Deanship of Graduate Studies

Al-Quds University

Women Satisfaction about Delivery Services Provided at Shifa Hospital

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MPH Thesis

Jerusalem - Palestine

2009م / 1430هـ

Women Satisfaction about Delivery Services Provided at Shifa Hospital

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A Thesis Submitted in Partial Fulfillment of Requirements for the Degree of Master of Public Health.

Al- Quds University

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Thesis Approval

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Master thesis submitted and accepted: Date: 19/8/2009

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Dedication

TO THE SPIRIT OF MY FATHER

TO MY HUSBAND

WHOSE ENERGY AND INTELLECT ARE AN INSPIRATION

TO MY CHILDREN

TO ALL OUR MOTHERS THE AFFECTIONATE TEACHER

Declaration

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

Signed: Etaf Ahmad

Etaf Mohammed Ahmed

Date: 19/8/2009

Acknowledgement

I would like to acknowledge *Dr. Bassam Abu Hamad*, my academic supervisor for him endless support, encouragement during the study.

Iam extremely grateful to *Dr. Yehia Abed*, who has been generous with his time and expertise.

I would like to acknowledge the staff in the School of Public Health.Thanks and respect to all teachers who taught me at the School of Public Health and provided me with update knowledge and skills.

Special thanks to *Dr. Akram El-Sh. Khalil* ,General director of the maternity Hospital for his help and support.

My deep thanks *to Dr. Jamal Al- Massry* for his kindly help.

My special thanks to *Mrs Seham Abu Saief* for her continuous support.

My deep thanks to *Ms* Nisreen Awad for her kindly help

My gratitude and extremely special thanks to my friend Amal Jad for her support and encouragement.

Thanks to Dr.Wisam Abu Amer and Dr Fatma Kasab.

Great thanks to all my colleagues; physician and nurses in Maternity hospital.

Deep thanks and gratitude, my appreciate and love to my family, for help, support and encouragement during the study period.

Great thanks to all my friends for their support and help.

Finally, I would like to thank all people who participated in this study and gave it a meaning.

Abstract

Recently, patients' satisfaction has gained an increasing attention in quality improvement efforts in health care. Satisfaction is not only important for gaining insights into the perception of the customers about health services, but also as key outcome of care which affects compliance and continuity of care. The aim of this study was to investigate women's levels of satisfaction with obstetric care received at Shifa Hospital. The design of the study is an analytical cross-sectional one. Through an exit interview, the researcher interviewed systematically selected 425 women (response rate, 96.5%) who gave birth during the data collection period. The overall questionnaire reliability was high (Cronbach's alpha 0.93).

The overall level of satisfaction was 61.8% which is the lowest reported figure among the recently carried out satisfaction studies in Gaza. The study concluded six dimensions comprising clients satisfaction namely; technical competency, availability and responsiveness of services, information and communication, interpersonal manner and physical environment. The dimensions of information and communication and the physical environment elicited the lowest scores (49%).

Older women, women with low educational levels, housewives, women with unemployed husbands and women with lower household monthly incomes had greater satisfaction levels with statistically significant differences in comparison to their counterparts. Also, the study found that women who were admitted during morning shifts, women with prior experiences of giving birth at Shifa Hospital, multi-parous women and those delivered by Caesarean Section were statistically significantly more satisfied with their child birth experiences than their counterparts.

The study provided a frame for improving women satisfaction about delivery services at Shifa Hospital. There is a need to reinforce information and communication and to improve the physical setting of the delivery services.

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List of abbreviation

ANOVA	Analysis of Variance
CS	Caesarean Section
CBR	Crude Birth Rate
CDR	Crude Death Rate
GDP	Gross Domestic Product
GNP	Gross National Product
GS	Gaza Strip
MMR	Maternal Mortality Rate
MOF	Ministry of Finance
MOH	Ministry of Health.
NGOs	Non Governmental Organizations
NIS	New Israeli Sheqal
PCBS	Palestinian Central Bureau of Statistics
PHC	Primary Health Care
PNA	Palestinian National authority
SPSS	Statistical Package for Social Sciences
TFR	Total Fertility Rate
UNRWA	United Nations Relief and Works Agency
WB	West Bank.
WHO	World Health Organization.

Chapter (1)

Introduction

Chapter 1

1.1 Introduction

Patient satisfaction is considered as one of the desired outcomes of healthcare service delivery, an element in health status, a measure for the quality of care, and as essential to assessment of quality as to the design and management of health care systems (Westaway et al, 2003). It has been proposed that the effectiveness of health care is determined, to some degree, by satisfaction with the services provided (Carr-Hill, 1992). Support for this point of view has been found in studies that have reported that a satisfied patient is more likely to utilize health services (Haldar et al, 2008), comply with medical treatment (Li and Jin, 2008) and continue with health care provider (Vincent et al, 2005). The assessment of satisfaction with care is considered as a major component of quality improvement and reflects healthcare professionals' ability to meet their patients' needs and expectations (Moret et al, 2007).

There are various reasons for assessing patient's satisfaction including, the knowledge gained from patient's feedback can help to understand patient's expectations and to identifying gaps in service delivery. In addition, patient's satisfaction can contribute to designing proper health services to meet the patients' needs and setting the direction to achieve hospital management goals (De Geyndt, 1995).

Satisfaction and related concepts are vital in reflecting patient's or user's views back into the system. Documenting their experience of care provides a window or source of information for health professionals, managers, and policy makers that can be used to make decisions about the organization and provision of services, avoid malpractice and assess the quality of health care (Hodnett, 2002).

Mother's satisfaction with childbirth experience has its implications for her health well-being and that of her newborn. A woman's satisfaction with her childbirth experience may have immediate and long-term effects on her health and her relationship with her infant (Goodman et al, 2003). A satisfactory childbirth experience has contributed to a woman's sense of accomplishment and self-esteem and has led to expectations for future positive childbirth experiences (Mackey et al, 1994).

Measuring the actual performance requires that the different aspects of a quality service responsible for client satisfaction or dissatisfaction are assessed; some examples of these aspects include: satisfaction with the access and facilities, with communication material, with the personnel, with the nature of the service per se, with service result/outcome, and with the hospital more generally (Hankins, 2007).

Most studies of the relationship of patient characteristics to hospital satisfaction scores have found that several key variables were significantly related to reports of satisfaction, most consistently patients' age and self-reported health status (Hjortdal and Laerum, 1992).

Various studies have shown that satisfaction is related to technical and interpersonal competence, more partnership building, more immediate and positive non verbal behavior, more social conversation, courtesy, consideration, clear communication of contact, information, respectful treatment, consultation, services availability, and waiting time (Westaway et al, 2003)

1.2 Research problem

This study will investigate women's levels of satisfaction with obstetric services and identify socio-demographic and service related factors most likely influencing women's satisfaction. The investigation will be conducted at the obstetric department in Shifa Hospital. There have been various international and local studies on patient's satisfaction in different health care settings, but locally there is a lack of evidence on women's level of satisfaction with childbirth experience. Moreover, factors affecting satisfaction are unrecognized in this area. This study will be concerned to answer the questions, how women would rate the level of satisfaction about obstetric care they received at Shifa Hospital and what are the main dimensions of women's satisfaction with childbirth experiences?

1.3 Justification of the study:

The current study is considered the first study aimed to explore women's experience in labour and birth at Shifa Hospital. In addition to that, the decision to conduct this study is based on the recognition and importance of women's views and satisfaction about delivery services. Because the investigator has a long experience working as an obstetrician and gynecologist at the same place, this facilitates access to information and to in depth knowledge about delivery services provided at Shifa Hospital. Another reason to carry out this study was the high admission rate, and huge numbers of deliveries in obstetric and gynecological department.

There is a lack of evidence and documentation on mother's level of satisfaction about obstetric services provided at Shifa Hospital and socio-demographic and service related factors most likely influencing women satisfaction. Better information about

the factors affecting satisfaction might assist health care providers and planners to improve the quality of services delivered to users.

1.4 General objective

To assess women's level of satisfaction with obstetric care received during hospitalization for delivery at Shifa Hospital. This assessment would help in improving maternity services.

1.5 Specific objectives

1. To assess mother's level of satisfaction about obstetric services provided at Shifa Hospital.
2. To explore the main dimensions of women's satisfaction with childbirth experience.
3. To determine hospital and obstetric services related factors affecting women satisfaction.
4. To identify the relationship between socio-demographic and economic factors and women satisfaction with obstatric care.
5. To identify women childbirth related characteristics most likely to affect satisfaction.
6. To provide suggestions and recommendations about priority areas for intervention and service delivery improvement.

1.6 Research questions

1. What is the level of satisfaction about obstetric care provided at Shifa Hospital?
2. What are the main dimensions of women's satisfaction with childbirth experience?
3. Are there significant differences in women's levels of satisfaction related to socio-demographic factors such as age at marriage, educational level and place of residence?
4. Are there significant differences in women's levels of satisfaction related to economic status factors such as working status and average monthly income?
5. What is the relationship between satisfaction and women obstetric characteristics, such as mode of delivery and pervious experience?
6. What are the most positive or negative terms or phrases selected by women during labour and birth to describe medical staff?
7. What is the relationship between women's satisfaction and hospital characteristics namely: admission time, waiting time, administrative procedures, buildings, cleaning, food, quietness and comfort?
8. What are the suggestions and recommendations that could be drawn from the study that could improve the quality of services and women satisfaction level?

1.7 Context of the study

1.7.1 Demographic context:

Palestine is located at the Eastern coast of the Mediterranean Sea, to the west of Jordan and to the south of Lebanon. Now, Palestine comprises two areas separated geographically: The West Bank (WB) and Gaza Strip(GS), the total area is 6,020sq. Km. with total population of 3,761,646 individuals in 2007 with 624 capita per sq Km. (PCBS, 2007).

The WB is divided into four geographical regions: The northern includes the district of Nablus, Jenin, and Tulkarem. The center includes the of Ramallah and Jerusalem where as the southern includes Bethlehem, Alkhalil, and Jericho districts. In 2007, the WB was a population of 2,345,107 which represent 62.3% of the total population of Palestine. (2007).

Gaza Strip (GS) is a narrow costal piece of land at the eastern side of the coast of the Mediterranean Sea. Its position on the cross roads from Africa to Asia made it a target for occupiers, invaders and conquerors over the centuries (PCBS, 2007).GS is a densely populated area of 365 sq. km; which made it, one of the most density populated areas worldwide. GS is divided into five governorates: the North, Gaza, the Mid Zone, Khanyounis, and Rafah. In 2007, the total population in GS was 1,416539 individuals comprising with 37.7% of the total population of Palestine. (PCBS, 2007).

Palestinian Central Bureau of Statistic (PCBS) reported that the natural increase rate in Palestine was 3.3% (3.0% in WB and 3.8% in GS), the percentage of population under 15 years old was 46.3% of the total population in Palestine (44.2% in WB and

49.1% in GS). The number of males in Palestine was 1,908,432 compared with 1,853,214 females; the sex ratio in Palestine was 103 (PCBS, 2007).

There is a slight increase in the median age for population in Palestine between 1997 and 2005, where it increased from 16.4 years in 1997 to 16.7 years in 2005. Palestinian Ministry of Health (MoH), has reported that, the crude birth rate (CBR) in Palestine was 27.5/1000 population in 2005 (33.7 GS and 23.9 WB). MOH has reported that, the crude death rate (CDR) in Palestine was 2.7/1000 population in 2005 (3.1 GS and 2.5 WB) (MOH, 2005).

1.7.2 Economic context

The Unstable political situation is negatively affecting the socio-economic status in Palestine. Based on the data from the Palestinian Expenditure and Consumption Survey (PECS 2007), the rate of the total diffusion of poverty among Palestinian households in the Palestinian Territory is 30.3% in 2007, (of which 19.1% in the WB and 51.8% in GS).The results showed that more than one fifth of the participants in the labour force are unemployed in the 1st quarter 2008 at 22.6% (19.0% in the WB and 29.8% in GS). Unemployment rate in the is considered very high compared to other countries; for instance unemployment rate was 14.0% in Jordan and 8.4% in Israel in 2006 (PCBS, 2006).The dependency ratio decreased from 113.3 in 1997 to 104.1 in 2007. This was due to a decrease in the total fertility rates, which led to a decrease in the percentage of people aged less than15 years (PCBS, 2006).

Following the 1993 Oslo Accords, it was expected that the Palestinian economy would enter a period of sustained and rapid growth. While performance was not as strong as hoped, the growth was steady and by 1999 the real Gross Domestic Product (GDP) had grown to around $4,896 million (World Bank, 2008). However, since

2000, when Israel instituted a strict closure regime in response to the second Intifadah, the Palestinian economy has been on a downward trend, and GDP fell by over a quarter to an estimated $3,540 million in 2002 and then recovered slightly in 2004 and 2005. (IMF& World Bank, 2008). However, with the continued settlements' growth, closures and the cut off in direct aid after the election of the Hamas government, GDP fell again in 2006. According to Ministry of Finance (MoF), The Palestinian Gross National Product (GNP) in Palestine decreased from 5,454 million US$ in 1999 to 3,720 million US$ in the year 2004 and , National production per capita was 1,806 US$ in 1999 and decreased to 1,020 million US$ in the same period. (MoF, 2005).

The situation in GS has widened the economic gap between the GS and the WB. The closure policy has recently been tightened following Hamas takeover in GS, and has eroded its economic backbone in a manner that may be difficult to reverse. The restrictions have led to the suspension of 95% of Gaza's industrial operations thus companies can neither access the inputs for production nor export what they produce, transforming GS into a consumer economy driven by public sector salaries and humanitarian assistance. The agricultural sector, with nearly 40000 dependant workers has also been adversely affected by the closures (PCBS, 2007).

1.7.3 Health care in Palestine

Health care services

The health system in the Palestine can be divided in two key components; primary health care system (PHC) including comprehensive and continuous health services, which also includes diagnosis, primary cure, health promotion, preventive health service management, and chronic diseases. The second component is secondary healthcare system including hospitals, which provide primary, secondary and tertiary health services. The provision of health services in WB and GS is shared by the main

four providers, the MoH, United Nation Relief and Works Agency (UNRWA), Non Governmental Organizations (NGOs) and the private sector.

