Finally, most women expressed satisfaction with giving them another appointment if there is a need to. This was evident by the high mean percentage (86.2%) as shown in Table (4.14).

The lowest mean percentage was related to transferring the cases to other medical centers in case of non- availability of the required service. The mean percentage was 77.2%. To conclude, the overall mean percentage of skills and competency of the health providers was 85.30 (SD= 9.24).

4.9 Communication

Communication dimension included seven items, as shown in Table (4.15). The mean percentage of satisfaction with providers' giving clients' opportunity to express their health issues was high; with a mean percentage of 89.6%.

As shown in Table (4.15), majority of study participants agreed that providers explain their health issues in an easy clear way and that providers make sure that clients understood all the given information. The mean percentages were 88.8% and 87.8%, respectively. With regard to the interaction between clients and providers, most women agreed that health providers ask questions in professional way and listen thoughtfully to their complaints. The mean percentages were 89.4% and 87.4%, respectively.

Table (4.15): Frequency distribution of the reported responses regarding communication

Items	Two WHCs	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree	Mean / Mean %
Health provider introduces herself before providing services	**No.**	5	65	90	145	70	3.56
	%	1.3	17.3	24.0	38.7	18.7	71.2
Health provider welcomes women in professional way	**No.**	0	5	7	230	133	4.31
	%	0.0	1.3	1.9	61.3	35.5	86.2
Health provider listens thoughtfully to women complaint	**No.**	0	1	5	225	144	4.37
	%	0.0	0.3	1.3	60.0	38.4	87.4
Health provider asks questions in professional way	**No.**	1	3	3	179	189	4.47
	%	0.3	0.8	0.8	47.7	50.4	89.4
Health provider gives women opportunity to explain their health issue	**No.**	2	1	5	175	191	4.48
	%	0.5	0.3	1.3	46.8	51.1	89.6
Health provider explains women health issues in a clear way	**No.**	0	1	2	203	169	4.44
	%	0.0	0.3	0.5	54.1	45.1	88.8
Health provider makes sure that women understood all information	**No.**	0	2	5	213	155	4.39
	%	0.0	0.5	1.3	56.8	41.3	87.8
Total Mean %	**Jabalia**	**Mean = 89.74,SD= 9.99**					
	Al-Bureij	**Mean = 84.11,SD= 6.59**					
	Total	**Mean = 86.55,SD= 8.68**					

The lowest mean percentage in the communication dimension was related to provider introducing herself to the clients. The mean percentage was 71.2%. However, most women agreed that health providers welcome them in a professional way. This was manifest by the high mean percentage (86.2%). The overall mean percentage for communication dimension was 86.55 (SD= 8.68).

4.10 Providers' respect of privacy, confidentiality and dignity

As shown in Table (4.16), the vast majority of the participants feel confident in dealing with health providers; this was manifest with the mean percentage (89.8%). Consistently,

the majority of the study participants indicated that the providers pay attention to their complaints and concerns. This was evident from the high mean percentage (89.2%). Most women indicated that providers treat cases equally without regard to any discriminatory factors. This was apparent from the mean percentage which was 85.2%. Finally, most of the study participants have indicated that providers respect their privacy during service delivery and maintain the confidentiality of their information. The mean percentages of maintaining privacy and confidentiality in the two WHCs ,from beneficiaries perception, was 87.6% .

Table (4.16): Frequency distribution of the reported responses regarding providers' respect of privacy, confidentiality and dignity

Items	Two WHCs	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree	Mean / Mean %
Feeling confident in dealing with service providers	**No.**	1	1	1	181	191	4.49
	%	0.3	0.3	0.3	48.3	50.9	89.8
Service provider gives attention to what client complaints and concerns	**No.**	0	1	3	193	178	4.46
	%	0.0	0.3	0.8	51.5	47.5	89.2
Confidentiality of client's is maintained	**No.**	0	1	25	197	152	4.33
	%	0.0	0.3	6.7	52.5	40.5	86.6
Health provider treats cases equally	**No.**	2	1	25	216	131	4.26
	%	0.5	0.3	6.7	57.6	34.9	85.2
Privacy during service delivery is maintained	**No.**	1	3	2	216	153	4.38
	%	0.3	0.8	0.5	57.6	40.8	87.6
Total Mean %	**Jabalia**	**Mean = 90.76, SD= 10.16**					
	Al-Bureij	**Mean = 85.36, SD= 7.44**					
	Total	**Mean = 87.68, SD = 9.08**					

4.11 Factors that encourage women to utilize services from WHCs

The researcher asked the study participants a non-prompted question about the factors that may encourage other women to utilize services from the two WHCs, results showed that the main factors, from participants perspectives, were the availability of female staff, as expressed by 49.9 % of participants, physical accessibility of the two WHCs, as mentioned by45.3% of participants, and respectful and caring staff which was expressed by 41.6% of participants.

Table (4.17): Frequency distribution of the reported factors encouraging women to utilize services from WHCs

	Items	Jabalia Center		Al-Bureij Center		Total	
		No.	**%**	**No.**	**%**	**No.**	**%**
	Physical accessibility of the two centers-distance to home						
	• No	120	74.1	85	39.9	205	54.7
	• Yes	42	25.9	128	60.1	170	45.3
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Skills and experience of staff						
	• No	123	75.9	106	49.8	229	61.1
	• Yes	39	24.1	107	50.2	146	38.9
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Affordability of services, low cost						
	• No	114	70.4	126	59.2	240	64
	• Yes	48	29.6	87	40.8	135	36
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Respectful and caring staff						
	• No	98	60.5	121	56.8	219	58.4
	• Yes	64	39.5	92	43.2	156	41.6
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Availability of female staff						
	• No	97	59.9	91	42.7	188	50.1
	• Yes	65	40.1	122	57.3	187	49.9
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**

Other factors were the staff skills and experience in their areas of expertise which was expressed by 38.9% of participants, and the financial affordability of the services which was reported by 36% of participants.

4.12 Obstacles that may hinder women from utilizing WHCs services

The researcher asked the participants about the obstacles that may hinder other women from utilizing services from the two WHCs (non- prompted question), the results showed that the main factors, from participants point of view, were the fee of the services in the two WHCs, this view was expressed by 59.3% of the study participants.

Table (4.18): Frequency distribution of the reported barriers of utilization of the two WHCs services

	Items	Jabalia Center		Al-Bureij Center		Total	
		No.	**%**	**No.**	**%**	**No.**	**%**
	Farness of the Center						
	• No	114	75.0	73.0	35.1	187	51.9
	• Yes	38	25.0	135	64.9	173	48.1
	Total	**152**	**100.0**	**208**	**100.0**	**360**	**100.0**
	Fee of the services						
	• No	83	55.0	63	30.3	146	40.7
	• Yes	68	45.0	145	69.7	213	59.3
	Total	**151**	**100.0**	**208**	**100.0**	**359**	**100.0**
	Family obligations						
	• No	121	80.1	135	64.6	256	71.1
	• Yes	30	19.9	74	35.4	104	28.9
	Total	**151**	**100.0**	**209**	**100.0**	**360**	**100.0**

Physical inaccessibility of the two WHCs as the two centers might be far away from woman's home; this was expressed by 48.1% of study participants. Finally, social factors and family obligations was also reported as a factor that may prevent other women from utilizing the services of the two center, this factor was mentioned by 28.9% of study participants.

4.13 Women satisfaction with the provided services

The researcher assessed the satisfaction of the provided services through ten items, as shown in Table (4.19). The overall satisfaction of the provided reproductive health services was high as expressed by the study participants. The mean percentage of overall satisfaction with the provided reproductive health services was 87.7%.

Table (4.19): Frequency distribution of the reported responses regarding to satisfaction

Items	Two WHCs	Absolutely unsatisfied	Unsatisfied	To some extant	Satisfied	Very satisfied	Mean / Mean %
Are you satisfied with the how the provider responded to your needs	**No.**	0	0	6	229	140	4.36
	%	0.0	0.0	1.6	61.1	37.3	87.2
Are you satisfied with the how the provider dealt with you	**No.**	0	1	5	222	147	4.37
	%	0.3	0.0	1.3	59.2	39.2	87.4
Are you satisfied with quality of the provided services	**No.**	0	0	21	218	136	4.31
	%	0.0	0.0	5.6	58.1	36.3	86.2
Are you satisfied with the price of the provided services	**No.**	3	9	104	151	108	3.94
	%	0.8	2.4	27.7	40.3	28.8	78.8
Appropriateness Satisfied with the service received.	**No.**	0	1	4	222	148	4.38
	%	0.0	0.3	1.1	59.2	39.5	87.6
Are you satisfied with the effectiveness of the provided services	**No.**	0	1	11	236	126	4.30
	%	0.0	0.3	2.9	63.1	33.7	86.0
Are you satisfied with available equipment at the center	**No.**	0	7	33	234	101	4.14
	%	0.0	1.9	8.8	62.4	26.9	82.8
Are you satisfied with the cleanliness of the center	**No.**	0	0	4	145	226	4.59
	%	0.0	0.0	1.1	38.7	60.3	91.8
General satisfaction with provided RH services	**No.**	0	0	13	204	158	4.39
	%	0.0	0.0	3.5	54.4	42.1	87.8
Total Mean %	**Jabalia**	**Mean = 90.43, SD= 8.93**					
	Al-Bureij	**Mean = 82.80, SD= 6.00**					
	Total	**Mean = 86.00, SD= 8.34**					

From women's perspective, as shown in Table (4.19), the providers were responsive to their need; the majority of the study participants have expressed satisfaction with how the providers responded to their needs. The mean percentage of satisfaction with providers' responsiveness to clients' needs was 87%. Mean percentage of satisfaction with the quality of the provided services was 86.2% and with the effectiveness of the provided services was 86%. Additionally, the mean percentage of satisfaction with the appropriateness of the provided services was also 86%.

More than two-third of women have expressed satisfaction with the available equipment at the two centers, with mean percentage of 82.8%. Finally, the lowest mean percentage was participants' satisfaction with the service cost, as it was 78.8%.

With regard to non-health needs, from women viewpoint, the highest mean percentage (91.8%) was reported for the satisfaction of the cleanliness of the two WHC centers. Additionally, most women expressed high level of satisfaction with the way that the provider treated them; as the mean percentage was 87.4%. This high percentage reflects good relationship between women and the providers. The overall satisfaction of the provided services was relatively high as perceived by the study participants. The overall mean percentage of the satisfaction dimension was 86% (SD= 8.34).

4.14 Effect of WHCs services on women health and well-being

The researcher helped women to evaluate their health status by asking them a set of questions; the results (Table 4.20) showed that the vast majority (99.2%) of the participants valuated their current health status as either good or very good. Only 3 women perceived their current health status as bad. Regarding women's general health status in comparison with the last year, about 41 % from the participants said that their current health status is as

the last year and about 38 % said that it is better than the last year. While 21.3% said that their health status now is worse than the last year.

Table (4.20): Distribution of responses regarding women's health status

	Items	Jabalia Center		Al-Bureij Center		Total	
		No.	**%**	**No.**	**%**	**No.**	**%**
	Current health status for women from their perspectives						
	• Bad	1	0.6	2	0.9	3	0.8
	• Good	62	38.3	106	49.8	168	44.8
	• Very good	99	61.1	105	49.3	204	54.4
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Current health status in comparison with the last year						
	• Worse	14	8.6	66	31	80	21.3
	• The same	39	24.1	115	54	154	41.1
	• Better	109	67.3	32	15	141	37.6
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	The provided services in the Center improved women's health status						
	• No	10	6.2	1	0.5	11	2.9
	• Yes	152	93.8	212	99.5	364	97.1
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**
	Patterns of health improvements						
	• Health improvement & treatment	123	80.9	203	95.8	326	89.6
	• Health &body improvement	37	24.3	88	41.5	125	34.3
	• Well-being improvements	37	24.3	63	29.7	100	27.5
	• Behavior improvements	6	3.9	55	25.9	61	16.8
	• Other improvements	0	0.0	4	1.9	4	1.1

The vast majority of the participants (97.1%) reported that the provided services in the two centers have improved their health status and only 2.9% of women indicated that the provided services did not improve their health status. The main sources of improvement from women perspective were the availability of medical treatment health education. Other women indicated improvements in their well-being through adoption of healthy behavior.

Responding to the hypothetical question if the two Centers were closed, what is the impact will be on your health. The table below shows the responses that were mentioned by the study participants.

Table (4.21): Effects of closing the two centers on women's health

	Items	Jabalia Center		Al-Buraj Center		Total	
		No.	**%**	**No.**	**%**	**No.**	**%**
	Effects of closing the two WHCs on women's health						
	• No significant impact	45	27.8	9	4.2	54	14.4
	• Health status will be negatively impacted, mild impact	54	33.3	71	33.3	125	33.3
	• Health status will be negatively impacted, moderate and sever impact	36	22.2	83	39	119	31.7
	• Women will face difficulties in finding other providers	27	16.7	50	23.5	77	20.6
	Total	**162**	**100.0**	**213**	**100.0**	**375**	**100.0**

As shown in Table (4.21), from women's perspective, about one-third of women indicated that their health will be negatively affected; however, the impact will be mild. Of the total participants, about 32% of women indicated that their health status will be getting worse as their health will be moderately and severely affected. Some women indicated that the closure of the two centers will have significant negative impact on their psychological well-being. Finally, about 15% of women indicated that the closure of the two centers will not have significant impact on their health as they will find other providers. In contrast, more than 20% of the study participants reported that it will be difficult for them to find other providers who can deliver the same services.

Inferential analysis

As a reminder, the researcher has used SPSS version 20 to analyses the data. The below sections show inferential statistics that were conducted. The researcher has run different statistical tests, namely One-Way ANOVA, Person Correlation, and Chi-square test.

4.15 Differences in satisfaction with the provided services

As shown in Table (4.22), the researcher have examined the relationship between satisfaction and other independent factors, namely age, level of education, and total family income. As shown in Table (4.22), there was a statistically significant relationship between women's age and satisfaction with the provided services (F= 4.6, p= .01). Post hoc comparisons using the Scheffe test was done to detect differences among age groups. The post hoc test revealed that women aged between 25 and 35years have higher level of satisfaction than women aged less than 25 years old or older than 35 years old, with (Mean = 2.57, P = .02). Statistics are not shown.

Table (4.22): Differences in beneficiaries' satisfaction by selected variables

Variables	Items	No.	Mean	SD	F	Sig.
Age groups	16 to 24 years	27	86.29	10.40	**3.984**	**0.019***
	25 to 35years	217	84.99	7.79		
	36-65 years	131	87.57	8.56		
	Total	**375**	**85.98**	**8.34**		
Women level of education	Less than 12 years of schooling	152	86.11	8.33	**0.404**	**0.668**
	12 years of schooling	106	86.42	8.19		
	More than 12 years of schooling	117	85.44	8.53		
	Total	**375**	**85.99**	**8.34**		
Total family income	Up to 1000 NIS	193	85.09	7.85	**2.338**	**0.098**
	From 1001 -2000 NIS	122	86.90	8.85		
	More than 2000 NIS	60	87.03	8.63		
	Total	**375**	**85.99**	**8.34**		

*Significant at 0.05

The analysis of variance showed no statistically significant difference in the satisfaction level and women's level of education and total family income (F = 4, p = .66 for level education and F = 2.3, p = .09 for total family income).