Palestinian Ministry of Health

The responsibility of health was transferred to MoH in 1994. MoH was handed a worn-out health sector with infrastructure that was neglected for approximately three decades. The Palestinian National Authority (PNA) has paid special attention to the health sector and primary care. For the PNA, the health sector is the second most important sector after education in the development plan.

MOH plays the main role in providing health care services to the Palestinian population. The PHC service is a major component of Palestinian health care system which provides accessible and affordable health care to all Palestinians especially for women and children. Generally, MOH operates 56 public health centers in the GS and 360 in the WB. (MoH,2005). Also MOH is responsible for a significant portion of secondary healthcare delivery (60% – 70% of general and specialized hospitals beds respectively). (MoH, 2005). In year 2005, MOH had 22 hospitals with 2,815 beds. In the WB there were 12 hospitals with 1,316 beds representing 46.7% of total MOH beds. In the GS there were 10 hospitals with 1,499 beds representing 53.3% of total MOH beds (MOH, 2005).

The United Nations Relief and Works Agency

The UNRWA health program focuses on primary, preventative, and comprehensive healthcare. It provides free-of-charge healthcare services to Palestinian refugees.

In year 2005, UNRWA operated 18 primary health care center in the GS and 35 primary health care centers in the WB. UNRWA operates and owns one hospital in Qalqilia with 63-bed capacity (MOH, 2005).

Non-Governmental Organizations

Non-Governmental Organization is (NGO's) are the third most important health care provider after the government and UNRWA . NGOs played a major role in healthcare service provision during the Israeli occupation years especially in remote rural areas with marginalized and impoverished people where they provide health services for minimal charges. NGO's role was most prominent during the 1st Palestinian Intifada in 1987 as well as the Al Aqsa Intifada in 2000. Despite the policy of the military occupation imposed on the Palestinian people, which stopped the development of the Palestinian healthcare services, many NGOs found an incentive in such policy to work harder in healthcare service delivery with deeply acknowledged dignified achievements. (MoH, 2004). In year 2004, NGOs operated 55 primary health care centers in the GS and 130 in the WB. The number of NGOs hospitals providing secondary health care has risen from 24 Hospitals to 230 hospitals during the last three years in the WB and GS (MOH, 2004).

In year 2005, the NGO's operated 1196 beds comprising 71% of the total NGO's beds and 40% of beds in the WB. More than one third of the NGOS services were in Jerusalem where they owned and operated 534 beds constituting 44.6% of the total NGOS beds in WB and 88% of the total hospital beds based in Jerusalem. In the GS NGOs own and operate 485 beds (10 hospitals), more than half of them are located in Gaza City (MOH, 2005).

The private sector

The Private sector owns and operates 23 hospitals, 4 in Jerusalem representing 18 % of the total private beds and 21 hospitals in the WB representing about 75% of the total private bed capacity (MOH, 2005). In GS, the private sector operates 2 hospitals only representing 7 % of the total private bed capacity.

1.8 Fertility and birth in Palestine

According to the MOH , the total fertility rate (TFR), which is defined as the average number of children born to women at the age of (15-49) years is estimated to be 4.2 in the WB, 5.4 in GS and 4.6 in Palestine. (MOH, 2008). These rates are substantially higher when compared to those in neighboring countries as Jordan (3.6), Lebanon (2.5) and Syria (4.1). (Shaheen et al, 2003). There are many reasons which contribute to high fertility including cultural norms and society values that support or encourage early marriage, preference for sons, and preference for large families.

The reproductive health situation of Palestinian woman is characterized by a very high fertility rate including early child bearing and short birth intervals, which is estimated to be 29.3 months among women in the WB and 27 months in GS (PCBS ,2004) . The universal rate of normal child births is 85%, while in the Palestinian Territory only 72.2% of child births are considered normal. Caesarian section (CS) rate has risen from 12.4 in 2004 to 13.1 in 2007 (MoH,2007).

The total number of deliveries in year in Palestine was 106.084 live births 57.859 of them in the WB and 48.225 in GS. 96.6% of these deliveries took place in health institutions while the other 3.4 were either at home or during transfer to hospital (MOH, 2008). According to MoH report 2007, more than half (53.2%) gave birth in governmental hospitals/health centers, and nearly (22.8%) delivered in private hospitals or health centers, while the remaining women were spread across a range of other hospitals, clinics and maternity homes. In GS more women use governmental hospitals (69,3%) while in the WB more women delivered at private hospital 56,9% (MoH, 2007). In the WB the percentage of women who delivered in a physicians' clinic was 2.6 compared to 9.5% for women in GS. (PCBS, 2006) .On the other hand,

home deliveries are more common in the WB (3,3%) as compared to those in GS (0.3%). (MoH, 2007).

The obstetric client load on the governmental hospitals has increased from (43.3%) in 2000 to (53.3%) in 2004, most probably because of universal availability of insurance, but the resources for these hospitals have not increased, resulting in an increased burden on human and other resources. In addition, fewer women are using private hospitals now (22.8%) compared to in 2000 (27.8%), perhaps also due to the deteriorating economic situation limiting private expenditures, and the availability of insurance (PCBS, 2006).

1.9 Maternal Mortality Rate

Maternal mortality rate (MMR) is one of the most important indicators to determine health status for women. The MOH estimates that pregnancy and maternity-related complications are the third leading cause of death among Palestinian women of reproductive age. Most maternal deaths are the results of hemorrhage , pregnancy induced hypertension , complications of unsafe abortion and obstructive delivery (MoH, 2008). The MMR is about 13.2 per 100,000 live births. However, these rates are comparatively lower than those in most other countries in the region (MoH, 2008).

1.10 El Shifa Hospital

The Hospital was established in 1946 on an area of 4.2 hectares. Since it's establishment, it passed many development stages. Shifa Hospital is considered the biggest health institution in the PNA .It provides secondary and tertiary medical and surgical services for more than 500,000 inhabitants (Hospital Records, 2008). In 2008 the hospital contained 506 hospitalization beds, distributed in different departments, such as internal medicine, general and special surgeries, burn unit, intensive care unit,

maternity and neonatal department. In addition, there are 94-day care beds including oncology, dialysis, emergency department and other specialize clinics (Hospital Records, 2008). The average occupancy rate in the El Shifa Hospital was 80.9% in year 2008. This includes the occupancy rate of day care beds. The average length of stay was 2.7 days.(Hospital Records, 2008)

El Shifa Hospital is subdivided unofficially into three hospitals. These hospitals are Surgical Hospital, Medical Hospital and Obstetrics and Gynecology Hospital, each of the three hospitals has its own administrative team that includes medical director, nursing director, and director for support and paramedical services. (Hospital Records, 2008).

The obstetrics and gynecology word includes 147 beds 9 of them at the out patient clinic. On average the facility receives about 40-50 delivery cases per day, despite the presence of four obstetrics and gynecology operation rooms only. In year 2007, about 12083 women delivered normally and 3003 (24.85%) delivered by cesarean section, in addition, to 70,000 outpatient visits. (Hospital Records, 2008).

1.11 Definitions and terms:

Satisfaction: can be defined as fulfilling expectations , needs , or desires (Sitzia, and wood, 1997).

Patient satisfaction: the degree to which the individual regards the health care service or product or manner in which it is delivered as useful, or beneficial (Biology-online,2008).

Level of satisfaction: "The extent to which women are happy and have positive attitudes abou the services they receive".

Socio-economic status. (SES). A term referring to prestige-based measures of socioeconomic position, as determined by rankings in a social hierarchy, Measures of SES are typically a composite of occupation, education, income, location of residence (WHO, 2004).

Live Birth: A birth is considered live if the newborn has shouted, cried or shown any signs of life upon birth (William et al, 2001).

Low Birth Weight: Weight of a newborn of less than 2.5 kg.

Childbirth period: The period from admission of the woman to hospital for delivery until discharged.

Availability: Presence of medical care resources (e.g., enough hospital facilities and providers in area).

Information and decision making: Giving and explaining information and mutual decision-making.

Interpersonal manner: Features of the way in which providers interact personally with patients (e.g., concern, friendliness, courtesy, disrespect, rudeness).

Intra partum: The period of time during labour and birth.

1.12 Layout of the study

Chapter one introduction

First, the researcher gives an introductory background about the study then sets the research problem and justification and identifies the main aim and the objectives of the study. After that, the researcher illustrate the research questions and provide some details about the context of the study.

Chapter two: Literature review:

The main purpose of the literature review chapter is to synthesize theoretical, and empirical evidence. The review sought to summarize the results of studies that

investigated alternative methodological approaches or examined determinants of satisfaction in different settings. It also considered the gaps in existing knowledge so that they can be addressed by future research.

Chapter three: Methodology of the study :

This chapter focuses on the research methodology, which is discussed in terms of how study participants were selected, how and when data from participants were gathered, and how data were analyzed. It encompasses the selection of research methods, study design, instruments, population, sampling, and ethics and data analysis.

Chapter four: Results and discussion:

This chapter presents the study main findings as they relate to the research purpose and research questions. It summarizes the results of the study to provide useful information about the study population, in terms of classification, tabulation, and presentation.

Chapter five: conclusion and recommendations:

The study conclusions are the researchers attempt to show what knowledge has been gained by the study also an attempt to summarize and recommend some suggestions.

Chapter (2)

Literature Review

Chapter 2

2.1 Conceptual Framework

Study conceptual framework attempts to incorporate all influences on satisfaction and thereby to provide a comprehensive framework for exploring interactions between variables that affect women satisfaction. Satisfaction is a multi-dimensional concept, derived from an evaluation of varied features of the health care experience. The determination of women satisfaction is a dynamic process. Information and communication are modified by interpersonal manner, which, in turn, alter and affect availability and responsiveness of services.

The literature review illustrates many dimension for satisfaction. The following dimensions were found to be relevant to this study, therefore, constructed the framework the researcher used .This study assumes that the following dimensions affect women satisfaction:

General satisfaction:

Is one of the main dimensions contributing to global women satisfaction with childbirth experience. This includes women views on general satisfaction experience on labour and birth. Women were asked about their expectations, if they would recommend the hospital to friends and family in addition to their trust in health providers.

Technical competency:

Technical competency is one of the main dimensions contributing to global women satisfaction with childbirth experience. This includes women views on continuous fetal monitoring, pain control and medical staff response, help and support in induction,of labour in addition to women's perceptions about child birth compared with previous experience

Responsiveness and availability of services:

The dimension of responsiveness and availability of services is one of the main dimensions contributing to global women satisfaction with childbirth experience. This includes women views on waiting time, availability of doctors, nurses and medications in addition to cooperation between medical staff.

Information and communication:

Providing women with enough information is important to encourage their involvement in decisions about their care and treatment. Women were asked if they had been given enough information and explanations during labour, birth and after the birth of their babies.

Interpersonal manner:

Interpersonal manner dimension is one of the main dimensions contributing to global women satisfaction with childbirth experience. This includes women views on medical staff attitudes such as support, encouragement and kindness. Women were asked if they had been treated with respect, humanity and dignity by medical staff in addition maintenance of privacy level and involvement in decision making.

Physical environment:

Physical environment dimension is one of the main dimensions contributing to global women satisfaction with childbirth experience. This includes women views on the cleanliness of wards, toilets/bathrooms both in the labour and in delivery rooms. In addition to temperature, noise level at night and food.

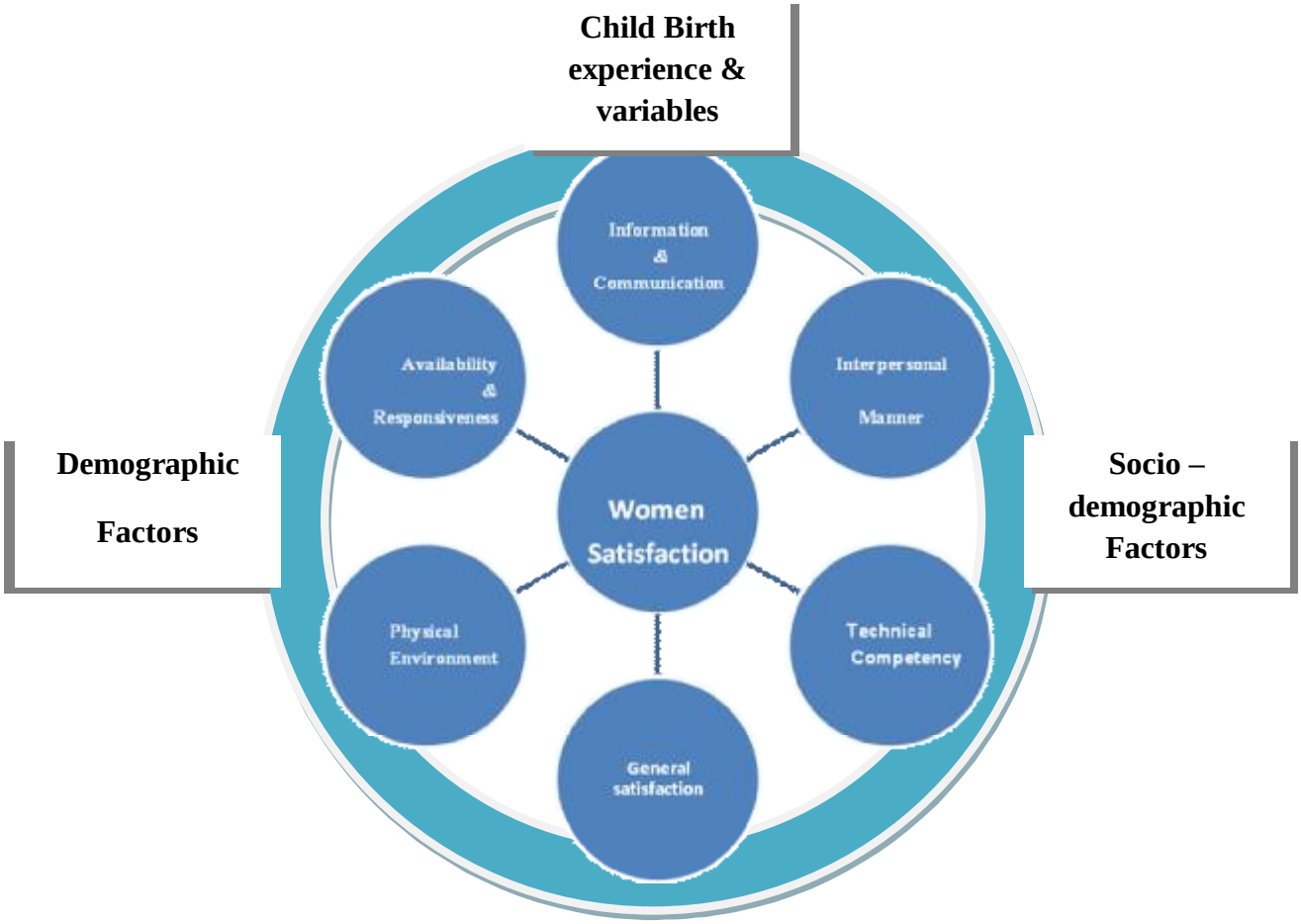

Figure (1) Women satisfaction with obstetrics service and socio-demographic and service related factors most likely influence satisfaction.

2.2 Definition and concepts of satisfaction

Crow, 2002 identifies three bases for conceptual development of patient satisfaction and its measurement, expectation theories; evaluation of health services attributes; economic utility.(Crow, et al 2002). He also identifies another important base a holistic approach which emphasizes feedback loops between expectation and experiences its also attempt to incorporate all influences on satisfaction and thereby to provide a comprehensive framework for exploring interactions between variables that affect consumers' evaluations (the actions, attitudes and appearance of human resources, the physical environment, and organizational aspect (Crow, et al 2002). According to expectation theory, satisfaction is based on the difference between what one expected and what occurs.

Another approach focuses on consumers' evaluations of health service, there are three attributes that affect satisfaction with healthcare, These features are the characteristics of the provider as technical competency, the patient–practitioner relationship and factors related to the structure of organization (Weiss, 1988).

In economic terms, satisfaction is defined by the utility of a product or services that person purchases for its utility generating attributes (Rice, 1998). Thus, satisfaction depends on the difference between the experience of actual utility and the utility that consumer expected.

Satisfaction like many other psychological concepts, is easy to understand but hard to define. The concept of satisfaction overlaps with similar themes such as happiness, contentment, and quality of life. Satisfaction is not some pre-existing phenomenon waiting to be measured, but a judgment people form over time as they reflect on their experience (Edward and Staniszewska, 2000).

Patient satisfaction is seen as a way to be responsive to public and the concept of patient is often seen by health care professionals as a suitable vehicle for addressing the issues of both “people centered” and “doing the best that they can” (Edward and Staniszewska, 2000). A simple and practical definition of satisfaction would be the degree to which desired goals have been achieved. Client satisfaction is an attitude – a person’s general orientation towards a total experience of health care (Keegan et al, 2003). Satisfaction is achieved when the client’s perception of the quality of care and services that they receive has been positive, satisfying, and meets their expectations. It is widely recognized that care cannot be of high quality if the patient is unsatisfied' (Vuori, 1987).

Satisfaction includes both cognitive and emotional facets and relates to previous experiences, expectations and social networks (Keegan et al, 2003). Meredith and Wood (1995) have described patient satisfaction as a particularly passive form of establishing consumer’s views (Meredith and Wood, 1995).

Donabedian (1980), identified the relationship of satisfaction to health achieving and producing health and satisfaction is the ultimate validator of the quality of care. Donabedian (1988), recognized the importance of patients' expectations, as well as the central role patients play in evaluation of their care “Client satisfaction is fundamental importance because it gives information on the provider's success at meeting those client values and expectations which are matters on which the client is the ultimate authority”.

The subjective nature of patients' evaluation of care was reported by Pascoe (1983), who defined patient satisfaction as “a comparative process involving both a cognitive evaluation and an effective response to the structure, process, and outcome of services”. As a subjective assessment of the quality of health care, satisfaction

represents a complex mixture of perceived need, expectations of care, and the experience of care (Wilkin et al, 1992). Patient satisfaction is influenced by patients expectation and their perception of care (Kravitz, 1996). Expectation can be defined as those responses that are situation specific, influenced by environmental factors, past experience, and properties of the situation (Rao et al 2000). Satisfaction can be defined as fulfilling expectations, needs or desires (Sitzia, and Wood 1997).

Also Anderson, et al (1988) defined patient satisfaction as the degree of consistent between patient expectations of care and their perception of care actually received. In addition, Linder- Pelz (1982) defined patient satisfaction as positive evaluations of distinct dimensions of the health care.

The challenge in measuring patient satisfaction is to define the facets of patient satisfaction and the possible stimuli, value judgments, and dispositional and experiential moderators that influence these reactions. To do this well, the patient satisfaction researcher and the health care manager must allocate a great deal of time and thought to this process (Strasser and Davis, 1991).

From these definitions of satisfaction we see three basic uses of the term first, need fulfillment and gratification, second, compensation and reparation, third, to inform, make certain and convince.

2.3 Value of patient satisfaction

Assessments of patient satisfaction with healthcare services are important for continuous quality monitoring and improvement in the provision of healthcare service. Feedback from patients can be used by healthcare administrators to identify patients' needs, perceptions and concerns and identify areas of service failure (Crow, et al. 2002). Patient satisfaction has emerged as a potentially valuable tool driving changes in healthcare (Robert et al, 2008). Assessments of patient satisfaction with

healthcare are not a recent phenomenon.. They were first developed in the United States during the 1950s, and by the 1960s began appearing in the United Kingdom (Speight, 2005). Patient satisfaction at first explored the relationship between satisfaction and compliance with recommended treatment, medication use and patient behavior, which as Draper and Hill (1995), noted, helped to legitimize patients' views and perceptions also leading to their inclusion in quality review activities. By the 1960s and 1970s, the consumer movement asserted that patients, as healthcare consumers, had a social right to be heard, and not merely to foster patient compliance (Draper and Hill 1995). During the 1980s, economic rationalist theories gained prominence among many governments, policy makers and healthcare administrators in a number of industrialized countries.

The increased number of studies regarding satisfaction with care in the 1980s was a result not only of the growing interest in the user perspective (Edwards and Staniszewska, 2000) and an interest in delivering more responsive care (Coyle, 1999), but also of a need to clarify important criteria for evaluations of health care (Williams, 1994).

Increasing attention was paid to concepts such as quality, outcomes, clinical indicators, total quality management, continuous quality improvement and benchmarking (Larson and Larson 2002). Indeed, evaluative activities increased significantly during this period, as governments investigated more efficient and effective ways to provide services within budgetary constraints (Speight , 2005).

Recently, healthcare systems have sought to achieve a balance in services that offer not only clinically effective and evidence based care, but which are also judged by patients as acceptable and beneficial (Fitzpatrick, 1997). Moreover, health care which

improves health only in some limited technical sense, but does not improve the quality or length of life, is not likely to be viewed as beneficial by patients (Jenkinson,1998). Therefore, interest has grown not only in the assessment of treatment interventions by patients, but in the systematic evaluation of the delivery of that care (Cleary, et al 1991).Most significantly, attempts have been made to determine the features of patient care that are likely to influence patient satisfaction.

2.4 Dimensions of patient satisfaction:

Several dimensions of satisfaction emerged from the literature, Ware et al (1988), developed eight dimensions affecting satisfaction including art of care/interpersonal manner, technical quality of care, accessibility/convenience, finances or how the service is paid, physical environment, availability of providers, continuity, and efficacy/outcomes. Sue (1998), conducted a study to explore quality in maternity care. .The result of study identified ten dimensions of quality which are continuity of care, environment, information, access care, and treatment relationship, outcome, staff attributes choice and control (Sue, 1998). Linder-Pelz (1982), identified ten constructs that are very similar to Ware et al (1988), accessibility/convenience, availability of resources, continuity of care, efficacy/outcomes of care, finances, humaneness, information gathering, information giving, pleasantness of surroundings, and quality/competence.

Domains used by Mousa (2000), in his study client satisfaction with family planning services in GS included attitudes and expectations , information and counseling ,communication and interaction , mechanism of care, and delivery of care.

Abu Shuaib (2005), conducted a study to assess women perceptions and experiences of childbirth services at governmental hospital in GS. The researcher identified these

dimensions of satisfaction: approach of women care, approach of baby care, counseling, attitude and respect, information and communication, decision participation, privacy, and ward environment

Abu Saleek (2004), conducted a study to assess the level of client satisfaction with nursing care, provided at selected hospital in GS the researcher, found six dimension of satisfaction with nursing care information and interaction, availability ,comfort and environment, skills and professionalism, organizational culture, counseling and advising.

Various dimensions of patient satisfaction have been identified, ranging from admission to discharge services, as well as from medical care to interpersonal communication. Well recognized criteria include responsiveness, communication, attitude, clinical skills, comforting skills, amenities, food services (Rubin, 1990 and Cleary et al, 1991). It has also been reported that the interpersonal and technical skills of health care providers are two unique dimensions involved in patient assessment of hospital care (Donabedian, 1988). The relationship between health care providers and patients has been reported to be the most influential factor for patient satisfaction (Hall & Dornan, 1990). We also know that personal channels of communication with relatives and friends are a major source of information for people wishing to obtain details concerning hospital performance and health care providers, findings are in agreement with previous reports indicating that patient satisfaction is determined mainly by provider's attitude and caring rather than technical skills (Hall and Dornan, 1990).Compassionate patient care, including personal attention, respect and comfort were the most important factors influencing Patient's intention to

recommend a provider or for that patient to return to the same provider in the future (Jacoby, 1988).

2.5 Expectations:

It's commonly known that each client to any type of institution has certain expectation from this institution. These expectation are related to the client needs which are assumed to be met by staff institution. Meeting these needs plays an important role in making this client/patient feel satisfied or unsatisfied (Ross et al, 1981).

The most important skills for health providers is to take the time and effort to elicit patients' expectations. When health providers are able to recognize patient expectations, satisfaction is higher not only for the patient but also for the health providers it may help to remember that patients often show up at a visit desiring information more than they desire a specific action (Rao, et al 2000).

There is evidence from the literature of a positive relationship between satisfaction and expectations. Patients with expectations of high-quality care reported higher levels of satisfaction and were more likely to return and recommend their providers than people with lower expectations (Hsieh and Kagle, 1991).

On the other hand, negative expectations about a healthcare provider that are based on no prior experience were associated with low reported satisfaction, but this was reversed over time as positive experiences accumulated (Ross et al, 1981).

Basic conceptual questions must to be answered, how expectations can be measured, and how patient judge, and interpret the discrepancy between what they expected from a care experience, and what they received. Expectations are based on

information that consumers may collect from various possible sources, including the cultural norms they are brought up with, personal experiences of the healthcare system, the reported views of family and friends, and media influences (Hall and Dornan 1990). There is a constant need to educate patient about appropriate care, and to manage their ideals and expectations about what can realistically and practically be provided (Swan et al, 1985).

Reforming patients' expectations, can be made after hospitalization. Keeping respectable degree of communication to patients helps much in shaping realistic expectation (Rao, et al 2000). Patients with the most unrealistic expectations are the least satisfied (Williams, 1994). Communicating to patients what they can expect from the various members of the hospital staff gives the critical opportunity to shape patients' expectations and their experience of satisfaction with care.

Women whose expectations for labour and birth were met have reported higher childbirth satisfaction compared with those whose expectations were not met (Green et al, 1990), For example, expectations of being in control (both self-control and control of what was done to them) have been positively associated with achieving control and with increased satisfaction (Gibbins and Thomson 2001). Women with childbirth preparation were more satisfied with their birth experience than those without preparation (Hodnet 2002). however, others have found no relationship between childbirth preparation and satisfaction.

2.6 Domains of women satisfaction.

2.6.1 Technical skills:

Patient perceptions of physician technical skills appear to play a significant role in predicting satisfaction with healthcare. In addition, it considered a useful component for assessing quality of care. Overall satisfaction with a general practitioner was found to be strongly related to the doctor-patient relationship and the practitioner's skills (Williams, and Calnan, 1991) .Several studies have looked at patients' assessment of their physicians' technical skills and the effect on satisfaction, but the findings are contradictory. In a survey of 236 "vulnerable" older patients, better communication skills were linked to higher patient satisfaction but technical expertise was not (Chang et al, 2006). However, another study found that when forced to make a trade-off, participants expressed a strong preference for physicians who have high technical skills (Fung et al, 2005). Patients also indicated that a physician's ability to make the correct diagnosis and craft an effective treatment plan were more important than his or her "bedside manner (Otani and Kurz, 2005).

Abu Saleek (2004), explored the client satisfaction with nursing care provided at different hospital in Gaza Strip, this study showed that the highest level of satisfaction was attributed to nurses' skills and professionalism (77.4%).

2.6.2 Communication:

Determining whether physicians' communication behaviors have a direct effect on patient satisfaction ratings is not straightforward. Physicians' communication behaviors are important contributors to patient satisfaction in the outpatient setting (Stewart,1989). In the inpatient settings, several studies have indicated that the quality of aspects of communication with physicians is important to hospitalized patients (Rubin,1990). Another study conducted by Clever (2008), aimed to determine the

relationship between physicians' communication behaviors and patients' overall satisfaction with hospital care. Claimed that there was a significant positive relationship between overall satisfaction and overall ratings of attending' communication behaviors (Clever, 2008).

Three experimental studies investigated the effect of training doctors in communication or psychosocial skills (Smith et al,1995) and of encouraging patients to participate more actively in consultations (Mccann and Weinman, 1996). Although, doctor training had a significant positive effect on satisfaction, a leaflet provided to patients did not, possibly because such an approach is insufficiently proactive and personal (Mccann and Weinman, 1996).