Table (4.23): Relationship between beneficiaries' satisfaction and both waiting time and time spent with health provider

Variables	N	Person Correlation R	Sig. P-value
Total of satisfaction and waiting time	375	-0.119*	0.021*
Total of satisfaction and time spent with health provider	375	0.043	0.402

*Significant at 0.05

The above Table (4.23) showed that there was a negative mild relationship between satisfaction of women and the waiting time in the two WHCs. This relationship was statistically significant (R= -.11, p = 0.02). One can imply that less waiting time is associated with higher level women's satisfaction. While there was no relationship between satisfaction of women and the time spent with health provider in the two WHCs (R = .04, p = 0.40).

Chapter (5)

Qualitative findings

This chapter presents results from six focus group discussions and nine in-depth interviews. All focus groups were assembled of Palestinian women. In total, thirty eight women participated in the focus groups; all of them have utilized RH services, legal services, and physiotherapy services. Participants of in-depth interviews involved two senior managers, four specialists from WHC in Jabalia and three specialists from WHC in Al- Bureij.

The focus groups and in-depth interviews aimed to address the following study questions:

1. How do the beneficiaries perceive the RH services they receive? And to what extent these services are responsive to their needs?
2. What about the accessibility, affordability and availability of the provided services, infrastructure and equipment of the clinics, skills and competency of health providers.
3. What about the communication between health providers and the beneficiaries. And to what extent the providers maintain and respect the privacy, confidentiality and dignity, according to the beneficiaries' perception?
4. What are the main factors that encourage women to utilize RH services?
5. What are the obstacles that may hinder women from utilizing WHCs services?
6. Do guide lines and protocols exist in the two WHCs?
7. What is the effect of these services on women's health status and well-being?

The data presented in this chapter are based on the participants' expressed opinions and perceptions and the results are presented according to the main themes that emerged from both the focus groups' discussions and the in-depth interviews. This chapter begins with descriptive demographic characteristic of participants; the rest of the chapter presents analysis from the discussions with participants, both women and service providers who participated in the focus groups and in-depth interviews. Quotations from participants are included throughout this chapter; those quotations are presented in italics style.

5.1 Demographic information on participants

Thirty-eight women participated in the six focus group discussions. The average age of participants in the focus groups was 44 years (range from 20 to 65 years) with average 12 years of schooling (range from 5 to 18 years). With regard to marital status, the groups were composited of single, married, divorced, and widowed women. Some of nine health providers participated in the in-depth interviews. Their professions are nursing, medical doctors, social workers, and psychologists. All participants have been working for long time period, at least couple of years.

5.2 Themes

5.2.1 Factors that encourage women to utilize services from WHCs

Along with the reproductive health services, the two WHCs provide a comprehensive package of services that include psychosocial, legal, and physiotherapy services. From women's perspectives, generally, most participants of focus group discussions indicated that the main motivating factors for utilizing WHCs services are: (1) providers' respectful and friendly treatment, (2) good quality care provided by providers, (3) receiving information that is relevant to their needs, (4) accessibility of services, (5) the quality of

interpersonal communication between clients and health-care providers, and (6) the high level of responsiveness to non-health needs such as cleanness of the centers.

It is very interesting to note that women greatly valued the interpersonal communication with their providers; one participant put it this way, "*Warm welcoming remarks and smiling faces encourage us to come here always",* (52 years old, RH user). Another participant stated, *"When we come here; we feel psychologically comfortable. Indeed, specialists deal with us as if we are sisters or friends",* (39 years old, RH user). The above motivating factors were expressed by most participants of the focus groups discussions. Regardless the utilized services in the two Centers, there were no differences among participants across the two Centers.

Other motivating factors include respecting clients' privacy during counseling sessions, examination, and procedures; and the competency of service providers. It is very interesting to mention that participants of the focus groups discussions judged the technical competencies of the providers by whether they meet their needs and solve their problems. One woman stated, "The *team is always available to hear us, they do their best to solve our problems*", (55 years old, RH and legal services user).

From provider's perspectives, in-depth interviews with service providers revealed that the competency and experience of the centers' staff, the good reputation of the centers, the sole availability of the female staff, and availability of different services at each Center are the main factors that encourage women to utilize the services. Service providers of the two Centers consistently mentioned the above motivating factors, and there were no differences between the two Centers. A social worker stated, "*In addition to our experience in women issues and our commitment to work, the center has a good reputation. From my point view, these are the main motivating factors*". One of the centers' senior staff stated, "*The sole*

*availability of female staff, and their understanding to women issues are the main factors that motivate women to come to our centres; we always look for solutions to solve women's problems".*Consistently, few participants of the focus groups discussions also mentioned the sole availability of female staff as a motivating factor from their point of view.

Finally, most of participants perceived offering integrated and comprehensive services as a main motivating factor to utilizing services in both centers. It was not surprising that all participants, focus groups and in-depth interviews, stated that offering comprehensive services is one of the main motivating factors for utilizing services. One woman stated, "*We benefit from psychosocial and legal counseling services; there is also RH clinic and physiotherapy department in the center",* (52 years old, RH user). The availability of legal services within the centers encourages some participants to seek services. Unsurprisingly, the participants of focus groups believed that the availability of legal services enhances women's autonomy and advocates their rights. One woman stated, "*With the presence of a lawyer here, we do not need to make big effort to get part of our rights", (*37 years old, legal services user).This view was consistent with what service providers mentioned, a social worker stated, "WHC *provides a pregnant woman with antenatal care; if she needs legal services, then I refer her to a lawyer. At the same time, a woman could receive psychosocial support. Also, we provide comprehensive reproductive services that include prenatal care, ultrasound examination, and treatment of gynecological problems*".

5.2.2 Obstacles that may hinder women from utilizing WHCs services

Most participants in the six groups mentioned that the main reasons that may hinder women's utilizing services from the two WHCs are: (1) women's social responsibilities and

busy schedules, (2) unaffordability of services, (3) work schedule of the two Centers, and (4) inaccessibility of the two Centers to physically disabled women.

Among the above barriers, women's social responsibilities and busy schedules were mentioned as the commonest barriers. The main barriers were expressed consistently by the health providers.

Although most of the WHCs services are either provided free of charge or with nominal fees, as expected, unaffordability was also mentioned as a substantial barrier that could prevent poor women from utilizing the two Centers' services. Unaffordability includes women inability of paying the fee of services and transportation cost.

It is very important to mention that the two Centers have in place a financial exemption mechanism. Health provider may refer any poor women to the Social Workers. The Social Workers assess cases individually and then provide exemption, if there is a need.

Participants reported that employed / working women do not come to the two Centers regularly. This view was expressed consistently by women in the six focus groups and health providers. The main reason is the working hours of the two centers as the two Centers work only one morning shift. Finally, limited accessibility of the two Centers to physically disabled women was mentioned by some participants in the focus groups. The two centers are not designed to be used by women with physically disabilities people.

Availability of other providers who deliver same services was also mentioned as a factor that might discourage some women from utilizing RH services from the two Centers, in particular the presence of UNRWA health care centers that provide all MCH services free of charge for all refugee women.

5.2.3 Skills and competency of the health providers

From in-depth interviews with health providers, it was evident that the management of the two Centers support capacity buildings of employees through continuous training and in-services training programs. In-depth interviews with participants revealed that the impact of the previously conducted training programs was enormous as it improved the performance of the team. One senior Manager put it this way," *In addition to the specialized trainings, staff had also administrative and other technical trainings that contributed to improving the work quality".*

5.2.4 Communication

With regard to communication between clients and healthcare providers, results of focus groups and in-depth interviews with two senior managers reflected good relationship and reciprocal respect between beneficiaries and the health providers. Most participants of focus groups expressed high level of satisfaction with the communication and interaction with the health providers; this was previously mentioned as one of the main motivating factors that encourage women to utilize services.

It is worth mentioning that all participants of focus group discussions expressed a high level of satisfaction with the received psychosocial, legal, and physiotherapy services. Most of them evaluated their satisfaction related the received services to be between (95-100%). They attributed their high satisfaction to the great benefit that gained from the department. They were also very satisfied with the education that they received.

5.2.5 Quality of provided RH services

Providing high quality services as a goal was expressed by all interviewed staff. Health care providers at the two Centers are constantly striving to improve quality and efficiency

of the provided services. The above was expressed constantly by the participants of in-depth interviews, regardless the nature of their professions. From managerial point view, according to the two Senior Managers, there is a quality monitoring system in place. The system involves documenting and reporting work achievements and progress according to the pre-determined work objectives and outcomes. Furthermore, conducting evaluation studies and assessment reports as requested by donors is a common behavior in the two Centers. One senior Manager put it this way, "*There is a following up committee in the Center, and I have my own monitoring and evaluation sheet that I complete every three months according to donor's request. Part of this monitoring and evaluation sheet is on financial monitoring".*

5.2.6 Clients' involvement and providers' responsiveness

To provide high-quality care, providers must understand and respect their clients' needs, attitudes, and concerns. In-depth interviews with health providers revealed that clients' needs and concerns are taking into account in every aspect of the provided services. Furthermore, the two senior managers reported that they involve women in the conducting needs assessment and in the decision-making process, in particular when it comes to new services to the provided package. One senior Manager put it this way, "*Women participate in decision making. In the past years, participation of women in decision making was given high priority and indeed it was very important to do so. The idea of establishment "Man Intervention Unit", came for a women who said once," the Center gives us awareness and education, and provide us with good services: where is the other partner?" Her point was taken into action as we established the Man Intervention Unit".*

With regard to responsiveness to women's health needs, there was a consistent view among participants of the focus groups and in-depth interviews that the WHC policies,

programs, and interventions are responsive to women's health needs. From providers' point of view, the available services at the two Centers response to about 90% of women's needs. With regard to the other 10% of needs, the two Centers have referral system in place as they refer cases for other organizations.

5.2.7 Current policies and guidelines

In-depth interviews with health providers revealed that there are existing protocols and guidelines in the two Centers. More importantly, the guidelines are accessible to all the staff and are under continuous revisions and modifications. Most of the interviewed staff admitted that they have received training on how to use the protocols and have seen hard copies of the protocols. During the data collection, the researcher saw copies of the currently used protocols.

In regard with the internal polices, the two senior managers reported that their centers committed to their internal policies. For example, RCA has its human resources policy and financial and administrative guidelines. Also, CFTA has the same polices in place. In the two Centers, there are hard copies of all policies and regulations.

Both two WHCs have procedures for staff safety and protection, one senior manager stated: "*All the workers in the two WHCs received training on infection prevention and control; there is also a protocol on infection prevention and control".* Interestingly, the interviewed staff indicated that there is a mechanism for medical waste disposal; this mechanism protects the team and the environment from spreading hazardous medical waste, including used needles and drug containers.

5.2.8 Effect of WHCs services on women health and well-being

Despite all the surrounding variables such as deteriorated economic conditions, frequent wars, and poverty, according to service providers, WHCs services have positively affected women's health and improved their overall well-being. Giving the complexity of measuring this impact, the researcher asked women directly to describe how the provided services affected their health status and well-being. Very interestingly, most participants stated that the provided services have improved their physical health, improved their psychological status, strengthen their personalities, improving the physical look and fitness, and reducing their level of daily stress. Unexpectedly, women emphasized the positive impact of the other non- health services. One participant stated, "*I was suffering from the problems of violence at home. The Social worker at the Center taught me how to control myself and how to avoid these problems. This improved my psychological status, now; I am calmer and know how to deal with the problems and how to control myself".* (50 years old, RH & psychosocial services user)

Also, WHCs services have increased women awareness of their rights and duties. A participant stated, "*My husband used to humiliate me, physical abusing me, kicking me out of my house; nobody was able to help me. I was admitted to hospitals several times as I am diabetic and hypertensive patient. I asked for help from the Lawyer at this Center; she helped me to file a cause against my husband at the court. The court protected me from my abusing husband*". (52 years old, RH and legal services user)

Additionally, participants of the focus groups underlined how the education programs at the two centers have improved the level of their knowledge, changed their behavior, and improved their well-being. One of participants women stated: "In *previous, I was not able to talk with other people, after awareness and education that received in WHC; I became*

able to express myself and my views". (35 years old, RH and psychosocial services user) Other woman stated: "When *I feel stress, I do the relaxation exercise that we learnt here*". (37 years old, RH and psychosocial services user)

Consistently, those effects of WHCs services on women's health and well-being were mentioned by most of the service providers. In terms of health behaviors changes, service providers mentioned that women's behaviors have been changed, they reported that women now give more attention to their health. Among the provided services, the two Centers offer preventive and early detecting services for breast cancer and sexuality transmitted diseases. There is a good use of the above services; this view was expressed by several health providers. Also, according to health providers, women's awareness on anemia prevention and treatment has increased.

Finally, in-depth interviews with psychosocial specialists and two senior managers revealed that women's communication skills have been improved. Consistently, participants of focus groups reported positive changes in their communication skills; in particular with their family members. Additionally, women clearly expressed that they learned how to deal with their children and how to build a strong relationship with them. A participant woman put it this way: "*My relationship with my 10 years daughter has improved; my relationship with my teenage son has also greatly improved"* (50 years old, RH and psychosocial services user). The above views were expressed by women in the two Centers; there were no differences among participants in the two WHCs.

5.2.9 Financial sustainability of services

Result of the in-depth interviews with the key informants revealed that there is a limited financial Sustainability of the services as the two Centers are funded by external donors. If donations stop, the possibility that the two Centers will continue to provide services is very limited. The generated income for the provided services is very minute; it covers part of the running cost of the two Centers. This is the only source that can generate income. In-depth interviews with senior managers revealed that the managerial team is aware of this limited financial sustainability, but their awareness undermined the importance of reaching financial sustainability. One senior manager put it this way, "*In case we have funding problems, we may decrease some services or work hours, but will not close Center. I am confident that our staff will continue to work even with reduced salaries, but our association has the ability to find funds from different resources*."

Chapter 6

Discussion

Since more than fifteen years ago, the two WHCs in Jabalia and Al-Bureij Camps provide women with a bundle of RH services to improve women's health status and the overall well-being. The population in the GS is among the fastest growing population in the world. Based on UNFPA demographic calculations, one hundred and sixty deliveries in the GS are taking place every day (UNFPA, 2014b). The fertility rate in the GS is high (4.5 births per woman), which explains the high growth rate as it is 3.41% (PCBS, 2014). Review of the literature revealed that there is a complex link among population growth, fertility rate, unemployment, and the poverty (Mallick and Ghani, 2005). Also, previous research studies have showed that socio-demographic factors affect people's utilization to health services (Aiken et al., 2002; and Clarke et al., 2002; Mark et al., 2003; Escarce and Kapur, 2006; Dagne, 2010; Dokuet al., 2012; Chubike and Constance, 2013; Dibabaet al., 2013; Abejeet al., 2014).