El Haj (2008), conducted a study to assess patient perception about the service provided at European Gaza Hospital (EGH), this study found that the information and communication domain reported 77% of the perception level meaning that patient have a high positive perception about information and communication domain.

2.6.3 Physical environment:

The hospital environment, particularly the birthing room, has always been considered as an unfamiliar place by pregnant women: strange, cold, frightening, and full of surprises, a place which will be the scene of a lot of pain and suffering at the time of birth. Health professionals are responsible for the undoing of this myth and should transform the environment into one associated with the image of pleasure and happiness, in which the arrival of a new and, almost always, very wanted human being, will occur. The previous familiarization of the woman with the environment makes her feel more secure and less anxious at the time of the birth (Bower, and Lutz, 2000).

Benoit, et al (2005) conducted a study to compare the delivery and childbirth situation in five municipalities in the state of Ceara in Brazil. Mothers were interviewed to identify health priorities, and then to collect accounts of childbirth, the results revealed that, many women reported that birthing facilities were inadequate. Delivery and labor rooms were often noisy, unventilated and hot, and offered little or no privacy.

Anastasios, et al (2003) in their study for Evaluation of patient satisfaction with nursing care; the patients expressed low satisfaction with the cleanliness of toilets, noise levels and the variety and temperature of meals.

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

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

2.6.4 Interpersonal manner

Beattie, (2000) conducted a large survey in England to explore expectation and experience about childbirth. The researcher found that 10% of new mothers were not satisfied with intra partum care. A more detailed analysis, including specific questions related to different aspects of care (interpersonal care ,information and decision-making, information and support, the physical environment), revealed a larger percentage of dissatisfied mothers Emotional dimensions of care seemed to influence women's assessments the most. Interactions with the caregiver and the interpersonal manner of the caregiver were particularly important. Further important factors were: having sufficient time for personal support, as well as information and involvement in care decisions. Findings indicate that women should be given the opportunity to talk through their birth experience (Rudman et al , 2003).

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

2.6.5 Responsiveness and availability:

Availability and responsiveness are considered as one important quality dimension. In this study, availability domain reflects Presence of medical care resources (e.g.,

enough hospital facilities and providers in area). It also considered the degree of met patients' needs and responsiveness to complaints (Fung, et al 2005).

Massoud (1994), reported that Palestinian national input into health care is high. Health providers are investing more in spite of scare of resources. Clients were moderately satisfied with the availability of radiology services (Al-Hindi, 2002)

2.7 Determinants of patient satisfaction

Determinants of patient satisfaction have been reported extensively. Most studies of that several key variables were significantly related to reports of satisfaction, most consistently patient age and self-reported health status. A patient health status and severity of illness are important predictors of patient overall satisfaction level (Young et al., 2000). According to previous studies, patient characteristics such as age and education may influence a patient assessment of hospital performance (Hargraves et al, 2001). In general, older patients tended to report greater satisfaction, and sicker patients tended to be less satisfied (Thi et al., 2002). Other patient characteristics that have been significantly related to hospital patient satisfaction include gender (Rosenheck et al, 1997). Education level (Hargraves et al, 2001). Insurance status (Finkelstein et al,1998). Income (Rogut, et al., 1996). having a regular physician (Rogut, et al., 1996). Past hospital experience (John, 1992). Hospital features such as hospital size have been reported to be associated with consumer assessment of hospital quality (Hall and Dornan, 1990). Some factors such as those related to practices in the hospital may be alterable by health managers and care providers. Recognition of non-modifiable factors such as patients' socio demographic characteristics is also important for health managers to target patients at risk for worse experiences (Hargraves et al, 2001).

2.8 Factor affecting clients satisfaction

Patient-related factors

The literature appears inconsistent on the importance of patients' demographic and social factors in affecting patient satisfaction. Some studies revealed that patient demographics are a minor determinant in patient satisfaction (Hall and Dornan, 1990). While others concluded that demographics represent 90 percent to 95 percent of the variance in rates of satisfaction (Sixma et al, 1998). Nevertheless, the literature does shed some light on how particular demographic factors affect patient satisfaction.

Age:

Age is a well- known determinant of patient satisfaction (Rahmqvist,2001). Past studies have also explored how levels of satisfaction varied in relation to basic demographic variables such age (Choi et al , 2005). The most consistent finding has been related to age, older patients scoring more highly and being more satisfied than young and middle aged patients (Owens and Batchelor, 1996) possible explanations include lower expectations of health care and reluctance to articulate their dissatisfaction. The effect of patient age on reported satisfaction was Al Hindi.(2002), who found that no statistical significant differences in satisfaction score based on client age, while, this result is not consistent with another study, which revealed that there was real differences between the age groups and overall satisfaction, older age group reported a higher level of satisfaction score compared with younger age group (Abu Saleek 2004). In the other hand, Mousa in 2000 found that the level of overall satisfaction decreased as the age increase and he concluded that old people in the Palestinian context tended to be less satisfied than the young (Mousa, 2000).

The findings of the 58 studies that investigated the relationship between reported satisfaction and age confirmed the conventional wisdom: older respondents were significantly more satisfied in 41 studies, which represent 70.7% (Crow et al, 2002).

Gender:

Studies on the effect of gender are contradictory, with some studies showing that women tend to be less satisfied and other studies showing the opposite. Swanson and Karen (2002), conducted a study to determine whether, gender plays modifying affect on the relationship between patient satisfaction and health provider switching, found that there were no gender differences in the relationship between patient satisfaction and provider switching. Concluding gender was not related or a moderator on this relationship.

No firm conclusions may be drawn about the relationships between reported satisfaction and gender. Al Hindi (2002) who investigated client satisfaction with radiology services in Gaza Strip found that there were no differences between males and females regarding satisfaction level. This finding is consistent with Abu Saileek (2004), who examined the client satisfaction with nursing care provided at different hospital in GS determined that there are no differences between male and female in their level of satisfaction with nursing care.

Socioeconomic status:

Most studies have found that individuals of lower socioeconomic status and less education tend to be less satisfied with their health care. The effect of patient Socioeconomic status (SES) on reported satisfaction was investigated in Neil et al. (2005). Who confirmed the significant association between SES and satisfaction., high SES respondents were about 1.5 times more likely to report excellent service compared with low SES respondents (Neil et al, 2005).

Education:

Studies on educational status provide contradictory findings. Educational status sometimes has a positive and sometimes negative influence on satisfaction and interacts with other socio-demographic variables (Fitzpatrick,1991).The effect of level of education on satisfaction was considered by 31 investigators. Education was not found to have a significant influence on satisfaction in 15 (48.3%) studies. Higher levels of education were associated with significantly less satisfaction in 11 (35.4%) studies, and significantly more satisfaction in five (16.2%)(Crow et al, 2002).

El Haj (2008), conducted a study to assess patient perception about the service provided at European Gaza Hospital (EGH) revealed that there was a real difference between patient educational level and perception. Illiterate and preparatory patients reported higher scores of perception, while, the university level of education reported the lowest scores of perceptions.

Income:

Crow et al (2002), report that a small number of studies which investigated the effect of income on reported satisfaction found that people with higher incomes were more satisfied with doctors' interpersonal skills, whilst, those with lower incomes experienced more problems as hospital inpatients. Studies from the United States where more affluent patients have reported higher satisfaction have been attributed to physicians providing 'better treatment' to wealthier people compared to those who were 'less privileged' (Sitzia and Wood 1997**).** Mousa (2000), study reported that the highest level of overall satisfaction was among women with bad economic status. Moreover, Al Hindi(2002), study found that the respondents with higher financial status tend to be more satisfied than the respondents with lower financial status (Al Hindi, 2002).

Health status:

The extent to which a patient's health status correlates with patient satisfaction has also investigated but the results are inconsistent (Rahamqvist, 2001). Among hospitalized patients, poorer health is generally associated with lower satisfaction and reporting more problems with care (Krupat et al, 2000). Perceived improvement in health has been linked to satisfaction (Carmel, 1985). Changes in health status have been shown to influence reported satisfaction over longer periods. Among patients undergoing surgery, those reporting the greatest absolute or relative improvements in symptoms 6 months after discharge were the most satisfied (Kane et al, 1997). Looking at patients with chronic disease has shown some consistent patterns. Patients with poorly controlled diabetes were less satisfied with their care (Redekop et al, 2002).

Locally , El Haj (2008), conducted a study to assess patient perception about the service provided at European Gaza Hospital (EGH) which revealed that there was a real difference between the patients evaluation of their health status and the overall perception as well as all dimensions of patients perception , patients who have excellent and very good health status reported a higher scores of perception while the patients who have poor health status reported lowest score of perception.

2.8.1 Health provider related factors

Patient–practitioner relationship

There is general agreement that physicians' interpersonal skills affect satisfaction (Hjortdal and Laerum, 1992). Affective behaviour by the health provider directly related to satisfaction, although this was described by investigators in terms of warmth and respect (Kenny, 1995), friendliness (Bertakis et al, 1991), trust (De la cuesta,

1997), courtesy, empathy (Comstock et al, 1982) , supportiveness (Greene et al, 1994) , sensitivity (Holloway et al, 1989) and understanding (Treadway, 1983). Shared laughter and chatting with patients have been associated with higher satisfaction (Gross et al, 1998). With respect to information gathering and giving, most evidence showed that satisfaction correlated positively with health provider feedback and discussions about treatment. The provision of general health promotion advice also generated satisfaction (Halpin et al, 1996). However, physician listening, undertaking a physical examination, and explaining patients' problems were noted to be positively related to satisfaction (Greene et al, 1994). Expressions of physician control, including dominating the conversation, reduced reported levels of satisfaction (Bertakis et al, 1991).

Decision-making:

In the last decade, the clinician-patient relationship has become more of a partnership. There is growing interest in shared decision-making in which the clinician and patient go through all phases of the decision-making process together, share treatment preferences, and reach an agreement on treatment choice (Joosten et al, 2008). Patients expressed a preference for physicians who recognized the importance of their social and mental functioning as much as their physical functioning (Sherbourne et al, 1999). The effect of decision participation on reported satisfaction was investigated in a study titled "Women perception of childbirth services provided at governmental hospitals in GS" conducted by Abu Shuaib (2005), which revealed that decision participation dimension score was 55.8%.

Studies have found that when physicians exhibited less dominance by encouraging patients to express their ideas, concerns and expectations, patients were more satisfied

with their visits and more likely to adhere to physicians' advice (Hargraves et al 2001**).**

Time spent:

Time spent during a visit plays a role in patient satisfaction, with satisfaction rates improving as visit length increases (Gross et al, 1998). Patient satisfaction is positively correlated with doctor effort, measured as a combination of time spent, questions asked and examinations performed (Das and Sohnesen, 2006). Moreover, a recent study conducted by Word Bank to determine how time spent with the physician might be related to patient dissatisfaction with their waiting time. Showed time spent waiting for the physician and time spent with the physician have consistently been shown to be important determinants of a patient's satisfaction with their visit (Feddock et al, 2005). Time spent chatting during the visit was also related to higher rates of satisfaction. Physicians with high-volume practices were more efficient with their time but had lower rates of patient satisfaction, offered fewer preventive services, and were viewed as less sensitive in the doctor-patient relationship (Fenkelstein et al ,1998).

Doctor gender:

Much has been written about the interaction between doctor and patient but little about where the sex of the doctor makes difference. There is no evidence that the gender or age of physicians had a consistent effect on satisfaction. Gender was not significant in eight studies conducted by Regula et al, (2008), to determine whether the expected gender differences in gynecologists' communication skills affect patient satisfaction and compliance revealed that patients were more satisfied with female gynecologists regarding the relationship and the consultation process(Regula et al, 2008). This is consistent with another study which found greater satisfaction with

female doctors amongst female patients than amongst male patients (Comstock et al, 1982). Another study showed trained female residents to be better on disclosure and empathy than their male counterparts (Smith et al, 1995).

The clinical team: Highly performing patient care teams are essential to have positive patient care outcomes and lead to high patient satisfaction. It is clear that patients' first concern is their doctor, they also value the team with which the doctor works. One study found that while physician care was most influential to patients' satisfactions, the compassion, willingness to help and promptness of the physician's staff were next in importance (Otani and Kurz , 2005). In another large database of surveys, nurses were the next most important source of satisfaction, ahead of access-to-care issues (Wolosin, 2005). Patients who had remained in a practice for more than 15 years attributed their loyalty to their physician first and to the "team concept" second (Brown et al, 1997).

Referrals: Patients have a relatively high degree of desire for specialist referral and general practionaire failure to recognize these desires have been associated with lack of clinical improvement and dissatisfaction with care (Rosenthal et al, 1996). On the other hand, specialty referrals are often associated with significant economic implications and do not always improve outcome. Effective referrals play a role in patient satisfaction. One study looked at referrals from the standpoint of the family physician, the referral physician and the patient, and found that satisfaction with the referral's outcome was higher when the family physician initiated the referral (Rosemann et al, 2006). Similarly, a study of patients treated for recurring headaches revealed that those who self-referred to a neurologist were less satisfied than those whose primary doctor had referred them (Bekkelund and Salvesen, 2001) .A survey of cancer patients found that they valued their family physician highly and wanted to

maintain contact with him or her, even when they were receiving cancer care elsewhere (Norman et al, 2001).

Continuity of care: A sustained partnership over time between a clinician and patient is considered a fundamental component of primary care (Fan et al., 2005). Patients who have been receiving regular care from the same doctor are more likely to be satisfied with the care they receive. This relationship ideally leads to a bond between clinician and patient, characterized by trust and a sense of responsibility (Saultz, 2003). A total of 3,918 patients were asked to rate their satisfaction with a medical consultation and to indicate how long and how often they had seen this particular doctor. Over half considered the doctor to be their regular doctor, and 82% were satisfied with the consultation. Those who had a long-term relationship with the doctor were seven times more likely to be satisfied with the consultation (Hjortdahl, and Laerum, 1992). Continuity of care, one of the pillars of family medicine. While it is unclear to what degree patients in general value continuity of care, it is clear that patients who have been followed by their physician for more than two years are more satisfied with their care (Donahue and Ashkin, 2005) particularly when they are able to see their own physician.