This quantitative/qualitative mixed method study evaluated the two WHCs programs in terms of input, process, and outcomes. Also, it assesses the programs contribution in improving the status of women's health of the WHCs' beneficiaries. The following discussion summarizes and emerges the key findings from the quantitative and qualitative studies. It also lays the groundwork for future applied research in the field of healthcare services utilization and evaluation, particularly within NGOs settings in the GS. This discussion concludes by identifying policy implications and recommendations for the two WHCs to increase the utilization of RH services.

Higher quality of the provided services increases women satisfaction

According to Donabedian's Model, physical infrastructure and equipment, skills and professional of the staff, affect the quality of RH services and the satisfaction of women. The findings of the quantitative study showed that the overall mean percentage for physical infrastructure and equipment of the two WHCs was 83.47%. It showed also that the mean percentage for the skills and professional of the staff was 85.30%.There were no significant differences between the two WHCs related to the two dimensions. These findings are consistent with another finding that the participated women expressed high general satisfaction level (87.8%) with the WHCs RH services. This is consistent with the Donabedian pioneering theory which, suggests that if the center has good infrastructure, good equipment and staff with high knowledge and good experience; consequently, high-quality services is expected to be provided. Also the findings are consistent with previous study conducted by Levin and Joseph (2009) that found the good state of infrastructure of health facilities and equipment is essential for effective health care and clients' satisfaction with the provided services.

Consistently, quantitative findings revealed that the vast majority of the participants (98.7%) have received the services they were supposed to, and the services in the two WHCs met health needs of more than 95% women. Also, the majority of participants (87.2%) was satisfied with the responsiveness (none - health needs), and (87.6%) was satisfied with the health service they had received. This is consistent with previous studies that suggest health providers should provide clients with appropriate and high quality services in a safe environment (WHO, 2005; IFC, 2010).

Consequently, the vast majority of women (99%) reported higher level of satisfaction with the provided quality compared with other health centers. This is unsurprising that the staff

in both two WHCs receives supervision and appropriate trainings that maintain their skills, in addition to their high experience gained by the working in RH field for many years at the same Centers. Also, the findings of the quantitative study revealed that about 78.9% from the participants received treatment for gynecological issues and infertility, vast majority of them (97.6%) was satisfied and said that the treatment they had received was effective. In addition, 71.1% from the respondents to questions related to the pregnancy following up reported that the number of antenatal visits during their last pregnancy was (four and more) visits. This finding is consistent with the recommendation of New WHO antenatal care model (2002), and confirm the health providers' commitment with the international standards. In regard with the rest percentage (28.9%) which represented the number of antenatal visits (up to 3 antenatal visits), this percentage could be attributed to the fact that poor woman follows up her pregnancy in UNRWA clinic, where the services are free of charge, but she comes to WHC to do an ultrasound's image and determine how her pregnancy is progressing. This issue was reported by participants in FGDs as mentioned in qualitative chapter. This also provides evidence about the positive perception of women related to quality of provided services in the two WHCs.

The findings above relating to healthcare quality and satisfaction of women in line with a previous study conducted in Jordan by Alrubaiee and Alkaa'ida (2011) that found there is a significant association between healthcare quality and patient's satisfaction.

All participants in FGDs and in-depth interviews reported that the WHCs policies, programs, and interventions are responsive to women’s health needs. Consistently, the participated women mentioned good quality care provided by providers as the second factor motivates women to utilize WHCs services. Also, they mentioned the high level of responsiveness to non-health needs such as clean of the two WHCs, as another important

motivating factor. This is consistent with a previous study (Creel et al., 2002) that found improved infrastructure and facilities, affected clients' outcomes.

Interestingly, providing high quality services as a goal was expressed by all interviewed staff. As mentioned in chapter five, the participants stated that there is quality monitoring system in place, and the management conducts evaluation studies and assessment reports as requested by donors in the two WHCs. Additionally, there are existing protocols and guidelines in the two WHCs, accessible to all staff and are under continuous revisions and modifications. Also, the two WHCs committed to their internal policies, and both of them have procedures for staff's safety and protection.

The findings above are consistent with the previous studies reviewed in the chapter two (Ibn El Haj et al., 2007; Steinwachs and Hughes, 2008). Also these findings are consistent with the study conducted by IFC (2010) that suggests health providers should provide clients with appropriate and high quality services in a safe environment. It is consistent also with another study conducted by FSRH (2013) that suggests all staff members working in RH services field, should receive appropriate training and their skills should be maintained. Also, it is consistent with previous study conducted in Ghana by (Ganleet al., 2014) that found poor care quality as an important factor affected the utilization of health services.

Providers' respectful and friendly treatment is one of the main factors that motivate women to utilize WHCs services

The findings of the quantitative study revealed that 41.6% of the participants mentioned this factor as an important one that affects women's utilization to RH services in the two WHCs. Quantitative findings showed that the majority of participants (89.8%) in the two

WHCs feel confident in dealing with health providers. And 89.2% reported that health provider gives attention to client's talking. Additionally, 87.6% from the participants indicated that their privacy during service delivery was maintained. This is consistent with the quantitative finding relating to the communication dimension that the overall mean percentage was 86.55%. And there were no significant differences between the two WHCs.

As expected, the qualitative analysis was consistent with the quantitative study: most participants mentioned that providers' respectful and friendly treatment, in addition to maintaining their privacy as the main factors that motivate women to utilize WHCs services. The above findings are consistent with previous studies reviewed in chapter two (DHSSPS, 2008; FSRH, 2013; Snyder, 2012; WHO, 2000b; Creel et al., 2002). All these studies reported that the clients have a right to experience respectful and professional care in supportive environment, where their privacy and dignity are maintained. Also, the findings are on the same line with other studies in other countries (Olayinkaet al., 2013; Abebe and Awoke, 2014; Ganleet al., 2014), which found that the attitude of health care provider as a barrier affects health services utilization. Additionally, Ghafari and Colleagues (2014) found that the lack of privacy and the lack of friendly health services as main barriers affected utilization of health services among post-secondary school Malaysian urban youths.

Good access to WHCs RH services

Access to health care defined as the degree to which people are able to obtain appropriate care from the health care system in a timely manner (Escarce and Kapur, 2006).Accessibility and affordability of RH services are essential to positive health outcomes, especially in developing countries, where long distances as well as poor transportation conditions, can affect women's utilization. The quantitative findings showed

that 45.3% from the participants mentioned the physical location, nearby by their houses, as a main factor that motivates women to utilize the WHC's services. Meanwhile, 48.1% from the participants mentioned Center's farness as a one barrier which may hinder some women from getting RH services. This is consistent with the quantitative findings relating to the accessibility dimension. Generally, findings showed good access to the two WHCs services. But there were significant differences between the two WHCs; the overall mean percentage of the accessibility dimension in Jabalia WHC was (87.36%) while it was in Al-Bureij WHC (76.48%).Interestingly, the mean percentage of easy access to WHCs in the two centers was the highest one (86.0%), in Jabalia (92.6%) and in Al-Bureij (80.8%). In regard with the suitability of WHCs layout to women's residence place (distance), there were also significant differences between the two centers. That the mean percentage in Jabalia was (89.8%) while in Al-Bureij was (79.0%). These differences could be attributed to the fact that many women come to the WHC in Al-Bureij from remote areas, such as Johor El Deek and Wadi Gaza. While in Jabalia, there are other health's centers that provide similar services, so women in Jabalia are not obliged to go to the health centers which are far from their residence places. This was clearly mentioned by some women in Jabalia when the researcher asked them about the results of WHC closure on their health, that 27.8% from them stated (no significant impact) while only 4.2% from Al-Bureij WHC mentioned this statement. Additionally, one senior manager mentioned that the existing of many health centers in Jabalia provide good quality services; some of them are free of charge, affect women's utilization to WHC health services.

The findings of the quantitative study showed also that the suitability of working hours and days was (89.6%) in Jabalia, and (78.4%) in Al-Bureij. As noticed, there are significant differences between the two WHCs. These differences could be attributed to the difference

in the distribution of working hours during the week in each Center. WHC in Jabalia provides RH services during six hours for six days weekly, while Al-Bureij WHC provides RH services during seven hours for five days weekly. The participatory observation in Al-Bureij WHC confirmed this analysis; whereas one woman expressed her negative feeling that she was receiving, during data collecting time, following up as a treatment for infertility and she needs an appointment on special date while the Center is being closed. This woman put it this way: *"I need to come for following up on Thursday, but it is a holiday, the week end",* (37 years old, RH user).This is highlighting the necessity of family planning and gynecology clinics to be available at all days. Importance of the suitability of working hours were mentioned in previous studies (Abebe and Awoke, 2014; Ghafari, et al.,, 2014) that found working hours and unsuitable service schedule as barriers affected health services utilization. Consistently, although the majority of the participated women (87.7%) reported that there were no unavailable services during the last six months (at data collection time) in the two WHCs, some women (12.3%) reported that sometimes they returned back home without getting the service they need. The first most reported reason (56.5%) was unavailable gynecologist, while the lack of medicine was the second reported reason that mentioned by 28.3%. This could be attributed to the fact that when the gynecologist goes on vacation for one day sometimes, no other gynecologist replaced her during the vacation time.

The findings of qualitative analysis is consistent with the above findings, women in FGDs in the two WHCs and the Social worker in Al-Bureij WHC suggested offering replacement specialists as volunteers in the two WHCs to solve this problem, particularly the specialists have other responsibilities out the Center such as outreach program and health education in

other institutions, in addition to their trainings' program which is implemented mostly outside the WHCs.

Concerning the finding of the quantitative study related to the suitability of working hours and days, this was consistent with the findings of qualitative analysis; women in FGDs mentioned the easy access to WHCs as one of the main factors that motivate women to utilize WHCs services, but the same participants mentioned that the work schedule of the two WHCs and being the two WHCs' inaccessible to physically disabled women, as main barriers which may hinder most workers and disabled women from getting WHCs services. The schedule of the two WHCs as one morning shift, do not work with working women and the two WHCs are not designed to be used by disabled women. This was consistently mentioned by the participants in FGDs and in-depth interviews. However, service providers in the two WHCs are aware of this limitation. They provide disabled women with the needed services during outreach programs. Interestingly, it is noticed during the writing of this study that WHC in Jabalia is establishing new building for the Center with more quality specifications, including accessibility for disabled people.

In regard with the lack of the medicine, it is worth mentioning that during the period of quantitative data collection, April and the first of May 2014, the two WHCs were waiting to the delivery of the drugs and supplements they need. Mostly there is a gap in time that WHCs become out of some drugs and supplements during it. This could be attributed to the complexity of the WHCs' financial system relating to purchases' procedures. More attention from the policy makers and management of the two WHCs is needed in this regard.

The findings of quantitative study revealed that (28.9%) from the participants mentioned family obligations as a barrier which may hinder women from getting the RH services.

Women and girls have the main responsibilities of the housework included childcare and elderly care. Therefore, women are mostly busy; in addition to those who live in nuclear family and could not leave their children alone. As expected, the participants in FGDs consistently explored how the responsibilities of women particularly in morning hours such as the time of preparing their children to go to schools and cooking, affect women's utilization and suggested if the WHCs expanded their working hours to be for two shifts. This is consistent with previous study in Al Bahrain; by Mukhaimer (2010) that found family obligations a social barrier affected Bahraini women to obtaining health care services.

Concerning the affordability of RH services, some of participated women (36%) mentioned that the little cost of the services as a main factor that motivates women to utilize RH services in the two WHCs. However, the mean percentage for reasonability of service financial cost according to women's perception was the least one among the sub domains of accessibility dimension (77.6%), in Jabalia it was (89.0%) and in Al-Bureij (69%). These differences between the two WHCs could be attributed to the fact that women, who come from far areas in Al-Bureij WHC, pay more for the transportation. Consequently, the mean percentage of satisfaction for the participants relating to the service cost in the two WHCs was 78.8%, in Jabalia (87.0%) and in Al-Bureij (72.6%).

These quantitative findings are consistent with the qualitative analysis, which indicated that all participants mentioned unaffordability of WHCs services as one of the main barriers that may hinder poor women from obtaining RH services. Despite the fact that most of WHCs services are free of charge or with nominal fees, poor women could not be able to pay for the fees of services and transportation cost. Additionally, the two WHCs have in place a financial exemption mechanism, health provider may refer any poor

women to the Social Workers who assess cases individually and then provide exemption; if there is a need. But it seems that the social departments in the two WHCs could not be able to cover all women's social needs specially those who suffering from extreme poverty. This could be understandable from the quantitative findings which showed less level of women's satisfaction in regard with social service (80.6%), while women's satisfaction relating to other services in the two WHCs reached (94.2%).

The findings above are consistent with previous studies reviewed in chapter two; study conducted by the WHO and UNFPA (2005) that mentioned the importance of the affordability of health care services. Also, with other study conducted in the United States by Escarce and Kapur (2006) that found the low average income of Hispanics people was a barrier to receiving timely and appropriate health care; even if the patients have health insurance coverage. Moreover, the findings are consistent with other studies (Andaleeb, 1988; Shook, 2005; Mukhaimer, 2010; Dibabaet al.,, 2013; Ganleet al., 2014)that found the transportation cost was a barrier that affected the utilization of health services.

The waiting time and time spent with the healthcare provider are suitable

In the literature, waiting time and time spent with health provider are considered as important factors that affect the utilization of health services (Tavrow, 2010; Ghafari, et al., 2014). Quantitative findings revealed that the average waiting time in the two WHCs was 20.9 minutes, in Jabalia WHC: woman waits about (13.66) minutes and spent about (14.31) minutes with the provider. It is worth mentioning that the vast majority of the participants (91.4%) perceived this waiting time as suitable. While in Al-Bureij WHC, woman waits about (26.41) minutes and spent with the provider about(16.80) minutes. About 79.2% from the participants perceived this waiting as suitable. As noticed, there are significant differences between the two WHCs relating to waiting time. This could be

attributed to two factors: 1) WHC in Al-Bureij receives more clients than WHC in Jabalia. This was obvious when the researcher calculated the sample size according to the number of women who utilized WHCs services in the first six months of 2013. The total number was 4,000 women, distributed as 1,500 in Jabalia and 2,500 women in Al-Bureij. In addition, 8.7% from the participants' women in Al-Bureij WHC mentioned "too many cases" as one of the reasons that affected the availability of health service during the last six months. 2) In spite of the previous fact, there is only one gynecologist and one nurse in Al-Bureij WHC's clinic, while in Jabalia WHC's clinic; there is a midwife in addition to the gynecologist and the nurse. It is worth mentioning that the range of waiting time was 150 minutes, it is due to the fact that women who come from far areas without appointments are forced to wait longer time to receive the service.