Al Hindi (2002), study was inconsistent with the literature, which found that the continuity and affordability as domain of client satisfaction had the lowest score compared with other domains. This finding indicated that what encourages clients to attend radiology department several times was the insurance coverage of radiology services.

2.9 Patient satisfaction with the childbirth experience

Patient satisfaction with the childbirth experience also has implications for the health and well-being of a woman and her newborn. A woman's satisfaction with her

childbirth experience may have immediate and long-term effects on her health and her relationship with her infant. A satisfactory childbirth experience has contributed to a woman's sense of accomplishment and self-esteem (Hodnett 2002) and has led to expectations for future positive childbirth experiences (Gibbins and Thomson 2001). In contrast, women who experienced unsatisfactory births'remember the birth of their child only with pain, anger, fear،or sadness, or they remember nothing, which is suggestive of traumatic amnesia' A traumatic and unsatisfactory birth could lead to postpartum depression or post-traumatic stress disorder in which women relive their labour in dreams and flashbacks that, in turn, trigger extreme distress (Goodman et al 2003). An unsatisfactory childbirth may also result in future abortions a lack of ability to resume sexual intercourse or preference for a caesarean for subsequent births (Hodnett 2002).

A woman's satisfaction with the childbirth experience is also important for the well-being of the infant. A mother's positive perception of her birth experience has been linked to positive feelings toward her infant and adaptation to the mothering role (Goodman et al 2003). Conversely, traumatic births have affected women's ability to breast-feed and bond with their children and have led to child neglect and abuse

2.9.1 Factors related to childbirth satisfaction

When measuring patients' satisfaction with intra partum care it is important to recognize the association between the experience of labour and birth (including, for example, pain and physical discomfort, negative emotional experience, fulfillment, joy, and emotional adaptation) and the experience of care (Van Teijlingen et al. 2003). Both of these outcomes are multidimensional and linked to each other, and studies of women's birth experiences or satisfaction with intra partum care do not necessarily separate the two (Van Teijlingen et al. 2003).

The attitudes and behaviours of caregivers appear to play a very important role, Negative assessments of maternity care have been linked to patients' experience of lack of support by the nurse or midwife during labour, lack of information, poor explanations, and poor participation in decision-making (Brown & Lumley 1994).

The findings, of an Australian study revealed no association between satisfaction with care and maternal age (Brown & Lumley 1994). Labour outcomes, such as an operative delivery and infant transfer to a neonatal clinic, lack of support and involvement in decision-making, have also been reported as risk factors for not being satisfied with intra partum care (Brown & Lumley 1994),

Labour pain:

Labour pain is considered an important factor which related to satisfaction with childbirth. Women who have experienced less labour pain have reported higher levels of childbirth satisfaction compared with women with more labour pain (Beattie 2000). In one study, 40% of women identified pain as the worst part of the labour and delivery experience. However, high levels of labour pain do not preclude a positive overall childbirth experience (Crow, and Baeyer, 1989).

Personal control and childbirth satisfaction:

Personal control is another factor related to satisfaction with the childbirth experience. Higher levels of personal control have been associated with greater childbirth satisfaction (Green 1990). Women have also determined their satisfaction with their childbirth experience according to how well they perceived they had managed their own performance (their ability to maintain control). Those who managed well (i.e. stayed in control) viewed childbirth as positive; whereas, those who had difficulty or managed poorly viewed childbirth negatively (Van Teijlingen et al. 2003).

Chapter (3)

Methodology

Chapter 3

Methodology

This chapter explains the methodology used in this study. It begins with the study-selected design, sample, sampling process and ethical consideration. Then, it presents the instrument, method of validation, piloting and data collection. Further, it illustrates the psychometric properties of the questionnaire. The chapter also depicts the methods of analyses, eligibility criteria and limitation of the study.

3.1 The study design:

The design of this study is cross sectional analytical study. It is usually used to assess the level of satisfaction of a group of clients at various stages of the process of receiving the services (Burns, and Grove, 1997). It has been selected because this method would be useful for descriptive analysis of study constructs, like perspectives, perceptions, experiences and satisfaction. It enables the researcher to meet the study objectives in a short time and low cost, besides that, this type of studies examines the association between cause and effect at a point of time (Coggen et al,1993).

3.2 The study population:

The study population consists of all eligible women who gave birth in labour wards at Shifa Hospital during the period of the study.

3.3 The study setting:

The study has been conducted in the Obstetris' Department at Shifa Hospital.

3.4 Period of the study:

The study was started in May 2008, by preparing the research proposal, and designing the questionnaire. Pilot study was conducted early in Sep. 2008. Data collection was started in October 2008 and continued till the end of December 2008. Data entry, analysis and writing the final reports continued till the end of May 2009.

3.5 Sample size:

The sample size for this study was determined using the statistical calculator of the EPI_INFO program. The total sample size is 385 subjects. The researcher increased the actual sample size to 425 subjects to compensate for any missing or non-respondents.

3.6 Sampling process:

According to Shifa Hospital records in 2008, the total number of births in Shifa Hospital was 15,086 (normal and CS) deliveries which represents 31.2% of total births in GS 48300). The average number of births per month is 1257 births, Data collection period was three months, and therefore, the total study population was 3771 births.

In order to get a representative sample, the researcher used systematic random sample through dividing the total number of study population (3771) by sample size (425) to get sample interval (every eight case). The researcher randomly selected a starting figure and chosen every eight case from the birth registration book.

3.7 Ethical consideration:

The researcher paid special considerations to the research ethics including:

Official letter of request was obtained from MOH to conduct the study in Shifa Governmental Hospital. (Annex3)

Every woman in this study received complete explanation about the research, purpose, confidentiality and sponsorship.

Anonymity was given to all participants, the questionnaire will be returned without any identifying information.

All participants received consent form (Annex 4)

Every woman in the study population knew that participation in the research was optional and she had the right to refuse unequivocally.

3.8 Research instrument:

Conducting a patient survey is a simple method for obtaining information from service users about their perception of the positive and negative aspects of a service and might be one of the only means for clients to express their needs and views (WHO, 2000).

A five point Likert Scale questionnaire has been designed based on literature review to cover the most important elements of the service under consideration, recognizing the needs to be as concise as possible.

The patient satisfaction questionnaire in this study is a 65-item instrument that taps global women satisfaction with medical care as well as satisfaction with six aspects of care: general satisfaction, technical competency, availability and responsiveness of

services, information and communication, interpersonal manner and physical environment. The questionnaire contains another section for women's socio-demographic and child birth information (Annex 5).

3.9 Pilot study:

Piloting was performed for 40 subjects selected randomly by the researcher from Shifa Hospital. Findings showed that participants found that the questionnaire was understandable, simple and quick (it took less than 20 minutes to complete). As a result of piloting minor rewording and rephrasing changes were done and two questions were dropped. Subjects who were selected for piloting were excluded from the study sample. The final version was limited to 65 questions about different service areas with space for additional comments.

3.10 Data collection:

Ultimately, the quality of the information obtained from a survey is dependent on the quality of the work done in the field. Good survey organization and preparation, coupled with meticulous fieldwork are thus vital for achieving high standards in terms of data quality. At the beginning of the interview the interviewer introduced herself and stated the purpose of the study; stressed confidentiality of responses. Throughout the interview the researcher was neutral and impartial, not reacting by gesture or word, either positively or negatively, to any responses; not changing the wording or sequence of questions; asking questions directly and consistently of all respondents; not creating false expectations; thanking respondents for their time and assuring them that their contributions are valuable.

3.11 Data entry:

Over viewing of the questionnaires was the first step prior to data entry. This step followed by designing data entry model using the computer software Statistical Package for Social Science (SPSS) version 16. Then coded variables were entered into the computer by the researcher. Data cleaning done through checking out number of questionnaires and through carrying out descriptive statistics frequencies for all variables. The objective of data-entry is to transfer data from questionnaires to the computer and to transfer data in a uniform numerical format which can be interpreted by the computer in the subsequent stage of tabulation.

3.12 Data analysis:

Data analysis is the process by which researchers take raw data and turn it into information that can be used to answer the questions posed by the research study. However, raw data by themselves are not very useful, but once summarized and analyzed it can provide useful and helpful information about the study population. The processing and analysis of data collected involves editing, coding, classification and tabulation of data in order to achieve data reduction and presentation. The analysis of data (both descriptive and inferential or statistical) involves exploratory analysis, computation of certain indexes or measurers, searching for certain patterns of relationships and trends, testing of hypothesis for interferences, and graphical presentation. Important techniques like chi-square test, t-test for dependent and independent variables and analysis of one way ANOVA are largely underused in this research study.

3.13 Psychometrics of the instrument:

Measurement is at the core of doing research. Measurement is the assignment of numbers to things. In almost all research, everything has to be reduced to numbers eventually. Precision and exactness in measurement are vitally important. A researcher needs good measures for both independent and dependent variables. Measurement consists of two basic processes called reliability and validity

3.13.1 Validity:

Validity is the most important concern regarding an assessment tool. Validity refers to the degree in which our test or other measuring device is truly measuring what we intended it to measure (Mark, 1996). A valid measure should satisfy four criteria Face Validity, Content Validity, Criterion-related Validity. The researcher measured face validity. Face validity is concerned with how a measure or procedure appears. Does it seem like a reasonable way to gain the information the researchers are attempting to obtain? Does it seem well designed? Does it seem as though it will work reliably?

Content validity is the extent to which a test's items actually express the domain or universe to be measured. Content validity concerns the extent to which a measure adequately represents all facets of a concept.

3.13.2 Reliability

Joppe (2000) defines reliability as the extent to which results are consistent over time and an accurate representation of the total population under study is referred to as reliability and if the results of a study can be reproduced under a similar methodology, then the research instrument is considered to be reliable. . The statistical test used for internal consistency was Coronbach Alpha coefficient that considered the most

popular test of reliability estimates. The total instrument reliability test was high as 93% (table1). It is concerned with homogeneity of sub- items compromising the scale (polit and Hungler, 1999).

Table3.1: Factor sub scales reliability estimates

Scale	Dimension name	No Items	Alpha Cronbach
Women satisfaction with childbirth experience	**General satisfaction**	10	0.793
	Technical competency	8	0.722
	Availability and responsiveness of services	11	0.748
	Information and communication	14	0.868
	Interpersonal manner	10	0.519
	Physical environment	11	0.877
	Total	64	0.930

3.14 Eligibility criteria:

3.14.1 Inclusion criteria:

All women who were admitted and gave birth at Shifa Hospital during the period of the study were eligible to participate.

3.14.2 Exclusion criteria:

The study excluded mothers of newborns who received treatment in an emergency setting (e.g. special care baby unit, premature baby unit, intensive care unit) and

mothers with multiple births, stillbirths or neonatal deaths at present pregnancy In addition to subjects who were selected for pilot study.

3.15 Response rate:

The researcher selected 425 women to participate in this study. Out of whom 410 participants agreed to participate with a response rate of 96.5%. The high response rate could be attributed to the approach utilized by the researcher and the convenience of the research instrument. The researcher used appropriate communication and interviewing skills, in addition to the participant's high interest in research topic which contributed to a high response rate.

3.16 Limitations of the study:

The support the researcher received from the School of Public Health and Shifa Hospital administration decreased the constraints and made the study relatively convenient. Following the research ethics and appropriate procedures decreased the constraints that faced the researcher. However, the main constraints were:

1. The main constraint faced researcher was the political situation especially during the period of war on Gaza and the frequent cutoffs of electricity.
2. Limited educational resources particularly updated journal and books.
3. Time factor.
4. The study was self funded therefore the researcher faced financial problems.

Chapter (4)

Findings and Discussion

Chapter 4

Results

This chapter presents the study main findings as they relate to the research purpose and research questions. It summarizes the results of the study to provide useful information about the study population, in terms of coding, classification and tabulation of data in order to achieve data reduction and presentation.

The analysis of data (both descriptive and inferential or statistical analysis) involves, computation of certain indexes or measurers, searching for certain patterns of relationships and trends, testing of hypothesis for interferences, and graphical presentation. Important techniques like chi-square test, t-test for dependent and independent variables and analysis of one way ANOVA are largely under used in this research study.

4.1 Descriptive analysis

4.1.1 Socio-demographic information

Total of 410 women have been selected randomly from the obstetrics and gynecology department in Shifa Hospital to complete the questionnaire aiming to investigate women's satisfaction with obstetric care provided at Shifa Hospital and to identify socio-demographic and service factors related to satisfaction with childbirth experience.

According to the results, the study subjects showed many variations in socio-demographic characteristics as shown in table(1).

Table 4.1: Distribution of the study population by socio demographic characteristics

Characteristics		Frequency	Percentage
Age groups	Below 25	163	39.8%
	26- 35	163	39.8%
	Over 35	84	20.5%
Governorate	North	94	22.9%
	Gaza	269	65.6%
	Middle	47	11.5%
Educational level	Diploma or University	118	28.8%
	Secondary	168	41%
	Prep. or Elementary	124	30.2%
Women working status	Working	68	16.6%
	Not working (Housewife)	342	83.4%
Husband working status	Working	240	58.5%
	Working temporary	123	30%
	Not working	47	11.55%
Average monthly income	Less than 1000 NIS	153	37.3%
	1001 – 2000 NIS	115	28%
	2001 – 3000 NIS	75	18.3%
	More than 3000 NIS	67	16.3%
Marriage years	1- 5 Yrs	170	41.46%
	6 – 10 Yrs	81	19.76%
	More than 10 Yrs	159	38.78%
Total		410	100

The study revealed that, the mean age of women who participated in the study was 28.4 years with standard deviation (SD) 7, median age was 28 years and women age ranges from 16 to 46 years old.

According to the results (Table1 and Figure1), 39.8% of participants age were less than or equal 25 years old, a similar proportion of women were within 26 to 35 age group and the rest were over 35 years with a percentage of 20.5% of study participants. According to Abu Shuaib (2005), study which discussed women's perceptions of childbirth , result shows that the mean age was 26.7 years , and the age group between 18-24 represented 41%.

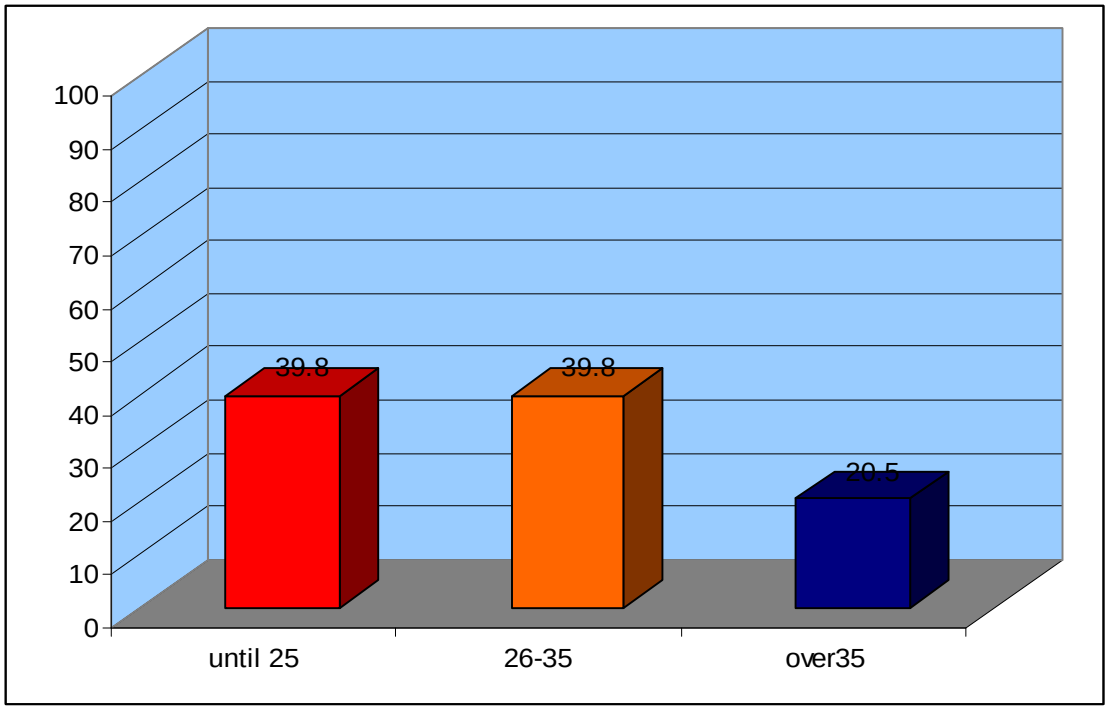

Figure 4.1: distribution of study participants by age group.

Table(1) shows the distribution of respondent's place of residence by governorate. The majority of women were living in Gaza Governorate (65.6%), followed by North Governorate(22.9%), then Middle area (11.5%) (Figure 2). There are no cases came from Khanyounis or Rafah Governorates because Naser and EGH hospitals serve and cover these areas. Mainly Shifa Hospital covers Gaza Governorate and surrounding areas like North and Middle areas which refer complicated cases.

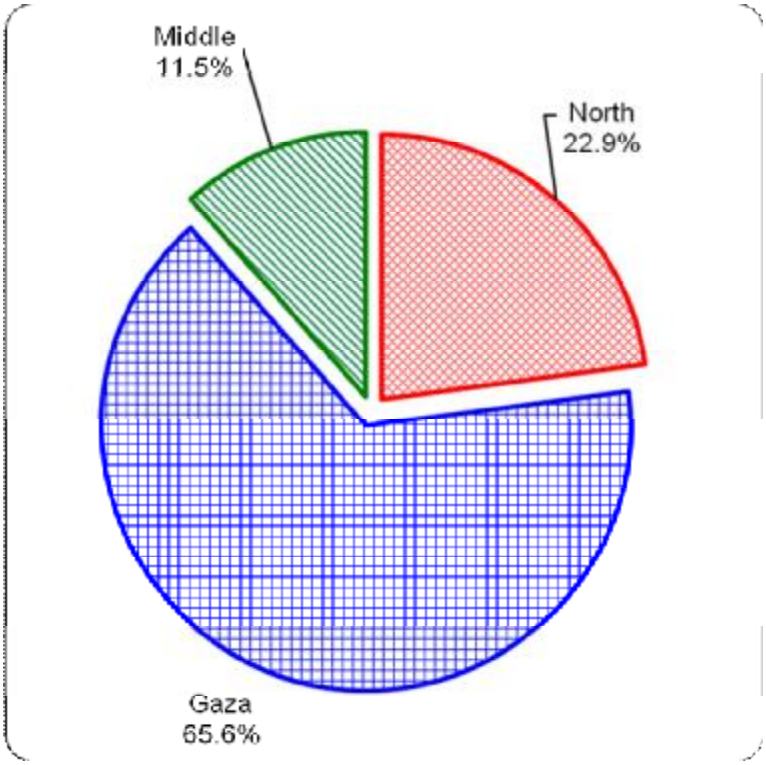

Figure 4.2 Distribution of study participants by governorate.

As shown in figure(3) the distribution of study participants by educational attainment. The percentage of women who had bachelor or diploma was 28.8%, 41% attained secondary school and 30.2% reached preparatory or elementary level. The majority of women reached till secondary level (elementary, prep. or secondary) which represented 71% of study participants.

A recent report conducted by PCBS (2006), found that 15.4% of women (15 years and over) were illiterate, compared with 10.2% who had diploma and above. Moreover, the percentage of females (15 Years and Over) who had bachelor and above was 3.8% in 2000 compared with 9.6 in 2006 (PCPS,2006).

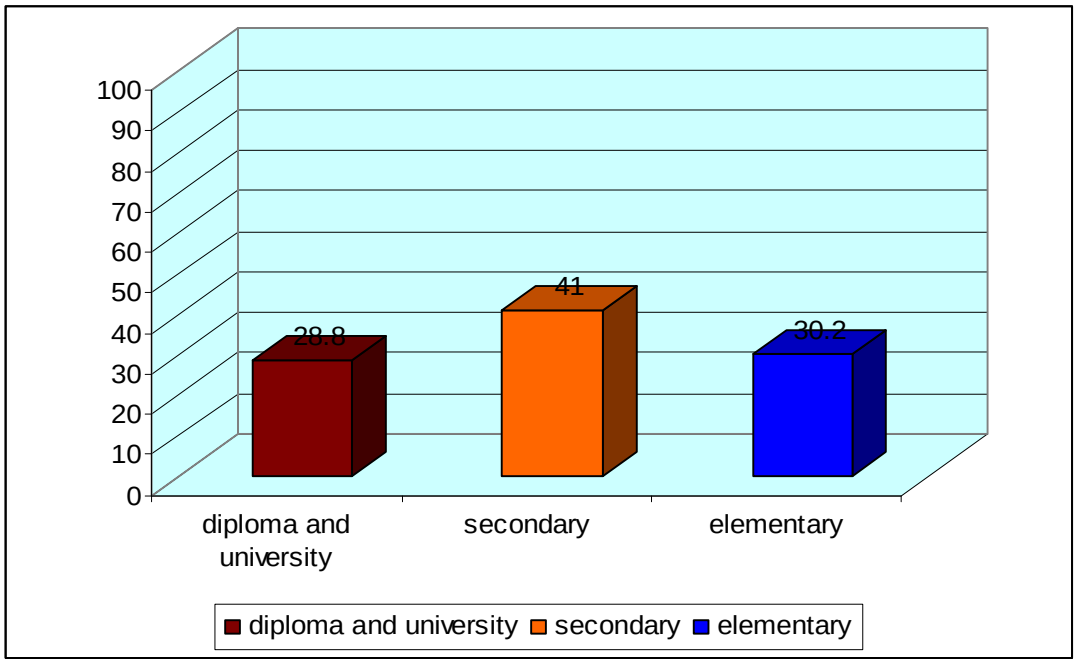

Figure4.3 distribution of study participants by educational level.

Regarding to working status, 16.6% of participants were working women compared with 83.4% who were housewives. While 58.5% of the women stated that they had working husbands and 30% had a husbands who worked on a temporary basis. In addition 11.5% of husbands were unemployed (Figure 4).

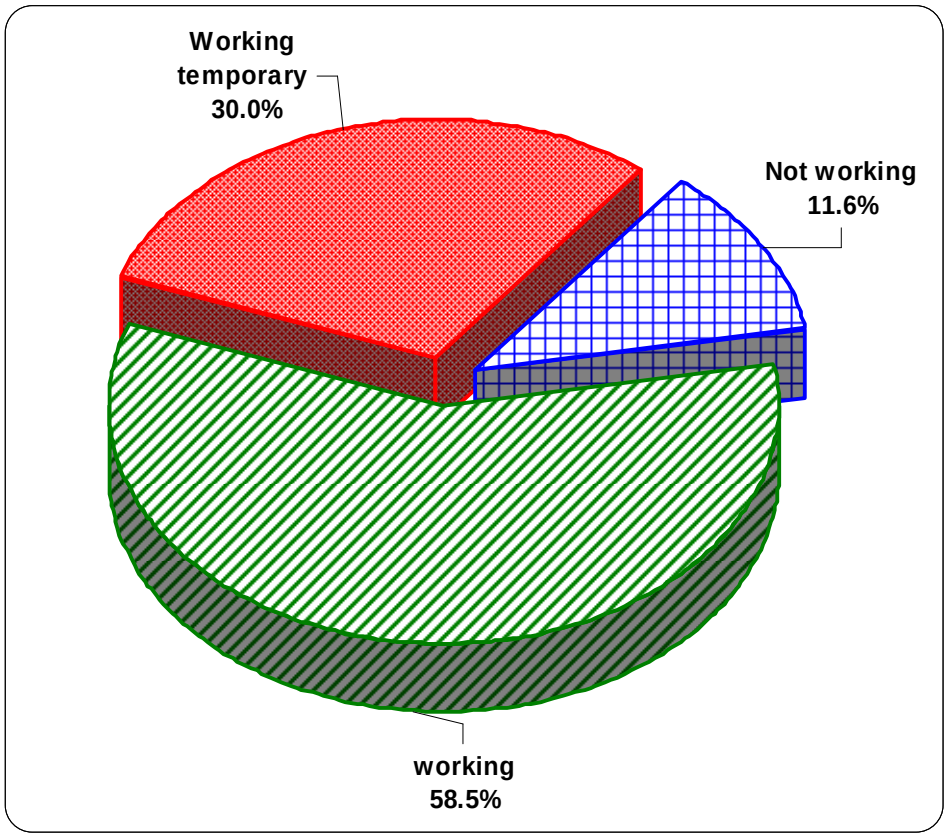

Figure 4.4 distribution of study participants by husband working status

According to the PCBS (2007), the results showed that more than 22.6% of participants in the labour force are unemployed in the 1st quarter 2008. (19.0% in the west Bank and 29.8% in Gaza Strip). Unemployment rate reached 21.7% among females compared with 22.7% among males. Unemployment rate in the Palestinian Territory is considered very high compared to other countries; for instance unemployment rate was 14.0% in Jordan and 8.4% in Israel in 2006. In the GS the

highest unemployment rate was in Khan Younis Governorate, at 38.8% followed by 33.1% in Deir Albalah Governorate, and the lowest was in Gaza Governorate at 24.9% during the 1st quarter 2008 (PCBS 2007).

According to women and men in Palestine issues and statistics (PCBS, 2007), the percentage of unemployment for women in the year 2001 was 14.1%. It increased during 2003- 2004-2005 and eventually amounted to 18.0% during the second quarter 2007. According to PCBS labour force survey database 1995 – 2007, the women participation rate in labour force (15 years and over) in the year 2001 was 10.3%.9 (PCBS 2007).

The current study revealed that the average household monthly income was 1800 NIS. It is worth to mentioning that 10.5% of the women stated that " household monthly income ranges from 0 to 300 NIS " . These extreme values will decrease the average monthly income. Generally, there was a tendency of understating the household monthly income between study participants. As indicated in table (1), 37.3% of study participants' household monthly income was less than 1000 NIS, 28% within (1001 – 2000 NIS) income category and these groups represent two-thirds of study respondents (65.4%). While 18.3% of study participants' household monthly income fell in 2001 and 3000 NIS band and 16.3% with household monthly income more than 3000 NIS.

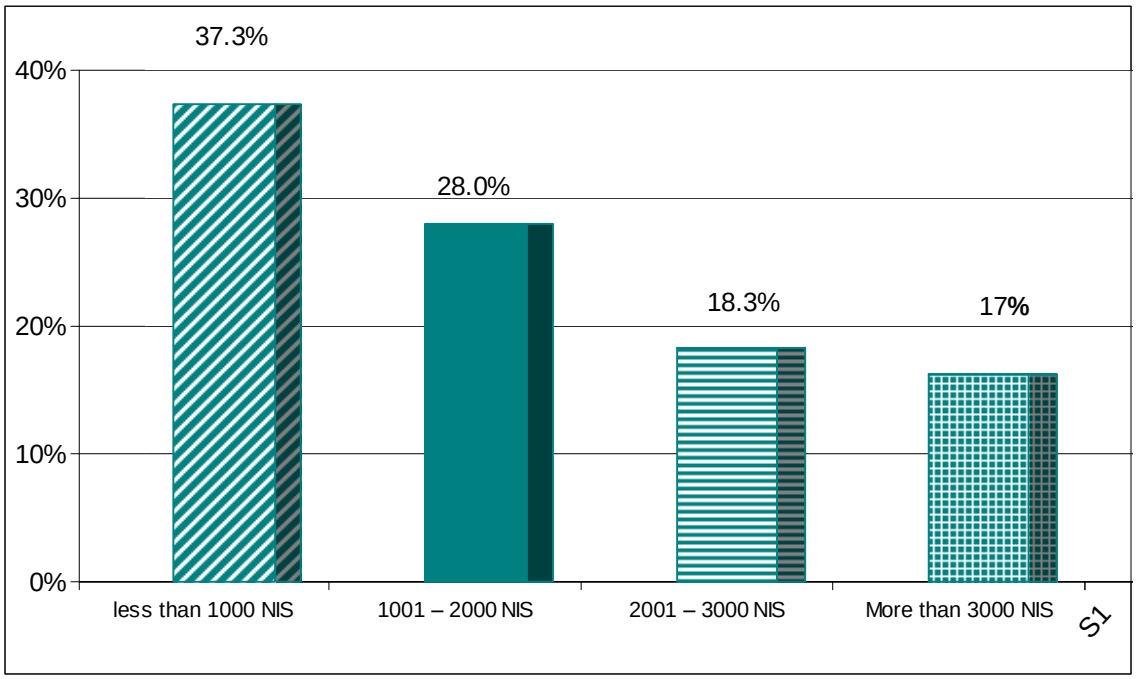

Figure 4.5: Distribution of study participants by husband monthly income.