However, the average waiting time in both two WHCs is suitable according to the participants' perception; it is less than the average waiting time shown in previous local studies such as a study by MRAM (2003) that found the average waiting time in PHC clinics in the G.S. 34.5 minutes. And another study conducted by Anan and Abu Hamad (2013) that found the average waiting time in PHC clinics in the GS (31.7) minutes. In comparison with other countries, Basaleem (2012) found that the waiting time in Yemen was between 15 to 30 minutes. While in Nigeria, Nwaeze (2013) found that the mean time spent during each clinic visit was 3.8hours.

In regard with the time spent with the health provider, whereas the mean was 15.7 minutes and the range was 56 minutes. An important issue could be noticed, that despite the overload on the team who works in Al-Bureij, specialists spend more time with their clients. With regard to the findings about the time spent with health providers, this was on the same line with a previous similar study in Tanzania by Both and Colleagues (2006) that

found the average time health workers spend with women during the first antenatal service 15 minutes. Furthermore, the WHO antenatal care model (WHO, 2002) recommended 30-40 minutes for the first visit, and 20 minutes for sequent visits to carry out all antenatal care's activities. To sum, the overall average of time spent with health provider in WHCs (56 minutes) seems appropriate and consistent with the WHO recommendations. It is worth mentioning that the quantitative findings provide evident that long waiting time affects women satisfaction. Quantitative results confirmed a relationship between women satisfaction and the waiting time. In this study, higher satisfaction is associated with less waiting time. ($r = -.119$, $p < .05$). This finding is consistent with other previous studies mentioned in chapter two (Andersonet al., 2007; Assefaet al., 2011; Nwaezeet al., 2013). Also, it is consistent with a study conducted in Egypt (Awadallaet al., 2009) that found long waiting time was the common cause of dissatisfaction among the clients of the rural center. Furthermore, previous studies conducted by (Ware et al., 1978; Abebe and Awoke, 2014; Ganleet al., 2014) found that long waiting time was an important barrier that affected access and utilization of services.

The integration of RH services motivate women to utilize WHCs services

It is worth mentioning that the findings of the quantitative study showed that the vast majority of the participants who received social, psychological, legal, and physiotherapy services, were satisfied (80.6%, 88.2%, 90,5%,94.2% respectively). Consistently, all participants in qualitative study perceived offering integrated and comprehensive services as a main motivating factor to utilizing services in both WHCs. This finding is in a line with similar previous studies reviewed in chapter two (WHO, 1996; Garner and Briggs, 2006; UNFPA, 2008). Also, the Health Development Information Team (2006) considered the integrated services as an approach for expanding access to the services.

Women's health status and well-being have been improved

Interestingly, the findings of the quantitative study revealed that the vast majority of the participants' women (99.2%) perceived that their current health status is good or very good. More than one- third of participants (37.6%) perceived that their current health status is better compared with the last year and 41.1% from them perceived that health status as the last year. While 21.3% perceived that it is worse. This could be attributed to women's socio-demographic factors. The vast majority of women (97.1%) reported that RH services improved women's health. This is consistent with the finding of quantitative study, which showed that vast majority of the participants (97.6%) reported that, the treatment they received for gynecological issues and fertility in the WHCs was effective and improved their health status. Concerning the women's well-being, more than 90% of the participated women expressed good well-being, while relatively 7% expressed bad well-being. This is consistent with the previous finding relating to women's health status that as mentioned earlier, 21.3% perceived that their health status during data collection time was worse than the last year. Logically this could affect their mental health and consequently affected their well-being. Additionally, this could be attributed to other social factors as found in previous studies conducted by WHO (2000) that found a strong relationship exists between social position and physical and mental health outcomes. And another previous study conducted in Al Bahrain by Mukhaimer (2010) that found women's physical functioning activities are affected by age, socio-economic, and disease status.

Concerning the expected results of WHCs closure from women's perception, consistently with the above findings, more than one- third of participants' women (33.3%) reported that in case of WHC closure their health status will get worse, and 31.7% reported that the WHC closure could resulted in large bad effects relating to their health and mental health.

And 20.6% reported that they will suffer from troubles and difficulties to find another place. While 14.4% reported that the WHC closure will not affect them significantly. This is consistent with the previous findings. In regard with those who will not be affected by the closure of WHCs, this could be due to the fact that those women, most of them from Jabalia WHC, have an access to other health centers as mentioned earlier.

In the literature, people's health status is one of the most commonly cited factors found to be positively correlated with the income. In this study, Chi-square test revealed that health status of women is not associated with the total income. This finding is inconsistent with previous studies by (WHO, 2009; Malarcher, 2010; Mukhaimer, 2010) that found improved woman's health has a relationship with the income status. This could be attributed to the fact that the cost of the services in the WHCs is minute. Furthermore, the two WHCs provide women with free of charge psychosocial services, which promote their health status and improve their overall well-being.

It is worth mentioning that the findings of quantitative study revealed that the vast majority of reproductive decisions making were shared between the spouses (88.5%) or taken by women alone (7.1%). Chi-square test showed that there is a significant relationship between the factor relating to who decides regarding RH issues and the use of family planning. This is consistent with the findings that empowering women is one of the social factors, which increase women's ability to take decisions relating to family planning and RH issues, and consequently improve their health. As expected, the qualitative analysis was consistent with the quantitative study.

Consistently with the participated women perception, all health providers reported that despite all the surrounding variables such as deteriorated economic conditions, frequent

wars, and poverty, WHCs services have positively affected women's health and improved their overall well-being.

The above findings on women's health status and well-being are consistent with previous studies as discussed in chapter two. It is clearly notable that the services provided in the two WHCs take into consideration RH rights and try to improve women's health and well-being as one of their rights. This is consistent with previous studies (Worku and Gebresilassie, 2008; UNFPA, 2008). Also, the above findings showed a link between the health status of women and their well-being. This is consistent with previous studies conducted by (Centers for Disease Control and Prevention, 1994; WHO, 2000).

Chapter 7

Conclusion, study limitations and recommendations

7.1 Conclusion

This quantitative qualitative mixed method study aimed to evaluate the RH services of the two WHCs in Jabalia and Al-Bureij refugee Camps in order to improve the quality and effectiveness of the provided services. Building on Donabedian's Model, the researcher assessed several domains and sub-domains in terms of input, process and outcomes.

As mentioned in the Chapter 5 and 6, the two WHCs have achieved relatively their objectives and their outcomes as they planned. Also, findings of the study revealed high level of relevancy and high level of effectiveness of the two WHCs activities. In addition, the study reflected good access and good service utilization rate. The provided services have been improved women's health status and the overall well-being. The findings of the study showed also that the vast majority of the participants were satisfied with the provided services and the higher quality of the provided services increased their satisfaction. Furthermore, the study showed that the provided services in the two WHCs enhanced women's culture and awareness regarding their roles and enabled them to be decision-makers particularly in regard with RH and sexual health issue. Interestingly, women expressed high level of satisfaction related to availability of female health providers. With regard to communication with providers, the study showed that health providers respect women's time through high level of compliance with the two WHCs' appointment system. The clients also have experienced respectful and professional care in supportive environment, where their privacy and dignity were maintained. This is unsurprising that the study revealed high level of providers' knowledge, information, and skills which

resulted in good interaction and communication between health providers and clients. The study also revealed that health professionals at the two WHCs are highly qualified; and they are frequently receiving in-service trainings on implementing the currently guidelines and protocols in the two WHCs.

The study showed also that the two WHCs offered clients with appropriate and high quality services and the provided services have met clients' health and none-health needs. With regard to affordability, most women expressed high degree of financial affordability, only few women considered financial affordability as a barrier that may hinder some women from utilizing the services of the two WHCs.

About two thirds of the participants agreed that drugs and supplements were available all the time, yet further improvements could be achieved and more concern should be given to this issue by decision makers in the two WHCs.

In regard with waiting time, as mentioned above, most women agreed that waiting time was reasonable and the two WHCs' working hours and days are suitable. Yet, more concern should be given to this issue in Al-Bureij WHC. The number of health providers does not work with the number of clients, which are received routinely.

Finally, it is worth mentioning that the findings of qualitative study revealed a weakness point related to sustainability in the two WHCs. The study showed that there is a limited financial sustainability of services as the two WHCs are funded by external donors, and they may stop funding any time. The senior managers were aware of this issue and they suggested secure salaries and insurance needs of the two WHCs at least three years.

7.2 Study limitations

Despite the importance and the methodological strengths of this study, some potential limitations should be mentioned:

- First, the sample of this study excluded women who did not utilize WHCs services, thus, the views and opinions of women who do not utilize the two WHCs services are not explored.
- Second, the study did not include men as participants. Thus, their views and opinions were not included in this study.

7.3 Recommendations

7.3.1 The study recommendations

For more improvements and more quality relating to the provided services, efforts should start at the policy level. This study suggests some policy areas that the two WHCs should address:

Recommendations relating to WHC in Al-Bureij

1. Renovation of Al-Bureij WHC building is needed. Currently, the buildings are old and do not have enough space.

2. To deal with shortages in human resources, there is a need to increase the number of working staff by hiring a medical secretary and midwife in Al-Bureij WHC.

Recommendations relating to the two WHCs in Jabalia and Al-Bureij camps

1. The constant availability of the essential drugs and supplements is important to maintain implementing the treatment plan effectively. Thus, it is important that the WHCs continue to secure funding to cover the cost essential drugs.

2. There is a need to focus on postnatal care service in the two WHCs. The team of the two WHCs needs to develop proactive approach to motivate women to utilize postnatal care services such as sending women text messages as reminders.
3. Offering integrated reproductive services was very efficient and effective way of providing services; it is important that the two WHCs continue to offer the integrated services and to make sure of the availability all medical staff, including gynecologist.
4. There is need to expanded the work time in the two WHCs to offer physiotherapy services in the evening time.
5. Increasing the adolescent and single women utilization of the two centers' services is important. It is recommended to establish special programs to deal these two groups in order to provide them with pre- marriage counseling and other services.
6. Health education was a core activity in the two WHCs. It is recommended that the staff of the two WHCs implement more health education activities outside the two WHCs.

7.3.2 The study recommendations for further research

1. There is a need to conduct additional research studies to assess the health care providers' satisfaction in the two WHCs.
2. There is a need to conduct studies to assess the perspectives and opinions of people who do not utilize services such as single women and men.
3. There is a need to conduct comparative studies to compare the effectiveness and efficiency of these programs with other similar program.
4. There is a need to conduct further research studies to assess the long term impact of the provided services on women health and women wellbeing.

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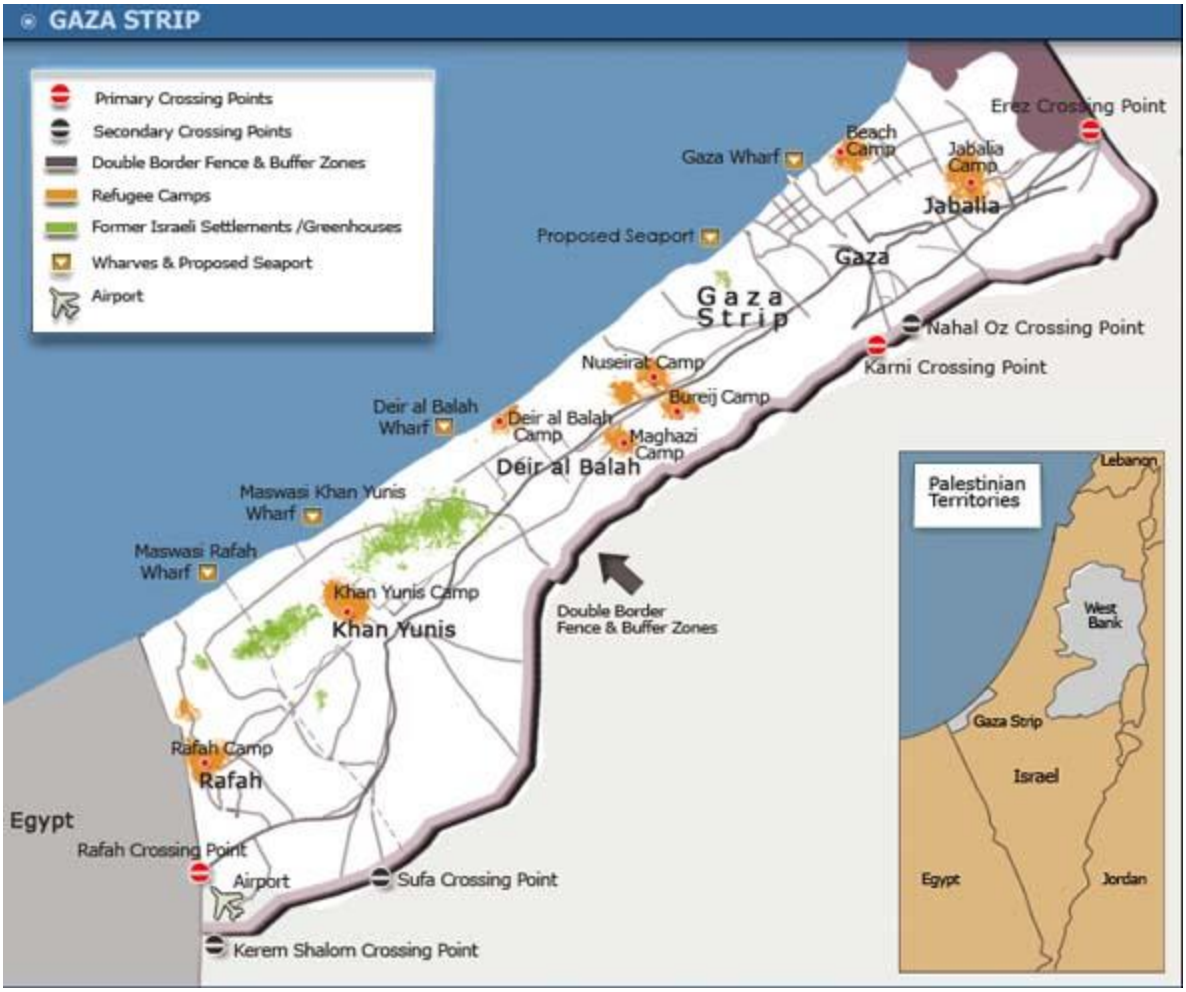
Annex 1: Gaza Strip map



Map: In and Out of Gaza, *Wide Angle*. PBC, 2007. Gaza E.R.

Annex 2: Helsinki committee approval letter

المجلس الفلسطيني للبحث الصحي

Palestinian Health Research Council

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

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

Helsinki Committee
For Ethical Approval

Date: 19\12\2013 **Number:** PHRC/HC/64 /13

Name: Maha S. El Akkad الاسم: مها صبري العقاد

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:-

"Evaluation of Reproductive Health Services at Jabalia and Al-Bureij Women's Health Centers"

The committee has decided to approve the above mentioned research. Approval number PHRC/HC/64/13 in its meeting on 19/12/2013

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

Signature

Member **Member**

Chairman

12 2013

Genral Conditions:-

1. Valid for 2 years from the date of approval.
2. It is necessary to notify the committee of any change in the approved study protocol.
3. The committee appreciates receiving a copy of your final research when completed.