The median household income, was NIS 2,600 prior to the Intifada, dropped to NIS 1,600, and some 51.6% of the WB and GS households had lost over 50% of their income during the second half of 2005 (PCBS, 2006). The average daily net wage in Sept. 2007 was 77.1 NIS in the West Bank and NIS 64.1 in Gaza (PCBS, 2007).

Table 4.2: Distribution of subjects by marriage age and number of pregnancies

Marriage age (Years)	Frequency	Percentage	Average number of pregnancies
less than 18	114	27.8%	5.8
18 – 19	161	39.3%	4.2
20 – 35	135	32.9%	3.1
Total	410	100.0%	4.2951

Regarding marriage age and number of pregnancies, the study found that 27.8% of participating women got married before the age of 18 years and the average number of pregnancies was 5.83, while 39.3% of them got married at the age of 18 to 19 years with an average number of pregnancies of 4.2. Furthermore 32.9% of participants got married after the age of 20 with average number of pregnancies of 3.1 times.

As shown in table (.2), the average number of pregnancies for study participants was 4.29 times and there was an inverse relationship between number of pregnancies and marriage age.

4.1.2 Information about child birth experience:

The study participants showed many variations regarding women childbirth experience:

The study results revealed that 37.5% of women were admitted to Shifa Hospital during evening and night shifts compared to 62.5% admitted during morning shift. It was observed that 54.9 % of women took less than 8 hours to give birth, while 24.1% of deliveries took more than 16 hours. The study results showed that 43.2% of women who were surveyed about their experience of childbirth reported that "It was their first time to give birth at Shifa Hospital.", and 27.5% of women had a previous experience of childbirth. (Annex)

Regarding delivery mode, in total 68.3% of the study participants had normal vaginal delivery, compared to 31.7% of women who had Caesarean- Section (CS) deliveries, 52.3% of CS cases were their first time to had CS delivery. Moreover, 24.4 % of study participants had a previous CS delivery. It was found that, 130 cases with a percent of 43.9 of all mothers who delivered vaginally had episiotomies. The results of Palestinian family health survey (PCBS, 2006) found that the percentage

distribution of last birth by delivery type, 75% of women delivered normally, 15% with caesarean section, 2.7% were suction and forceps lastly 6.5% was episiotomy.(PCBS, 2006).

Women were asked about the reason for choosing Shifa Hospital as a place for birth, The main reason was referral from other health centers (47%), (High risk women, Need for neonatal care unit NCCU …etc), followed by previous experience (14.1%), then private doctor works there (12.4%).

4.2 Dimensions of women satisfaction: All 64 items in the questionnaire six subscales are used to score the women satisfaction with obstetric care and constructed as a statement of opinion, each item is accompanied by five responses categories (Strongly agree, Agree, Uncertain, Disagree, strongly disagree).

The patient satisfaction questionnaire taps global women satisfaction with medical care as well as satisfaction with six different aspects of care (multi- item subscales/ dimensions): technical competency, availability and responsiveness of services, information and communication, interpersonal manner and physical environment.

Item scoring rules depend on whether the item represents a favorable or unfavorable opinion about obstetric care. Women indicate the degree of agreement or disagreement with each item on a five Likert scale. All subscales are scored so that higher scores indicate greater satisfaction with the aspect of care or dimension on a scale of 1 (strongly disagree) to 5 (strongly agree). Items within each subscale are simply averaged to compute the subscale score and then transformed linearly into 1 – 100 scale formats by multiplying subscale score by 20 and categorized into five categories as shown in table (3).The overall satisfaction level was 61.8% and in

different satisfaction dimensions, the level of satisfaction about obstetric care received at Shifa Hospital ranges from 49.3% to 69%.

Table 4.3: Women satisfaction sub dimenstions mean scores

Domain name	Mean	Percent	Std. Deviation	Variance
General satisfaction	3.447	68.96%	0.53	0.28
Technical competency	3.302	66.05%	0.52	0.27
Availability and responsiveness of services	3.321	66.42%	0.50	0.25
Information a nd communication	2.468	49.385	0.53	0.28
Interpersonal manner	3.303	66.06%	0.48	0.23
Physical environment	2.700	54.01%	0.61	0.38
Overall satisfaction	3.090	61.81%	0.40	0.16

4.2.1 General satisfaction:

General satisfaction dimension contains ten items contributing to global satisfaction with child birth experience. This includes women views on general satisfaction experience in labour and birth, meeting expectations, recommending the hospital to friends and family in addition to their trust in health providers. The majority of respondents were within 61 to 80 score (70.7%).

The overall measure of general satisfaction domain was 68.9 scores on a scale of 100, meaning that women have a moderate level of satisfaction on this dimension. This is

consistent with the reported level in other studies. In congruence with Al Hindi (2002), study which was conducted to assess the degree of client satisfaction with radiology services at Shifa Hospital the researcher reported that the overall satisfaction level 82.5% and she attributed this result to the difficult political and socio-economic situation of Palestinian people which might lowered their expectation and have resulted in a high satisfaction level (Al Hindi, 2002).

Another study was conducted in GS and WB which investigated the Palestinian satisfaction with health services provided by MOH the result should that 61.9% of the client should high level of satisfaction with health services as overall (Abu Dayya, 2000). Abu Dayya attributed the high level of satisfaction of Palestinian people to the limited expectation with regard to the difficult political and socio-economic situation in the Palestinian territory (Abu Dayya, 2000).

Mousa (2000), conducted a study in the GS to assess client's satisfaction with family planning services, the investigator reported that overall satisfaction as expressed by the Palestinian women was 72% and only 28% of them were dissatisfied (Mousa, 2000). The result reported was lower than the result revealed with El Haj (2008), study which was conducted in European Gaza Hospital to examine the perception of hospitalized patients about the services. The researcher reported that the patient reported high degree of perspective with hospital services 78% (El Haj, 2008). El Haj attributed the high level of satisfaction of Palestinian people to the political, economical and social factors of the population which made the patient accept the health services even they were not satisfy with it. The expectation of the Palestinian patients were low due to the closure of GS the Israeli sanctions against the civil population living there. Moreover, the people want to support the elected government against the attacks of the Israeli occupational forces (El Haj, 2008).

In general and in spite of the quality concerns of the health care services as Massoud reported in his situational analysis about health care in Palestine (Massoud, 1994), the findings from this study indicate that woman reported relatively moderate degree of satisfaction with child birth services (68.9%). This is consistent with other patient satisfaction studies discussed before. The social and cultural factors of the Palestinian society might have made the women appraise the services even they were not satisfied. The women may enter the health care system with low expectation because of the information provided by the community, relatives, mass media and the generally unfavorable social attitude towards the governmental hospital's services.

More than (82%) of participants in agreement with "There are things about health service delivery that need to be improved". The majority of women (76%) were satisfied with gender of health provider. The proportion of women who disagree with the opinion "I have received health service that I expected" was 40.5%, however a similar proportion 42% agree with the same statement. 43% of women indicated that, labour and childbirth experience didn't go smoothly.

The researcher attributes the low level of client satisfaction especially in the sphere of physical environment .GS has suffered from complete siege for three years , health sector is one of the sectors that is affected by the present condition. The study setting is considered the central hospital in Gaza and renders its services to all citizen .Its needs more than any other hospital in Gaza strip. Seige negatively impacts strongly on the quality of services.

4.2.2 Technical competency:

Technical competency dimension contains eight items contributing to global satisfaction with child birth experience. This includes women views on continuous fetal monitoring, pain control, medical staff response, help and support in induction. In addition to, women perception about child birth compared with previous experience. the majority of respondents were within 61 to 80 score (70.7%).

The overall measure of technical competency domain was 66 scores on a scale of 100, meaning that women have a moderate level of satisfaction on this dimension. Study participants pointed to most important issues regarding this dimension:

A high percentage of women (85%) described their transferring way between obstetrics units in a good way. (82%) reported that "During labour and birth, both myself and the baby were continuously observed.."

Patients are likely to have expectations of the technical competency of their professionals. The technical competency is an important element to evaluate the quality of health services (Donabedian 1988). Divided health care activities into two domains: technical and interpersonal, the technical domain refers to the application of the science and technology of health care, whereas interpersonal aspects of care involve the social-psychological component of the health care provider-patient relationship included the interpersonal domain are confidentiality, concern, empathy, and effective communication (Donabedian, 1988). To enhance client satisfaction regarding health providers skills and Professionalism domain, health providers may need to increased their knowledge about client health condition and treatment, providers can engage in training courses to improve the technical skills effectiveness and increase capability of their profession.

4.2.3 Responsiveness and availability of services:

Dimension of responsiveness and availability of services contains eleven items contributing to global satisfaction with child birth experience. This includes women views on waiting time, availability of doctors, nurses and medications in addition to cooperation between medical staff. The majority of respondents were within 61 to 80 score (67.6%). The overall measure of responsiveness and availability of services domain was 66.4 scores on a scale of 100, meaning that women have a moderate level of satisfaction on this dimension. Study participants pointed to most important issues regarding this dimension:

More than (82%),of participants reported that "scheduled medical procedures and tests performed on time without delay." And 75% of women in disagreement with the statement "I had to wait unnecessary long time during the admission process." Meaning admission was handled promptly. About the availability of nurses and the ability to reach them for help, 77.8% of women answered they haven't any problem with that.

Abu Saileek (2004), conducted a study which examined the clients satisfaction with nursing care provided at selected hospitals in GS. The researcher reported that the higher satisfaction level regarding availability and responsiveness was in the European Gaza Hospital (83.8%) while the lowest level of satisfaction reported in Nasser Hospital (62.9%).In consistent with Al-Hindi (2002), study which reported that the clients' reported moderate satisfaction level (82.5%) with the availability of the services

4.2.4 Information and communication:

Providing women with enough information is important to encourage their involvement in decisions about their care and treatment. Women were asked if they had been given enough information and explanations during labour, birth and after the birth of their baby. Information and communication dimension contains fourteen items (14) tapping satisfaction with child birth experience in this issue. The majority of respondents were within 41 to 60 score (68.8%). The overall measure of women responses about amount of information and communication domain was 49.4 scores on a scale of 100, meaning that women have a low level of satisfaction on this dimension.

Study participants pointed to most important issues regarding this dimension:

Women responses from information and communication domain items support the same results above, the majority of women (88%) disagree with statement "Medical staff introduced themselves to me", and a similar proportion also disagrees with statement "The doctor or nurse explained to me the results of lab tests in a way I could understand".

Most of the women (84.6%) were in disagreement with "One of medical staff explained the purpose and side effects of my medicines in a clear way I could understand", and 90.2% of women declared that no advice about expected danger sings after discharge.The previous results indicate that , no enough information or gaudiness were provided to patients and their families including lab tests, medicine side effects and danger signs to watch after discharge.

The importance of communication as one of the satisfaction domains was emphasized in the literature. For example study conducted by Abu Saileek (2004). who examined the clients satisfaction with nursing care provided at selected

hospitals in GS should that 67.4% of clients were satisfied with information and interaction diminution. Al Hindi (2002) conducted a study which investigated clients satisfaction with radiology services. The researcher reported that communication and interaction as expressed by Palestinians clients was 77.5% satisfied and 22.5% dissatisfied. Mousa (2000), conducted a study about clients satisfaction with family planning services in GS and should that communication and interaction were reported to have the lowest degree of satisfaction only 45% of the respondents were satisfied

This study showed that communication and interaction were reported to have the lowest degree of satisfaction which reflect the nature of health providers working in obstetric department and huge amount of work. Improving communication could be achieved by providing training courses in therapeutic communication including listening skills, silence, information material, reducing distance, seeking clarification , acknowledgment .

4.2.5 Interpersonal manner:

Interpersonal manner dimension contains ten items contributing to global satisfaction with child birth experience. This includes women views on medical staff attitudes such as support, encouragement and kindness. Women were asked if they had been treated with respect, humanity and dignity by medical staff in addition maintenance of privacy level and involvement in decision making. The majority of responses were within 61 to 80 score (73.4%). The overall measure of interpersonal manner domain was 66 scores on a scale of 100, meaning that women have a moderate level of satisfaction on this dimension. Compared with Abu Shuaib (2005), study which included privacy, his finding showed that privacy dimension reported 78.6% perception level. Abu Saleek (2004), study showed that

the clients reported lower level of satisfaction 69.7% with privacy. Al Hindi (2002), study showed that the clients reported higher level of satisfaction 90% with comfort and privacy .Anyhow, hospital staff has to do more in this issue by providing privacy when needed, respect patient privacy, dignity and confidentiality.

4.2.6 Physical environment:

Physical environment dimension contains eleven items contributing to global satisfaction with child birth experience. This includes women views on the cleanliness of wards, toilets/bathrooms both in the labour and delivery rooms. In addition to temperature, noise level at night and food. The majority of responses were within 41 to 60 score (62.2%). The overall measure of physical environment domain was 54 scores on a scale of 100, meaning that women have a low level of satisfaction on this dimension. Compared with Abu Saleek (2004) study, which reported 69.7% satisfaction level with comfort and environment domain. Also Al-Hindi (2002) study, reported the highest level of satisfaction 90% with comfort and privacy.