Specific Conditions:-

The subject was approved following the World Medical Association Declaration of Helsinki-Ethical principles for medical research involving human subjects, adopted by the 18th World Medical Association General Assembly, Helsinki, Finland, June 1964 and amended by the 59th WMA General Assembly, Seoul, Korea, October 2008.

E-Mail:pal.phrc@gmail.com

Gaza - Palestine غزة - فلسطين

شارع النصر - مفترق العيون

Annex 3: Official letter from Al Quds University and the Red Crescent Society for Gaza Strip approval

Al-Quds University
Jerusalem
School of Public Health

جامعة القدس
القدس
كلية الصحة العامة

التاريخ: 2014/2/16
الرقم/: ك ص ع –غ/22/2014

حضرة الأخ/ عبدالعزيز أبو القرايا المحترم
مدير عام جمعية الهلال الأحمر الفلسطيني لقطاع غزة
تحية طيبة وبعد،،،

الموضوع: مساعدة الطالبة مها العقاد

تقوم الطالبة المذكورة أعلاه بإجراء بحث بعنوان:

"Evaluation of Reproductive Health Services at Jabalia and Al-Bureij Women's Health Centers"

كمتطلب للحصول على درجة الماجستير في الصحة العامة–مسار الإدارة الصحية، وعليه نرجو التكرم بالموافقة والايعاز لمن يلزم للسماح وتسهيل مهمة الطالبة بجمع البيانات الخاصة ببحثها من مركز صحة المرأة –مخيم جباليا التابع لإدارتكم الموقرة.
علماً بأن المعلومات ستكون متوفرة لدى الباحثة والجامعة فقط وسنطلعكم على النتائج في حينها .

و اقبلوا فائق التحية و الاحترام،،،

د. بسام أبو حمد
منسق عام برامج الصحة العامة
فرع غزة

نسخة: المحترم
– الملف

Jerusalem Branch/Telefax 02-2799234
Gaza Branch/Telefax 08-2644220 -2644210
P.O. box 51000 Jerusalem

فرع القدس / تلفاكس 02-2799234
فرع غزة / تلفاكس 08-2644220-2644210
ص.ب. 51000 القدس

Annex 4: Official letter from Al Quds University and the Culture and Free Thought Association approval

Al-Quds University
Jerusalem
School of Public Health

جامعة القدس
القدس
كلية الصحة العامة

التاريخ: 2014/2/16
الرقم/: ك ص ع –غ/ 21 /2014

حضرة الأخت/مريم زقوت المحترمة
جمعية الثقافة والفكر الحر
تحية طيبة وبعد،،،

الموضوع: مساعدة الطالبة مها العقاد

تقوم الطالبة المذكورة أعلاه بإجراء بحث بعنوان:

"Evaluation of Reproductive Health Services at Jabalia and Al-Bureij Women's Health Centers"

كمتطلب للحصول على درجة الماجستير في الصحة العامة–مسار الإدارة الصحية، وعليه نرجو التكرم بالموافقة والايعاز لمن يلزم للسماح وتسهيل مهمة الطالبة بجمع البيانات الخاصة لبحثها من جمعيتكم الموقرة.
علماً بأن المعلومات ستكون متوفرة لدى الباحثة والجامعة فقط وسنطلعكم على النتائج في حينها .

و اقبلوا فائق التحية و الاحترام،،،

د. بسام أبو حمد
منسق عام برامج الصحة العامة
فرع غزة

نسخة:
- الملف

لا مانع من جمع المعلومات الخاصة بالموضوع

Jerusalem Branch/Telefax 02-2799234
Gaza Branch/Telefax 08-2644220 -2644210
P.O. box 51000 Jerusalem

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فرع غزة / تلفاكس 08-2644220-2644210
ص.ب. 51000 القدس

Annex 5: Distribution of the sample

Name of the center	Number of the beneficiaries during the first 6 months of 2013	Number of the participants
Jabalia WHC	1500	180
Al-Bureij WHC	2500	240

Annex 6: Clients' questionnaire

الاستبانة الخاصة بالنساء

نموذج موافقة

عزيزتي المشاركة

أنا الطالبة/ مها صبري العقاد ملتحقة ببرنامج ماجستير الصحة العامة– تخصص ادارة صحية بجامعة القدس.

لقد تم اختيارك بشكل عشوائي للمشاركة في هذه الدراسة التي تهدف إلى تقييم خدمات الصحة الإنجابية المقدمة من خلال مركزي صحة المرأة في البريج وجباليا مما سيساهم في تحسين الخدمات الصحية المقدمة.

ستجرى هذه الدراسة كجزء من متطلبات برنامج الماجستير – كلية الصحة العامة.

أختي المشاركة، إذا أبديت الموافقة للمشاركة في هذه الدراسة، عليك الإجابة على أسئلة الاستبانة مع العلم بمايلي:

- مشاركتك في هذه الدراسة طوعية، يحق لك القبول أو الرفض أو حتى الإنسحاب في أي وقت تشعرين بعدم رغبتك في اكمال تعبئة الاستبان.
- سيحتاج هذا الاستبيان لتعبئته 30–45 دقيقة على الأقل.
- لا يوجد اجابات صحيحة وأخرى خاطئة، عبري بصراحة عن وجهة نظرك وقناعاتك.
- آراؤك وإجاباتك لن تؤثر على الخدمات الصحية التي تتلقيها من المركز.
- السرية مكفولة ولن نسألك عن اسمك.

شكراً لتعاونك

مع فائق الاحترام و التقدير

الباحثة

مها صبري العقاد

كلية الصحة العامة

جامعة القدس/أبو ديس

استبانة تقييم الخدمات الصحية في مركزي صحة المرأة بمخيمي البريج وجباليا

رقم الاستبانة: ..... اليوم: ..... التاريخ: ..... اسم جامع البيانات: .....

موقع المركز: ◘ محافظة الوسطى (البريج) ◘ محافظة الشمال (جباليا)

بيانات عامة

1. تاريخ أول زيارة لك للمركز: ..... **(الاستمارة تعبأ فقط عندما يكون تاريخ أول زيارة قبل1 أكتوبر 2013م)**
2. عدد مرات زياراتك للمركز خلال آخر ستة شهور: .....
3. سبب زيارتك الحالية للمركز(بالإمكان اختيار أكثر من سبب)(غير منطوق): ◘ رعاية حمل ◘ رعاية بعد الولادة

◘ خدمة تنظيم أسرة ◘علاج أمراض نساء ◘عمل تحاليل مخبرية ◘ خدمة الصيدلية

◘أخرى/حددي .....

4. هل حصلت على الخدمة التي جئت من أجلها؟ ◘ نعم ◘ لا
5. هل الخدمات الصحية في مركز صحة المرأة متناسبة مع احتياجات النساء الصحية؟ ◘ نعم ◘ إلى حدٍ ما ◘ لا
6. بالمقارنة مع مؤسسات صحية أخرى في المنطقة، تقيمين جودة الخدمة المقدمة في مركز صحة المرأة بأنها أفضل:

◘ أوافق بدرجة كبيرة ◘ أوافق بدرجة متوسطة ◘ لا أوافق

7. فترة الانتظار بشكل عام لتلقي الخدمة/الخدمات: ..... دقيقة
8. الوقت الذي قضيتيه مع مقدم الخدمة لتلقي الخدمة/الخدمات المطلوبة؟ ..... دقيقة

الصحة الإنجابية (خاص بالمتزوجات)

9. كم عدد مرات الحمل جميعها؟ ..... مرة/ات
10. كم عدد أطفالك؟ ..... اناث ..... ذكور

11.من يتخذ القرارات المتعلقة بالصحة الإنجابية (مثلاً الإنجاب، تنظيم الأسرة..... إلخ) ؟

◘ أنا ◘ زوجي ◘ أنا وزوجي معاً ◘ والدة زوجي ◘ آخرين/ حددي .....

12.هل تتبعين طريقة للحماية من إمكانية حدوث عدوى الالتهابات أو أي أمراض أخرى؟ ◘ نعم ◘ لا توجه لسؤال رقم 14

13.ما هي هذه الطريقة (غير منطوق): ◘ استخدام الواقي الذكري ◘ استخدام الواقي الأنثوي

◘ وسائل طبيعية مثل تجنب الجماع ◘ طرق أخرى/ حددي.....

14.هل انت حامل؟ ◘ لا ◘ نعم توجه لسؤال 16

15.متى كانت آخر ولادة لك؟ .....

اذا كانت الاجابة عن سؤال رقم 14 لا، وآخر ولادة للسيدة قبل شهر أبريل لعام 2012 ، يرجى الانتقال لسؤال رقم 44

<u>أسئلة تتعلق بالحمل:</u>

16.كم مدة الحمل لديك بالأسابيع: ..... (خاص فقط بالسيدة الحامل حالياً)

17.كم كان عدد اسابيع حملك عند أول زيارة لك لمتابعة الحمل في مركز صحة المرأة: ..... (خاص بالسيدة الحامل حالياً)

18.هل يتم عمل زيارات منزلية من قبل مركز صحة المرأة لك ؟ ◘ نعم ◘ لا

19.هل تم تثقيفك حول أهمية تناول الفولك أسد،الحديد والفيتامينات ؟ ◘ نعم ◘ لا

20.هل تم تثقيفك حول أهمية الرياضة خلال الأشهر الأخيرة للحامل ؟ ◘ نعم ◘ لا

21.هل تلقيت معلومات حول التغذية السليمة أثناء الحمل؟ ◘ نعم ◘ لا

22. هل تلقيت تثقيف صحي حول تنظيم الأسرة أثناء الحمل ؟ ◘ نعم ◘ لا

23.هل تلقيت معلومات حول الرضاعة الطبيعية أثناء الحمل؟ ◘ نعم ◘ لا

24.هل تلقيت معلومات حول الطريقة المثلى للفطام؟ ◘ نعم ◘ لا

25.هل تلقيت معلومات حول كيفية العناية بالمولود ؟ ◘ نعم ◘ لا

26. هل تلقيت معلومات حول الولادة ؟ ◘ نعم ◘ لا

27. ما هي العلامات التي تدل على خطورة الحمل (غير منطوق):

◘ النزف المهبلي أو نزول ماء ◘ ألام حادة أعلى أو وسط البطن ◘ ارتفاع درجة الحرارة عن 38 دون وجود انفلونزا أو نزلة برد ◘ انتفاخ في اليدين والوجه والعينين مع صداع يستمر لأكثر من ساعتين

◘ اختفاء حركة الجنين لمدة تزيد عن 24 ساعة.

28. هل الحمل الحالي/السابق، كان مخطط له؟ ◘ نعم ◘ لا

29. هل الحمل الحالي/السابق، كان مرغوب فيه؟ ◘ نعم ◘ لا

30. كيف تتصرفين في حالة حدوث مشكلة صحية تتطلب الرعاية الطارئة، مثلاً حدوث نزيف أو نزول ماء قبل موعد الولادة؟

(غير منطوق)

◘ أذهب للمستشفى ◘ أذهب لعيادة الوكالة ◘ أذهب لعيادة خاصة ◘ غير ذلك، حددي.....

31. ما تاريخ آخر ولادة لك ؟ ..... ، اذا كانت آخر ولادة للسيدة قبل أبريل عام 2012 ، يرجى الانتقال لسؤال رقم 44

<u>أسئلة تتعلق بمرحلة بعد الولادة:</u>

32. خلال فترة الحمل: كم عدد مرات زياراتك لعيادة مركز صحة المرأة بهدف متابعة الحمل؟ .....

33. هل زرت مركز صحة المرأة بهدف الكشف والاطمئنان على صحتك بعد الولادة؟ ◘ نعم ◘ لا توجه لسؤال رقم 35

34. بعد كم يوم من الولادة زرت المركز ؟ .....

35. هل قام فريق الزيارات المنزلية في مركز صحة المرأة بزيارتك بعد الولادة؟ ◘ نعم ◘ لا توجه لسؤال رقم 38

36. بعد كام يوم من الولادة تمت زيارتهم لك؟ .....

37.كام كانت عدد زياراتهم لك؟ .....

38. هل مارست رياضة وتمارين بعد الولادة؟ ◘ نعم ◘ لا

39. هل تلتزمين بارضاع طفلك رضاعة طبيعية ؟ ◘ نعم ◘ لا

40.كم شهراً تلتزمين بإرضاع أطفالك من ثديك بدون أي مساعدات(بدون أعشاب أو حتى ماء)؟ .....

41. هل تلقيت ارشادات كافية من مقدمي خدمات المركز حول كيفية الرضاعة الصحيحة؟ ◘ نعم ◘ لا

42. هل تلقيت تثقيفاً وتوعية حول تنظيم الأسرة ؟ ◘ نعم ◘ لا

43. هل ترغبين في انجاب المزيد من الأطفال؟ ◘ نعم ◘ لا

<u>أسئلة تتعلق بتنظيم الأسرة: (خاص بالنساء اللاتي يستخدمن وسائل تنظيم أسرة)</u>

44. هل تستخدمين وسائل تنظيم أسرة ؟ ◘ لا ◘ نعم توجه لسؤال رقم 46

45. اذا كانت الاجابة بلا، هل استخدمت وسائل تنظيم أسرة خلال العامين الماضيين؟ ◘ نعم ◘ لا توجه للسؤال رقم 51

46.منذ كم شهر تستخدمين وسائل تنظيم الأسرة ؟ منذ ..... شهر

47.ما الوسائل التي استخدمتيها أو تستخدمينها ؟

◘ حبوب منع الحمل ◘ لولب ◘ الواقي الذكري ◘ غير ذلك، حددي .....

48.من صاحب الرأي في اختيار هذه الوسيلة؟

◘ أنا وحدي ◘ زوجي ◘ مقدم الخدمة (الطبيبة/الحكيمة) ◘ آخرين/حددي.....

49. هل تلقيت من خلال مركز صحة المرأة تثقيف صحي ومعلومات حول وسائل تنظيم الأسرة واستخدامها؟ ◘ نعم ◘ لا

50. هل الوسيلة التي استخدمتيها أو تستخدميها متوفرة في مركز صحة المرأة ؟ ◘ نعم ◘ لا

<u>أسئلة تتعلق بعلاج أمراض النساء والوقاية منها</u>

51. هل سبق وأن تعالجت للإلتهابات أو للعقم بمركز صحة المرأة ؟ ◘ نعم ◘ لا توجه لسؤال رقم 53

52. هل كانت نتيجة العلاج فعالة؟ ◘ نعم ◘ لا

53. هل يرافقك زوجك عند زيارتك عيادة مركز صحة المرأة؟ ◘ نعم ◘ أحياناً ◘ لا توجه لسؤال رقم 55

54. ما سبب مرافقة زوجك لك؟ (غير منطوق)

◘ رغبة منه في متابعة أمورى الصحية ومشاركتي ◘ زوجي لا يحب أن أتحرك لوحدي

◘ أنا وزوجي بحاجة للعلاج معاً ◘ بناءً على طلب الطبيبة ◘ لتقصير زمن الزيارة

55. ما سبب عدم مرافقة زوجك لك؟ (غير منطوق) ◘ انشغال الزوج ◘ عدم التقبل الاجتماعي

◘ عدم اهتمام زوجي ◘ أسباب أخرى/ حددي .....

56. هل سبق وأن عملت فحص اكلينيكي (يدوي) للثدي من خلال طبيبة/ممرضة المركز؟ ◘ نعم ◘ لا

<u>أسئلة تتعلق بشمولية خدمة الصحة الإنجابية</u>

57. هل سبق وأن تلقيت مشورة أو خدمة من العاملة الاجتماعية في المركز؟

◘ نعم ◘ لا توجه للسؤال رقم 60

58. هل تذكرين السبب الذي دفعك للتوجه للقسم الاجتماعي؟ (غير منطوق)

◘ الوضع الاقتصادي السيء ومشاكل الفقر(عدم القدرة على دفع تكاليف الخدمة) ◘ مشاكل تفكك أسري

◘ مشاكل اجتماعية مع أهل الزوج ◘ مشاكل زوجية وعنف ◘أسباب أخرى.....

59. هل كنت راضية عن الخدمة الاجتماعية التي تلقيتيها في المركز؟ ◘ نعم ◘ إلى حدٍ ما ◘ لا

60. هل سبق وأن تلقيت مشورة أو ارشاد من الأخصائية النفسية في المركز؟ ◘ نعم ◘ لا توجه للسؤال رقم 67

61. هل تذكرين السبب الذي دفعك للتوجه للقسم النفسي؟ (غير منطوق)

◘ رغبة في تحسين نفسيتي ◘ طلب ارشاد ومشورة تتعلق بتربية الأطفال ◘رغبة في حل مشاكل زوجية وعنف ◘ طلب مشورة وارشاد للتعامل مع أبناءنا وبناتنا في سن المراهقة ◘ أسباب أخرى.....

62. هل كنت راضية عن الخدمة التي تلقيتيها من القسم النفسي في المركز؟ ◘ نعم ◘ إلى حدٍ ما ◘ لا

63. هل سبق وأن تلقيت مشورة أو خدمة من المحامية في المركز؟ ◘ نعم ◘ لا توجه للسؤال رقم 66

64. هل تذكرين السبب الذي دفعك للتوجه للقسم القانوني؟ (غير منطوق)

◘ مشاكل ميراث ◘ نفقة زوجة ◘نفقة أطفال ◘ مشاكل حضانة وضم أطفال

◘ مشاكل عنف ◘ أسباب أخرى .....

65. هل كنت راضية عن الخدمة القانونية التي تلقيتيها في المركز؟ ◘ نعم ◘ إلى حدٍ ما ◘ لا

66. هل سبق وأن تلقيت خدمة من أخصائية العلاج الطبيعي والرياضة في المركز؟ ◘ نعم ◘ لا توجه للسؤال رقم 69

67. هل تذكرين السبب الذي دفعك للتوجه لقسم الرياضة والعلاج الطبيعي؟ (غير منطوق)

◘ خدمة علاج طبيعي ◘ لياقة بدنية وتخفيف وزن ◘رياضة الحوامل ◘ رياضة بعد الولادة

◘ أسباب أخرى .....

68. هل كنت راضية عن الخدمة التي تلقيتيها من قسم الرياضة والعلاج الطبيعي في المركز؟

◘ نعم ◘ إلى حدٍ ما ◘ لا

يرجى وضع علامة (√) في الخانة المناسبة مقابل كل فقرة

	العبارة	غير موافق بشدة	غير موافق	غير متأكد	موافق	موافق بشدة
	سهولة الوصول/ الحصول					
.69	من السهل الوصول إلى مركز صحة المرأة					
.70	موقع المركز مناسب لمكان سكنك					
.71	التكلفة المالية للوصول إلى المركز لتلقي الخدمة معقولة					
.72	التكلفة المالية للحصول على الخدمة /الخدمات معقولة					
.73	عند قدومك للمركز تجدين مقدمي الخدمة متواجدين في أماكن عملهم					
.74	يلتزم مقدمي الخدمة بالمواعيد المحددة للسيدات المراجعات					
.75	وقت الانتظار في عيادة المركز للحصول على الخدمة معقول					
.76	ساعات الدوام في المركز مناسبة لك					
.77	العلاج/الأدوية اللازمة متوفرة بدون تقطع في صيدلية المركز					
.78	الفولك أسد والحديد والفيتامينات اللازمة متوفرة بدون تقطع في صيدلية					

	المركز					
	تجهيزات المركز					
.79	مساحة المركز مناسبة لحجم الخدمات					
.80	مساحة عيادة المركز مناسبة مقارنةً بعدد الحالات					
.81	مساحة غرفة الكشف الصحي مناسبة					
.82	يوجد اضاءة كافية في غرفة الفحص					
.83	يوجد سرير فحص طبي في غرفة الفحص					
.84	يوجد ستائر حول سرير الفحص تحافظ على خصوصية متلقي الخدمة					
.85	يوجد ستائر على شبابيك غرفة الفحص					
.86	يوجد مكان مخصص للانتظار لحين تلقي الخدمة المحددة					
.87	تتوفر بيئة مناسبة في المركز (تهوية جيدة وتدفئة مناسبة)					
.88	تتوفر وسائل ترفيهية وتثقيفية في صالة الانتظار(تلفزيون، نشرات صحية، مجلات علمية .....إلخ)					
.89	تتوفر الكهرباء في المركز					
.90	يتوفر مولد كهرباء يتم تشغيله عند انقطاع الكهرباء في المركز					
.91	يتوفر الماء النقي في المركز					
.92	توجد دورات مياه نظيفة في المركز					
.93	توجد سهولة في التنقل والذهاب للقسم الذي تريديه في المركز					
.94	يوجد ممرات وحمامات لذوي الاعاقات الحركية وكبار السن					
.95	توجد سهولة في عمل الاجراءات والدفع لتلقي الخدمات					
.96	تجدين عيادة المركز والأقسام نظيفة في كل مرة تأتين لأخذ الخدمة					
	مهنية ومهارة مقدمي الخدمة					
.97	قام مقدم الخدمة بإجراء الفحوصات اللازمة لتشخيص حالتك الصحية					
.98	قام مقدم الخدمة بوصف العلاج والإرشادات اللازمة لحالتك الصحية					
.99	قام مقدم الخدمة بمشاورتك في الخطة العلاجية.					
.100	يعطيك مقدم الخدمة موعداً آخر للمراجعة إن لزم.					
.101	في حال عدم توفر الخدمة المناسبة في القسم يقوم مقدم الخدمة بتحويلك إلى مكان صحي آخر تتوفر فيه الخدمة المطلوبة					
.102	تشعرين أن مقدم الخدمة يمتلك معلومات ومعرفة كافية تؤهله لفهم حالتك					
.103	تشعرين أن مقدم الخدمة يمتلك مهارات كافية تؤهله للتعامل مع حالتك.					
	الاتصال والتواصل					
.104	يقوم مقدم الخدمة بالتعريف بنفسه قبل البدء بتقديم الخدمة المطلوبة					
.105	يقوم مقدم الخدمة باستقبالك بشكل مهني					
.106	يستمع مقدم الخدمة لشكواك باهتمام قبل البدء بعملية الفحص والعلاج.					

107.	يقوم مقدم الخدمة بطرح الأسئلة بأسلوب مهني					
108.	تأخذين الفرصة الكافية لشرح مشكلتك					
109.	تشعرين بالثقة في التعامل مع مقدمي الخدمة في المركز					
110.	عندما تتحدثين مع مقدم الخدمة فإنه يهتم بحديثك ولا ينشغل بأشياء أخرى.					
111.	يقوم مقدم الخدمة بشرح حالتك الصحية بشكل واضح					
112.	يتم الحفاظ على سرية المعلومات التي تدلين بها لمقدم الخدمة في المركز					
113.	لا يميز مقدم الخدمة بين السيدات المراجعات خلال تقديم الخدمة المطلوبة					
114.	يتوفر جو من الخصوصية خلال فترة تقديم الخدمة (يتم غلق الباب والستائر خلال الفحص وتقديم العلاج، ...)					
115.	كان مقدم الخدمة حريصاً على أن تستوعبي كل المعلومات					

120. من وجهة نظرك: ما العوامل التي تشجع النساء على الاستفادة من خدمات المركز:

بالإمكان ذكر أكثر من سبب، (غير منطوق)

◘ قرب المركز من سكني ◘ جودة الخدمات التي يقدمها المركز ◘ كفاءة وخبرة مقدمي الخدمات ◘ توفر العلاج

◘ قصر الوقت الذي تقضيه السيدة في المركز لأخذ الخدمة ◘ توفر أكثر من خدمة في نفس المكان ◘ قلة التكاليف

◘ حسن معاملة مقدمي الخدمات ◘ وجود فريق نسوي متخصص ◘ أسباب أخرى

.....

121. من وجهة نظرك: ما المعيقات التي تمنع النساء من الاستفادة من خدمات المركز:

بالإمكان ذكر أكثر من سبب (غير منطوق)

◘ بعد المركز عن سكنهن ◘ عدم جودة الخدمات التي يقدمها المركز ◘ عدم كفاءة مقدمي الخدمات في المركز

◘ تكاليف الخدمات لا يناسب الوضع الاقتصادي للنساء ◘عدم ابداء الاحترام الكامل من قبل مزودي الخدمات

◘الضغط العائلي ◘ أسباب أخرى.....

122. هل يوجد خدمات تتعلق بالصحة الإنجابية غير موجودة في المركز وتتمنين وجودها؟ ◘ نعم ◘ لا توجه لسؤال رقم 124

123. ما هي هذه الخدمات التي تتعلق بالصحة الانجابية وغير موجودة في المركز ؟

.....

124. هل عدت يوماً خلال الستة شهور السابقة دون الحصول على الخدمة التي تريدينها؟ ◘ نعم ◘ لا توجه لسؤال 126

125. لماذا؟ غير منطوق(يحتمل أكثر من اجابة)

◘ وقت الانتظار طويل ◘ عدم وجود مقدم الخدمة ◘العيادة مزدحمة ◘ عدم وجود الدواء

◘ لم أستطع الدفع مقابل تلقي الخدمة ◘ غير ذلك، حددي .....

الرضا العام عن الخدمات الصحية المقدمة من خلال مركزصحة المرأة

	الرضا العام	غير راضية نهائياً	غير راضية	راضية إلى حدٍ ضئيل	راضية	راضية جداً
126	هل انت راضية عن استجابة مقدم الخدمة لاحتياجاتك؟ (استقبالك، راحتك، التعاون معك، تسهيل مهمتك، ....)					
127	ما مدى رضاك عن قدرة تفهم مقدم الخدمة لمشكلتك؟					
128	ما مدى رضاك عن طريقة تعامل مقدم الخدمة معك ؟					
129	ما مدى رضاك عن جودة الخدمة المقدمة؟					
130	ما مدى رضاك عن تكلفة الخدمة المقدمة؟					
131	ما مدى رضاك عن توفر الأدوات اللازمة؟					
132	هل أن راضية عن الخدمة التي حصلت عليها؟					
133	ما مدى رضاك عن الدعم والمشورة المقدمة لك؟					
134	ما مدى رضاك عن فعالية الخدمة المقدمة لك؟					
135	ما مدى رضاك عن تجهيزات المركز ؟					

136	ما مدى رضاك عن نظافة المركز ؟					
137	ما مدى رضاك العام عن خدمات الصحة الانجابية المقدمة في المركز؟					

تقييم الوضع الصحي العام للنساء من وجهة نظرهن:

138. بشكلٍ عام، هل تعتبرين صحتك:

◘ ممتازة ◘ جيدة جداً ◘ جيدة ◘ لا بأس بها ◘ سيئة

139. مقارنةً بعامٍ مضى، كيف تقيمين صحتك بشكلٍ عام:

◘ أفضل بكثير ◘ أفضل إلى حدٍ ما ◘ تقريباً كما هي ◘ أسوأ إلى حدٍ ما ◘ أسوأ بكثير

140. هل صحتك الآن تحد من قدرتك على انجاز المهمات البيتية كإعداد الوجبات الغذائية، تنظيف البيت إلخ...

◘ نعم تحد من قدرتي كثيراً ◘ نعم تحد من قدرتي قليلاً ◘ لا، لا تحد من قدرتي على الاطلاق

141.هل صحتك الآن تحد من قدرتك على الذهاب إلى السوق وحمل المشتريات؟

◘ نعم تحد من قدرتي كثيراً ◘ نعم تحد من قدرتي قليلاً ◘ لا، لا تحد من قدرتي على الاطلاق

142. من وجهة نظرك:هل أحدث المركز تحسين على صحتك؟ ◘ نعم ◘ لا توجه لسؤال 144

143. ما هو التغيير الذي أحدثه المركز كنوع من التحسين في وضعك الصحي؟

.....

.....

144. **تخيلي لو أنه تم اغلاق مركز صحة المرأة، ما نتائج ذلك على صحتك؟**

.....

الخصائص الاجتماعية الديمغرافية

العمر بالسنوات: ..... مكان السكن: ..... عدد سنوات التعليم:.....

البيت الذي تسكنين فيه، هل هو: ◘ بيت وكالة ◘ ملك ◘ إيجار

الحالة الاجتماعية: ◘ آنسة ◘ متزوجة ◘ مطلقة ◘ أرملة

المهنة: ◘عاملة ◘ ربة بيت ◘ أخرى، حددي/ .....

الدخل الكامل الشهري للأسرة:..... شيكل عدد الأفراد المعتمدين على الدخل:.....

شـــكراً لتعاونـــك...

Annex 7: The guide questions of the focus group discussion with the women

أسئلة المجموعة البؤرية المركزة مع النساء

أعمل بحث للجامعة حول تقييم خدمات الصحة الإنجابية. سوف تفيد نتائج البحث في تحسين خدمات المركز، لذا ارغب في عمل هذا اللقاء معكم علماً بأن مشاركتكم طوعية لكنها مهمة وستساهم في عملية التطوير.

1. ما الأسباب التي تشجع النساء على الحضور إلى مركز صحة المرأة والاستفادة من خدماته؟
2. ما الأسباب التي قد تعيق النساء وتمنعهم من الاستفادة من خدمات المركز
3. مستوى الرضا عن الخدمة

- كيف تقيمين مستوى رضاك عن الخدمات التي تلقيتيها في مركز صحة المرأة ؟ الخدمة التي تلقيتيها فقط.
- ماهي اسباب رضاك؟ ماهي اسباب عدم رضاك؟

4. كيف أثرت المشورة النفسية والاجتماعية والقانونية وبرنامج التثقيف المجتمعي على صحة النساء؟

5. هل شاركتم في تحديد احتياجات لخدمات المركز واولوياتها؟ هل يستشيركم المركز في ذلك؟ كيف؟
6. ما اقتراحاتكم لتحسين خدمات الصحة الانجابية في المركز ؟

هل ترغبون في إضافة شيء؟

شكراً لكم

ملاحظة:

يتم توجيه السؤال حسب نوعية الخدمات التي تلقتها المجموعة المركزة بالإضافة لخدمات الصحة الانجابية (المشورة النفسية، المشورة الاجتماعية، المشورة والخدمة القانونية، الرياضة والعلاج الطبيعي، خدمة التثقيف المجتمعي).

Annex 8: The In-depth interviews guide questions with the WHCs' senior managers

أسئلة المقابلات المعمقة مع المدراء

1. مقارنة مع خدمات الصحة الإنجابية المقدمة من مراكز أخرى، بماذا يتميز مركزكم؟
2. المركز يعمل منذ عام 1995/ 1998م

كيف أثرت خدمات الصحة الإنجابية التي تم تقديمها للنساء على صحتهم الجسدية والنفسية؟

3. هل يوجد سياسات يلتزم بها المركز، باعتباره مقدماً لخدمات صحة انجابية؟

ما هي؟ يرجى التوضيح.

هل يوجد بروتوكولات للخدمات المقدمة، ما هي؟؟

هل هذه البروتوكولات متاحة للطاقم..هل تم تدريبه عليها؟ هل يتم تحديثها دوريا؟

4. كيف تقيمون مستوى التفاعل ما بين مقدمي الخدمة والفئة المستهدفة؟

- ما هي ادوات المتابعه للتطوير والتحسين؟ هل موجود ارشادات مكتوبة وهل يتم عمل ذلك.

5. ما نوع التدريبات التي يتلقاها فريق العمل سواء كانت داخل أو خارج المؤسسة ؟
6. هل يوجد نقاط ضعف في المركز؟ هل هذه النقاط تعتبر معيقات ؟ هل هناك معيقات أخرى تؤثر على تقديم الخدمات؟ هل هناك استمرارية لتقديم خدمات الصحة الإنجابية للنساء؟
7. من وجهة نظركم، ماهي العوامل التي قد تمنع بعض النساء من الحضور إلى المركز والاستفادة من خدماته ؟
8. ما هي اقتراحاتكم لتطوير خدمات الصحة الانجابية التي يقدمها المركز؟ بناءً على ماذا قررتم ذلك.

- هل تشارك النساء في تحديد أدوات التطوير أو نوعية الخدمه المقدمة؟ كيف،
- هل للمجتمع المحلي شأن للمشاركة في سياسات المركز وتنوع خدماته؟ كيف.

هل ترغبون في اضافة شيء.. شكراً لتعاونكم،،،

Annex 9: The in-depth interviews guide questions with the specialists

أسئلة المقابلات المعمقة مع الأخصائيات:

1. من وجهة نظرك: ما مدى تلبية المركز لاحتياجات النساء في مجال صحة المرأة الإنجابية الجسدية والنفسية والاجتماعية وما يخص الجانب القانوني؟ 2
2. .من وجهة نظرك: هل الحالات تصل للخدمات التي يقدمها المركز بسهولة؟ ما العقبات التي قد تمنع بعض النساء من الاستفادة من خدمات المركز؟

3. المركز يقدم خدماته منذ سنوات عديدة: هل لمست فائدة وأثر لاستخدام هذه الخدمات على النساء ؟ ما الفارق الذي أحدثه المركز في حياة النساء من ناحية صحية جسدية ونفسية واجتماعية وقانونية ؟ هل هذا موثق؟ ما هي أدوات القياس؟

4. ما رأيك وكيف تقيمين: التسهيلات التي توفرها المؤسسة لتقديم الخدمات المتعلقة بالصحة الانجابية والجسدية والنفسية والاجتماعية والقانونية للنساء
5. هل يوجد دليل (بروتوكولات) تسترشدون به خلال تقديم الخدمة؟

ماذا بخصوص التدريبات الخاصة بفريق العمل بشكل عام

6. من وجهة نظرك: ما هي عوامل القوة الأساسية في المركز؟ كيف تقيمين مستوى جودة الخدمات التي يقدمها المركز مقارنةً بالمؤسسات التي تعمل في نفس المجال في المنطقة؟

7. ما هي اقتراحاتك لتطوير الخدمات الصحية والنفسية والاجتماعية والقانونية التي يقدمها المركز؟

هل ترغبين في اضافة شيء؟ شـكرا لك

ملاحظة

يتم توجيه جميع الأسئلة حسب طبيعة عمل الأخصائي

Annex 10: Experts and professionals consulted

Data collection tools, the questionnaire and guide questions for FGDs and in-depth interviews, were evaluated by thirteen experts as following:

- Dr. Yehia Abed, Al-Quds University
- Dr. Ali Abu-Zaid, Al-Azhar University
- Dr. Mazen Abuqamar, World Vision Association.
- Dr. Nihaya El-Telbani, Al-Azhar University
- Dr. Amna Shurbasi, UNRWA, Health programme
- Mr. Jehad Okasha, Palestinian Ministry of Health
- Dr. Yousif El-Jeash, The Islamic University
- Dr. Sanaa Abu Dagga, The Islamic University
- Dr. Bassam Abu Hamad, School of Public Health
- Dr. Rafeeq El-Farra, Al-Azhar University
- Ms. Mariam Shaqiura, Woman's Health Center- Jabalia
- Ms. Firyal Thabet, Woman's Health Center- Al-Bureij
- Ms. Majeda El Saqqa, Culture and Free Thought Association

Annex 11: The Project's describtion (in the two WHCs)

The WHC Al Bureij was inatiatited in 1995 and the WHC Jabalia started in 2000. The WHCs provide comprehensive reproductive health (RH) program serving in Al Bureij and Jabalia refugee camps. The WHCs are run and operated under full responsibility of two Palestinian NGOs; The Culture and Free Thought Association (CFTA), running Al Bureij Women's Health Center. The staff in this center consists from: a director,administrative assistance, accountant, cleaner, guider, social worker, psychologist, lawyer, in addition to the health team which consists from: gynecologist, nurse, laboratory analyzes specialist, field worker, and pharmacist. While the Red Crescent Society for Gaza Strip (RCS), running the WHC of Jabalia. The staff in this center consists from, a director, secretary, accountant, cleaner, guider, social worker, psychologist, lawyer, in addition to the health team which consists from: the gynecologist, nurse, midwife, laboratory analyzes specialist, field worker and pharmacist.

The leading partner for this proposed action was CFTA. The project is responding to a real and present need on the ground, as identified by a rapid needs assessment study.

Objectives and the Purpose of the Action

Currently in the Gaza Strip - even beyond the proposed target areas of this action - many women face challenges accessing quality care facilities that protect their health and psychological well being. Consequently, the prevelance of chronic disease, breast cancer, violence, nutrition and psychosocial problems is significant. The overall objective of the action is therefore to contribute to the improved RH, psychological and social well being of refugee women and adolescents of the Gaza Strip by offering comprehensive quality services which focus on sexual health care, legal aid services, prevention of GBV and the protection of victimized women. This project will work on addressing the challenges and issues that hinder women's wellbeing. This will be done by building on the existing work of the two WHCs giving focus to the following three main areas: access to reproductive and sexual health care services and products; counseling and empowerment support; and, service quality and technical capacity building. More specifically, the interventions of this project will seek to: 1) improve the health status of women and adolescents in Al Bureij and Jabalia camps through greater outreach and enhanced range and quality of services and

2) instigate a positive change in attitudes and behaviors in relation to RH issues and choices amongst those communities.

Outputs and Expected Results

The inventions that made during the project required a series of complementary outputs which will contribute to actual change. It is expected that over the lifetime of the project, through the completion of these outputs, four significant results will have been achieved. These results and their related outputs are as follows:

Result 1: **Better access to a comprehensive range of RH services for women and adolescents in and beyond the communities where WHCs operate**

The provision of a comprehensive set of integrated RH services will therefore continue and be expanded as a key output for the project. These include the following services at the 2 WHCs:

- laboratory testing
- family planning advice
- pharmaceutical services
- anti-natal and post natal services
- detection and primary care of gynaecological problems
- ultrasound examination
- detection of breast and cervical cancer
- individual and group support sessions for women undergoing breast cancer treatment
- advice and treatment for menopausal women
- preventive programme on reproductive tract infections (including STDs through a pap smear)
- dermatology clinical treatment
- nutrition supplements (vitamin supplements, folic acid and iron) and dissemination of awareness information
- early detection of psychosocial problems
- physiotherapy, fitness, psycho-somatic related postural behaviours problems
- yoga and relaxation sessions

The services will be provided on a daily basis at the Centres and will be presented as a package to the women and their families. The internal networking at the center will help facilitate the internal and external referrals from one section to the other as well to other institutions operating in the area if needed.

The Centres' activities will directly contribute to improving physical well-being and reproductive health of women and adolescents in the targeted communities by reducing maternal and neonatal mortality and morbidity rates as well as improving the nutritional status of pregnant and lactating women. The Centres will also contribute towards improved infant health and decreased child mortality. Additionally the WHC teams expect to see a marked improvement in the psychological well-being of its service-users, in which women's self-esteem is enhanced.

Result 2: **More victims and those at risk of gender-based and domestic violence receiving prevention and protection support**

The WHCs have proven to be a trusted and safe environment for women and adolescents seeking support for GBV. The Centres will therefore continue their efforts in this field and again, target more people at risk through their outreach, counselling and awareness programmes. The work related to the GBV component of the project will empower both the victim and the staff with the goal of preventing and reducing the incidence rate of GBV including domestic violence, rape and incest. Moreover, clients will end the isolation they have experienced as holders of this secret, lessen or ameliorate their guilt and self-blame, and increase their understanding of the connections between their symptoms and GBV. All foreseen interventions will assist survivors in feeling more in control of their lives, thus empowering them. The WHCs will promote self-empowerment through supporting women who have been exposed to violence and advocates to support others. They will be encouraged to make use of social media tools, such as blogs and social network sites to talk anonymously and freely on the issue. Those women wanting legal counseling and advice will also be supported.

The counselling activities and psychological support sessions that will be offered by the WHCs, will also stimulate the debate among local communities on the issue of GBV, which still represents a sensitive subject associated to a general feeling of stigma. Specific recreational and awareness raising activities for men on gender roles will be carried out, as

well as training on gender mainstreaming within CBOs. The expected result of these activities being reduced acceptability of GBV within the targeted communities,

The WHCs activity will therefore support the efforts exerted by local and international organizations to bring about a debate and general discussion stimulating awareness and motivating the local community to take actions accordingly. In this regard, through their activities, the WHCs will become active players at the national level to support actions to combat GBV.

Result 3: **Greater awareness and better decision-making among the WHCs' service-users and communities towards reproductive and sexual health issues**

It is expected that Palestinian women, benefiting from the WHCs services and its awareness programmes will improve their RH status. They will increase their knowledge of all phases of women's health from adolescence till after menopause, by adopting a more aware attitude toward their health care as well as their reproductive choices. This behavioural change, induced through the counselling and training activities organized at the WHCs, will promote a better quality of life among Palestinian families as well as improving the dialogue between Palestinian couples in terms of sharing influence vis-à-vis their family decisions. Through the interventions of this project, the WHCs' beneficiaries are also expected to adopt a more conscious approach toward family planning, reduced birth rate and increased birth spacing; this will not only improve their RH status, but also lead to higher productivity of people, in particular women, and thus contribute to poverty reduction. The action will also empower women in the exercise of their rights, and subsequently in their decision-making capacities at family and community level.

The WHCs' activities to increase adolescents' awareness on reproductive health issues will also induce local youth to exchange views related to their sexual behaviour in a way which takes into account its health and psychological implications. Youth's attitude vis-à-vis their sexual life is generally characterized by a feeling of shyness often inducing them to ridicule or deride its related and multifaceted aspects. Such behaviour, deriving from lack of knowledge often exposes them to unprotected sexual practices. By attending sensitization activities organized both at the WHCs as well as in other institutions, local youth will have a chance to openly discuss about these issues and reflect on them. Group sessions will certainly foster the propagation of this approach based on awareness and

sensitizations, not only among the local youth directly involved in the WHCs' activities but also among their families, friends and peers, with whom they are in contact.

Men's full involvement in the WHCs' activities cannot be expected to be achieved in the short term, however, the experience of other NGOs working in community advocacy activities, shows that men more often than not, appreciate receiving information to improve their lifestyle and their family conditions. Through the WHCs' counselling, workshops and outreach activities, the male community is expected to progressively contribute improving health conditions in their family, support their wives throughout different stages of their reproductive life, appreciate their involvement in the socio and economic activity and enhance their dialogue with them. Related implications at the level of religion and tradition will be taken into account to ensure that a full understanding and consideration of this approach is achieved.

The WHCs' beneficiaries will become also knowledgeable of opportunities available in the Gaza Strip for income generation activities. The WHCs' beneficiaries will be therefore exposed to a variety of opportunities and prospects enabling them to face their own reality and contribute improving their lifestyle and psychological well-being.

As part of this action, several publications will be produced over the two years. The publications will be targeting the team as well as the target groups. Part of the publications will be related to the prevention such as the publications related to breast cancer manual checkups illustrations and HIV/AIDs. Other publications will focus on awareness raising in regards to women's rights, GBV and access to services. Other publications will be promotional about the centres activities and might include multi-media, internet and radio broadcasts productions. All publications of all kind will recognize the EC contribution to the project clearly.

Result 4: **WHCs become models of good practice in service delivery and information management**

In the absence of similar service providers within the Gaza Strip, the WHCs teams recognize the importance of not only improving their quality, but also setting the standard on this type of community level service provision. The WHCs attract women from allover the Gaza Strip for the uneiqniss of the services provided. The two centers gained trust and

good reputation, therefore the quality of the services should be maintained and ensured. Both centers will continue to meet the expectations and demand of women.

The capacity building component will be based on the findings of the previous evaluation missions conducted and recommendations as well as a continuation of the several trainings that already started but not finished yet for the team of the WHCs. The capacity building component will include; advanced training of the staff, intiating a Medical Managment Information System (MMIS) at the two centers, initiating and adapting some missing systems and policies such as the environmental protection policy.

The WHCs' staff will also have the opportunity to improve the quality of their services. This will contribute to a general upgrading of the whole CFTA and RCS as institutions, as well as increasing their networking power with respect to other regional and international NGOs such as Medico International who is going to be the main facilitator for the implementation of the capacity building component of this action. On the administrative level, the CFTA and RCS will have increased their financial and technical reporting skills as well as their abilities to liaise with international partners and international donors. CFTA and RCS will also have improved their managerial skills and abilities to manage and administrate, at local level, EU funds. Indeed, CFTA and RCS at the end of the action will have upgraded their role at national level as two of the main providers of high quality reproductive health and counselling services and will have expanded the scope and number of their beneficiaries, hence serving a larger portion of the Palestinian population.

The new environmental and ecological policy which will be developed for the WHCs will help the center be more environmental friendly and will introduce a whole new culture of the camps and the health organizations in Gaza Strip.

Activities pertaining to Result 1: Improved access to a comprehensive range of RH services

1.1 Women's health care and prevention services: including detection and primary care of gynaecological problems; ultrasound examination; detection of breast and cervical cancer; advice and treatment for menopausal women; testing during pregnancy. Special attention will be given to a preventive programme on Reproductive Tract Infections (RTIs), including STDs, iatrogenic infections (including post abortion and postpartum sepsis) and endogenous infections. The programme includes the strengthening of primary prevention

approaches based on Pap smear and vaginal swabs provision. The gynaecologists, responsible for obstetrical and gynaecological care as well as ultrasound examination and family planning services, will provide the clinical services assisted by the midwives and the staff nurses.

1.2 Family planning services: Women and adolescents will be provided with information and counselling regarding all possible contraceptive methods: natural methods, condom, injections, pill and IUDs, in order to facilitate an optimal and responsible free choice. Contraceptive will also be provided. Meetings and workshops on reproduction and family planning will be organized for various target groups with special focus on adolescents. A monitoring system will be established to identify any side effects and problems of contraceptive use through regular controls in the Clinic and home visits in case of non-compliance. The staff will mainstream gender in FP and gynaecological care. This approach is based on the standpoint that FP is no longer a "women" issue, but rather a *family* issue; it is therefore necessary to practically integrate this perspective into the counselling service. The staff will provide FP and other related clinical services taking into account the woman's circumstances and needs within her environment; this will include gender relations in the family, the needs of men in this regard and how to provide gender sensitive care to clients.

1.3 Ante and postnatal care: *Pre-natal counselling services,* including ultrasound examinations, will be offered to women. Pre-delivery courses will be offered to women in the last quarter of pregnancy consisting of suitable physical exercises, relaxation and breathing techniques and health education sessions regarding pregnancy, delivery, breast-feeding, baby-care and family planning. *Post-delivery counselling and services* will be offered for women who have recently given birth and who will receive information on breast-feeding, family planning, baby care and conduct physical exercises. The Centres will provide pregnant and lactating women and children with, multi vitamins for pregnant women, Calcium, Iron, kin and hair protection and other needed supplements. The center will also provide Antibiotics, Antimicrobials, Antifungal, Analgesia, Gastrointestinal Drugs, Vaginal Drugs, and Hormonal Drugs. The physiotherapist, the midwife and the psychologist will provide these services.

Physiotherapy, ante-natal and post natal care services at the two WHCs

Notes: the fees are waivered if women can't afford

1.4 Laboratory services: Both Centres are endowed with equipped laboratories and laboratory technicians and will conduct medical laboratory tests to facilitate the diagnostic work of the medical doctors. Two laboratory technicians will carry out the lab activities. The laboratory will provide Serology tests, Chemistry tests, Routine tests, Hormonal tests.

1.5 Physical activities: In order to help women to gain self-confidence, the WHCs will offer exercise and gymnastic classes combined with dietary lectures and physiotherapy services. Physiotherapy services are provided in both WHCs. In each Center, the services are provided by a physiotherapist, working on a full time basis at Al Bureij WHC and on a part time basis at the Jabalia WHC. The Jabalia WHC is in need for new equipment. Gymnastic classes are attended by women, adolescents and menopause women.

1.6 Psychological counselling: Psychological counselling for individuals and couples will be provided by two female psychologists. The counselling will be provided to women of all ages (from adolescence to menopause) suffering from psychological disorders, depression and/or victims of domestic violence or sexual abuse. *Group sessions* will be held divided by age and needs. Group therapy on most frequent and recurrent topics such as depression, anxiety and violence will allow a better allocation of resources. Several workshops related to a great variety of psychological topics will be held in the Centres, in private houses and public places in the Camps. The psychologists will also work with school-teachers in order to support them in dealing with cases of child abuse, children with aggressive behavior, lack of concentration and anxiety.

The Jabalia WHC has established contacts with several schools in the camp and implements regular awareness sessions with adolescent students and occasional meetings with teachers on reproductive health issues.

In Al Bureij camp, every school has a development committee composed of teachers. These committees regularly invite the Al Bureij counsellors to conduct workshops and to participate in meetings with students.

The project intends to strengthen the work with the school teachers through an in-depth need assessment and the organization of regular training courses and awareness sessions on how to deal with study problems and students, on reproductive health issues, gender, GBV.

The action will specifically deal with upgrading the skills of the psychologists on the gender based violence component.

1.7 Social-counselling services: Social counselling will be provided by the social workers to individuals, couples and groups and will include community education and a well-organized referral system in collaboration with other organizations. The socio-economic aspect represents a fundamental component of the project as it is related to poverty, unemployment and social exclusion, which have a strong effect on women's reproductive health. The service does not provide financial assistance but offers social counselling and advice, refers women to governmental and non-governmental institutions offering financial or in kind support and facilitates women's access to employment or training and credit opportunities to start a small business. This service has empowered many women increasing their self esteem and improving their social and economic situation through the creation of projects for sewing, chicken and rabbits raising, flowers production, Palestinian traditional knitting, art production and minimarket in coordination with other organizations and traders.

1.8 Socio-Psychosocial counselling for men and male adolescents will be provided at individual and group level by the male socio-psychological counsellors who will complement the women's counselling and will offer assistance in dealing with psychological disorders and family violence. Couple counselling on social and psychological problems will be provided in collaboration with the psychologists. The male counsellors will reach men in their meeting places and will conduct the counselling activities in the Center on the basis of men's knowledge and needs regarding reproductive health. Men will also be advised regarding income generation activities, employment opportunities and micro-credit. The men counsellors will also conduct workshops on reproductive health, gender roles, gender-based violence, and men's role in women's reproductive life. The workshops will be addressed to men and male adolescents and will be carried out at the WHCs, in public places and at schools. The counsellors will implement specific workshops on GBV addressed to adolescents as a way to prevent the future occurrence of violence.

Activities pertaining to Result 2: Better prevention and protection support on GBV issues

A special programme will be implemented using the United Nations Population Fund (UNFPA) guidelines "A practical approach to gender based violence: a program guide for health care providers and managers", which offer a step-by-step guidance on how RH facilities can begin their own GBV activities. The manual foresees a step-by-step process to integrate GBV services into the health facility's organizational structure and allows for the selection of activities that best suit its infrastructure, financial and referral resources and capability.

The following activities will be implemented by the WHCs:

2.1 Awareness and mobilisation: Producing, distributing and displaying materials about GBV with effective images/messages (including information about where to get help) at the WHCs and off-site (schools, shops, meeting places, hairdressers), if feasible; film screening

2.2 Support of GBV cases and referrals: GBV cases can be assisted by the WHCs, the staff will conduct an in-depth assessment and on-site treatment for GBV survivors. The action foresees the strengthening of the psychologists and health providers' expertise on GBV, its dynamics and health consequences as well as on the in-depth assessment and treatment of GBV victims.

2.3 Legal counselling services: Legal counselling will be provided to the women of the Camps by the part-time lawyers. This service provides advice and assistance regarding a wide range of legal issues, including Islamic law, marital law and domestic violence. Home visits and workshops have proved the best way to meet people in need. Therefore, the lawyers will conduct a wide range of workshops related to women's rights in order to increase their participation through better knowledge, awareness and understanding of gender issues.

The WHCs will screen all clients about GBV. If clients disclose they have experienced GBV and the case is beyond the WHCs capacity, they are referred to specialized institutions providing the necessary care and support such as the Gaza Mental Health Program, legal assistance organizations. The screening activity will include the adaptation

and finalization of the UNFPA screening form and specific training on its use. The WHCs will also strengthen the referral system and network with specialized centers, thus expanding its activities beyond the walls of their settings.

The guidelines also help prepare the facility by progressively guiding and sensitizing the staff through the various practical steps. The focus of the training given by the international experts will be on the delivery of a spectrum of appropriate services to GBV victims, ranging from information and education activities to screening for all users, from assessment to diagnose and treatment for victims. This innovative approach provides crucial care and services to victims/survivors of violence within a supportive and validating environment. In order to do so, before any GBV related activities is carried out, health-care managers and providers will be sensitized on the connections between reproductive and sexual health and GBV. The cultural myths and social barriers to effectively tackle the issue will be actively discussed by the staff and explained so as to share unspoken beliefs and overcome them. Helping staff to look at their own responses, beliefs and biases is key to an effective programme and a supportive environment. For these reasons, an active and participatory training methodology will be adopted as this facilitates staff members' personal involvement as well as experience and understanding of such innovative services. This will include group sessions on gender issues and their cultural implications, active elaboration and presentation to other participants and, more importantly, role plays to experience providers' role and its constraints while dealing with GBV and better understand victims' needs.

The GBV component will be incorporated as a specialized and regular activity of the WHCs.

The two WHCs are included in the country program of UNFPA and UNIFEM, which will be also co-financing the project. Both UNIFEM and UNFPA have offices in Gaza in charge for the monitoring and supervision of the activities in the field. The WHCs are in regular contact with UNFPA offices in Jerusalem and Gaza. At operational level, the GBV component will be implemented with the involvement of those WHCs staff concerned with this component including the directors, the medical staff, the counselors (psychologists, social workers, men counselors), the field workers. The staff of both WHCs have been already trained on the approach and methodology of UNFPA GBV guidelines through a first training conducted in Jordan in 2005 and through a mission conducted in September-

October 2007 by two international psychologists experts within the EC co-financed project "Preventing and reducing the occurrence of Gender Based Violence (GBV) in the Gaza strip through an innovative methodology and an integrated approach", implemented by the Culture and Free Thought Association (CFTA), under the European Initiative for Democracy and Human Rights (EIDHR), Micro-Projects Program 2005.

Activities pertaining to Result 3: Increased awareness on RH issues

3.1 Home visits: The methodology that characterises the WHCs services is their proactive approach. Home visits will be carried out by the field workers, the nurses and the counselors (social workers, psychologists, men counselors) on a regular basis, such as post-natal visits, ante-natal visits, family planning monitoring visits, etc. Home visits will be also organized within the single families on specific topics regarding all aspects of reproductive health. The WHC staff will be dynamic and mobile across the target area, to ensure the involvement of the female population and facilitate their participation, adapting visit and meetings to the women's needs and schedule.The resources needed by the program include, in addition to human resources, transportation, hygiene kits, and information materials such as health booklets, leaflets, posters, cards, files.

3.2 Community workshops: Community-based workshops on specific topics regarding several aspects of reproductive health will be organized at the WHCs, throughout the camps in co-operation with various organizations involved in the health/social sector and in public meeting places such as schools, community-based organizations, training centres, societies, clubs, homes, unions and committees (CFTA, 2012).

عنوان الدراسة: تقييم خدمات الصحة الانجابية في مركزي صحة المرأة في جباليا والبريج

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ملخص الدراسة

تعتبر مشاكل الصحة الإنجابية، في جميع أنحاء العالم من بين أبرز الأسباب المؤدية للمراضة والوفاة بين كافة النساء في عمر الإنجاب.

تقدم معظم المؤسسات الصحية في قطاع غزة برامج وخدمات صحة إنجابية، ومع ذلك فليس جميع هذه البرامج تقدم خدمات شاملة. يعتبر مركزي صحة المرأة في مخيمي البريج وجباليا للاجئين من بين البرامج التي تقدم خدمات صحة انجابية شاملة. كما يقدم المركزان أيضاً خدمات علاج طبيعي وخدمات نفسية اجتماعية وخدمات قانونية.

تهدف هذة الدراسة إلى تقييم خدمات الصحة الإنجابية في مركزي صحة المرأة من أجل تحسين نوعية وفعالية الخدمات المقدمة للمستفيدين. اعتمدت هذه الدراسة طريقة البحث المندمج، حيث قامت الباحثة بجمع وتحليل البيانات ودمج النتائج والاستنتاجات التي حصلت عليها من الطرق أو الأدوات الكمية والنوعية في نفس الدراسة. تم جمع البيانات الكمية من المستفيدات من خدمات الصحة الانجابية في عيادتي الصحة الإنجابية بمركزي صحة المرأة في جباليا والبريج، حيث شارك 375 من النساء اللواتي تم اختيارهن بطريقة عشوائية، في الدراسة الكمية. هذا وقد بلغت بنسبة استجابة 89,3%. وقد تم جمع البيانات النوعية عبر اللقاءات المعمقة مع المدراء ومزودي الخدمة، ومن خلال 6 مجموعات بؤرية مركزة مع المستفيدات من خدمات المركزين، بمشاركة 38

امرأة. تأكدت الباحثة من مصداقية وثبات أدوات الدراسة. تم استخدام الاختبارات الاستنتاجية والاحصائية الوصفية لتحليل البيانات الكمية، في حين تم استخدام طريقة الترميز المفتوح والتحليل المرتبط بأفكار رئيسة، لتحليل البيانات النوعية.

أظهرت نتائج الدراسة الكمية أن المشاركات نساء تراوحت أعمارهن ما بين 16–65 سنة، أتممن سنوات دراسة بمعدل 11,86 عام. معظم المشاركات (96,8%) متزوجات، منهن فقط 16% موظفات أو عاملات، وقد بلغ الدخل الشهري الكلي لعائلات حوالي 52% من المشاركات أقل من 1000شيكل.

كشفت كلتا الدراستين، الكمية والنوعية أن حال النساء ووضعهن الصحي قد تحسن نتيجة لتلقيهن الخدمات التي يقدمهما المركزين. تلقت الغالبية العظمى من المشاركات (98,7%) الخدمات التي ترغب بها، وقد أعرب 95,2% من المشاركات عن أن هذه الخدمات قد لبت احتياجاتهن الصحية. بلغ المعدل المتوسط لنسبة الوصول للخدمات والقدرة على الدفع، بالإضافة لمدى توفر الخدمات المطلوبة 81,18%. كما بلغ المعدل المتوسط لتجهيزات المراكز 83,4%، في حين بلغ المعدل المتوسط لمهارة وكفاءة مقدمي الخدمات الصحية 85,30%. بلغ معدل رضا النساء العام عن خدمات المركز 87,8%، وقد أظهرت النتائج النوعية، بشكلٍ متطابق مستوى عالٍ من الرضا عن خدمات العلاج الطبيعي والخدمات النفسية الاجتماعية والخدمات القانونية. كما وأظهرت الدراسة استدامة مالية محدودة للخدمات، حيث أن المركزين ممولين من قبل جهات مانحة خارجية.

في الختام، كان تقديم خدمات الصحة الانجابية بصورة متكاملة وسيلة فعالة جداً. ولكن هناك حاجة لمزيد من الجهود لزيادة الاستفادة من خدمات رعاية مابعد الولادة ولزيادة الاستفادة من خدمات المركزين من قبل فئة الشباب اليافعين والنساء الغير متزوجات.