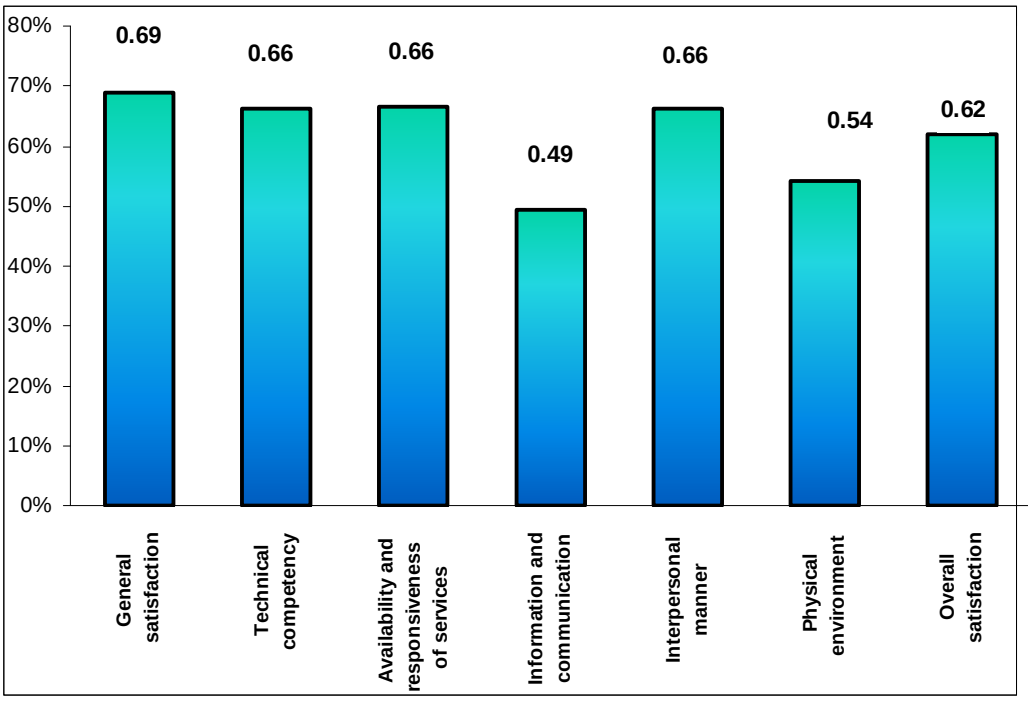

Figure 4. 6 : Means of women satisfaction dimension

The literature appears mixed on the importance of patients' demographic and social factors in determining satisfaction. Many studies tried to explore the relationship between these factors and satisfaction in order to understand such relationship . Some studies showed that patient demographics are a minor factor in patient satisfaction (Calnan et al 1994)while others concluded that demographics represent 90 percent to 95 percent of the variance in rates of satisfaction (Sixma et al, 1998). Nevertheless, the literature does shed some light on how particular demographic factors affect patient satisfaction.

Table 4.4: Difference between age groups regarding women satisfaction mean scores:

Dep. Variables Satisfaction Domains	Age group (Years)	Mean	Ind. Variable Age	Sum of Squares	df	Mean Square	F	Sig.
General satisfaction	Below 25	3.22	Between Groups	16.446	2	8.223	33.132	.001
	26- 35	3.52	Within Groups	101.017	407	.248		
	Over 35	3.75	Total	117.463	409			
Technical competency	Below 25	3.12	Between Groups	12.504	2	6.252	25.617	.001
	26- 35	3.33	Within Groups	99.331	407	.244		
	Over 35	3.59	Total	111.835	409			
Availability and responsiveness of services	Below 25	3.14	Between Groups	13.837	2	6.919	31.240	.001
	26- 35	3.34	Within Groups	90.135	407	.221		
	Over 35	3.63	Total	103.972	409			
Information and communication	Below 25	2.37	Between Groups	2.817	2	1.408	5.086	.007
	26- 35	2.54	Within Groups	112.697	407	.277		
	Over 35	2.53	Total	115.514	409			
Interpersonal manner	Below 25	3.15	Between Groups	9.776	2	4.888	22.527	.001
	26- 35	3.31	Within Groups	88.310	407	.217		
	Over 35	3.57	Total	98.086	409			
Physical environment	Below 25	2.52	Between Groups	21.061	2	10.531	31.761	.001
	26- 35	2.65	Within Groups	134.946	407	.332		
	Over 35	3.13	Total	156.007	409			
Overall satisfaction	Below 25	2.92	Between Groups	11.215	2	5.608	39.880	.001
	26- 35	3.12	Within Groups	57.229	407	.141		
	Over 35	3.37	Total	68.444	409			

Table (4), illustrates the comparison between women satisfaction based on age groups. The results revealed statistically significant differences among groups in terms of mean satisfaction score in all dimensions (P-value =< 0.05). Scheffe multiple comparisons test showed that older age group has a higher score of satisfaction than younger one. Older age and better self-perceived health status were identified as

strong predictors of satisfaction both in obstetrical and non-obstetrical inpatient settings (Thi et al, 2002).

The effect of patient age on reported satisfaction was explored in Abu Saaleek (2004),who found that there are statistical siginificant differences in stisfaction score based on women age groups were older respondents generally record higher satisfaction level. The findings of Mousa (2000), revealed that the level of overall satisfaction was decreased as the age increased. Generally, older patients tend to be more satisfied with their health care (Pope and Mays, 1993). A possible explanations includes lower expectations of health care, reluctance to articulate their dissatisfaction and older people are more long-suffering and accepting than the young.

The researcher attributes this result to the lack of experience among the younger women and fear of experience.

Table 4.5: Differences in mean satisfaction score based on women place of residance (governorates)

Dep. Variables Satisfaction Domains	Gover.	Mean	Ind. Variable Governorate	Sum of Squares	df	Mean Square	F	Sig.
General satisfaction	North	3.49	Between Groups	.524	2	.26	.911	.403
	Gaza	3.42	Within Groups	116.9	407	.28		
	Middle	3.49	Total	117.4	409			
Technical competency	North	3.31	Between Groups	.030	2	.01	.055	.946
	Gaza	3.29	Within Groups	111.8	407	.27		
	Middle	3.31	Total	111.8	409			
Availability and responsiveness of services	North	3.36	Between Groups	.481	2	.24	.946	.389
	Gaza	3.29	Within Groups	103.4	407	.25		
	Middle	3.37	Total	103.9	409			
Information and communication	North	2.44	Between Groups	.19	2	.09	.346	.708
	Gaza	2.46	Within Groups	115.3	407	.28		
	Middle	2.52	Total	115.5	409			
Interpersonal manner	North	3.37	Between Groups	.732	2	.36	1.531	.218
	Gaza	3.27	Within Groups	97.3	407	.23		
	Middle	3.31	Total	98.0	409			
Physical environment	North	2.74	Between Groups	5.687	2	2.84	7.699	.001*
	Gaza	2.63	Within Groups	150.3	407	.36		
	Middle	3.00	Total	156	409			
Overall satisfaction	North	3.12	Between Groups	.5	2	.28	1.736	.178
	Gaza	3.06	Within Groups	67.8	407	.16		
	Middle	3.17	Total	68.4	409			

***Statistically significan:**

Table (5), illustrates the differences in mean satisfaction scores based on women place of residance, the results of one way ANOVA test indicate there were no statistically significant differences between dependent variable (satisfaction score) based on respondents place of residance.

Abu Shuaib (2004), found statistical siginificant differences in stisfaction score based on women place of residance (governorates); women who lived in Rafah had more

positive perspective than women who lived in other provinces, while, women who were living in Gaza province reported the lowest score. higher satisfaction levels were reported by respondents living in refugee camps in GS as Mousa (2000), mentioned in his study. These results are inconsistent with our findings. This means that all palestinians are expose to the same social , political, and financial situation and requier attention regarding of the residency place.

Table 4.6: Differences in mean satisfaction score based on women's educational attainment

Dep. Variables Satisfaction Domains	Educational Level	Mean	Ind. Variable Education	Sum of Squares	do	Mean Square	F	Sig.
General satisfaction	Prep. or Elementary	3.74	Between Groups	14.7	2	7.36	29.15	.001
	Secondary	3.33	Within Groups	102.7	407	0.25		
	Diploma or university	3.32	Total	117.5	409			
Technical competency	Prep. or Elementary	3.53	Between Groups	9.4	2	4.69	18.63	.001
	Secondary	3.22	Within Groups	102.5	407	0.25		
	Diploma or university	3.18	Total	111.8	409			
Availability and responsiveness of services	Prep. or Elementary	3.58	Between Groups	11.8	2	5.89	26.02	.001
	Secondary	3.24	Within Groups	92.2	407	0.23		
	Diploma or university	3.17	Total	104.0	409			
Information and communication	Prep. or Elementary	2.48	Between Groups	1.7	2	0.85	3.05	.048
	Secondary	2.40	Within Groups	113.8	407	0.28		
	Diploma or university	2.55	Total	115.5	409			
Interpersonal manner	Prep. or Elementary	3.54	Between Groups	9.8	2	4.90	22.58	.001
	Secondary	3.20	Within Groups	88.3	407	0.22		
	Diploma or university	3.20	Total	98.1	409			
Physical environment	Prep. or Elementary	3.15	Between Groups	37.4	2	18.68	64.07	.001
	Secondary	2.58	Within Groups	118.7	407	0.29		
	Diploma or university	2.41	Total	156.0	409			
Overall satisfaction	Prep. or Elementary	3.34	Between Groups	10.7	2	5.33	37.51	.001
	Secondary	2.99	Within Groups	57.8	407	0.14		
	Diploma or university	2.97	Total	68.4	409			

Table (6) indicate that , there are a statistically significant differences in satisfaction score based on women educational attainment. Women with low educational level were more satisfied than women with high educational attainment. It is clear from the multiple comparisions results of Post-Hoc Scheffe test that , women attained preparatory school has the highest significant satisfaction score among others. Similar to our findings, McCrea and Wright found a relationship between lower educational level and childbirth satisfaction (McCrea and Wright. 1999). Green found no relationship (Green et al. 1990).

The effect of women educational attainment on reported satisfaction was considered by (Mousa, 2000). Who found statistical siginificant differences in stisfaction score based on women educational level. Concluding higher educational levels were associated with lower satisfaction scores .This findings is not consistent with Abu Shuaib (2005), who found no siginficatint statistical differences.

A meta-analysis conducted by Hall and Dornan, which focused on socio-demographic factors, found that satisfaction was statistically significantly related to higher age and less education, and marginally related to marital status and higher social status (Hall &Dornan 1990). Evidance from Singh et al (1998), found that the percentage of satisfied patients decreased with increasing level of educational attainment.

The researcher attributed this study finding to the high level of expectation among educated women because of the high expectation, knowledge relationship so their needs is more.

Table 4.7: Differences in mean satisfaction scores based on women working satus

Dep. Variable Satisfaction Domains	Women working status	N	Mean	Std. Deviation	t	Sag
General satisfaction	Working	68	3.28	.581	-2.496	.014*
	Housewife	342	3.47	.521		
Technical competency	Working	68	3.16	.584	-2.45	.014*
	Housewife	342	3.33	.506		
Availability and responsiveness of services	Working	68	3.14	.479	-3.228	002*
	Housewife	342	3.35	.502		
Information and communication	Working	68	2.61	.657	2.561	.011*
	Housewife	342	2.43	.498		
Interpersonal manner	Working	68	3.17	.472	-2.489	.014*
	Housewife	342	3.32	.489		
Physical environment	Working	68	2.34	.475	-5.397	.0008*
	Housewife	342	2.77	.618		
Overall satisfaction	Working	68	2.95	.418	-2.936	.004*
	Housewife	342	3.11	.402		

***Statistically significant**

Table (7) shows that working women had overall mean satisfaction score of 2.9555 which is lower than housewife women 3.1175. The differences between two groups were statistically significant in all satisfaction dimensions (P- value =<0.05).

This result was not consistant with (Abu-Shuaib, 2004) study who found that there is no significant statistical differences between working and not working women . The same result has been founded by (AL-Hindi, 2002). Lower satisfaction of working women found in this study may be attributed to their higher expectation possibly, due to more exposure to option of medical care and wider experiences.

Table 4.8: Differences in mean satisfaction scores based on hasband working satus

Dep. Variables Satisfaction Domains		Mean	Ind. Variable	Sum of Squares	df	Mean Square	F	Sig.
General satisfaction	Working	3.33	Between Groups	7.4	2	3.7	13.779	.001
	Temporary	3.56	Within Groups	110.4	407	.27		
	Not working	3.70	Total	117.4	409			
Technical competency	Working	3.22	Between Groups	5.2	2	2.6	9.977	.001
	Temporary	3.33	Within Groups	106.6	407	.26		
	Not working	3.58	Total	111.8	409			
Availability and responsiveness of services	Working	3.23	Between Groups	6.4	2	3.2	13.365	.001
	Temporary	3.37	Within Groups	97.5	407	.24		
	Not working	3.62	Total	103.9	409			
Information and communication	Working	2.46	Between Groups	.6	2	.34	1.204	.301
	Temporary	2.43	Within Groups	114.8	407	.28		
	Not working	2.57	Total	115.5	409			
Interpersonal manner	Working	3.24	Between Groups	2.2	2	1.1	4.837	.008
	Temporary	3.35	Within Groups	95.8	407	.23		
	Not working	3.45	Total	98.0	409			
Physical environment	Working	2.52	Between Groups	22.2	2	11.1	33.814	.001
	Temporary	2.86	Within Groups	133.7	407	.32		
	Not working	3.18	Total	156.0	409			
Overall satisfaction	Working	3.00	Between Groups	5.5	2	2.7	17.880	.001
	Temporary	3.15	Within Groups	62.9	407	.15		
	Not working	3.3	Total	68.4	409			

***Statistically significant**

Table (8) illustrates the comparison between women satisfaction based on husband working status. The results revealed statistically significant differences among groups in terms of mean satisfaction score in all dimensions (P-value =< 0.05).

Scheffe multiple comparisons test showed that women with unemployed husbands have a higher score of satisfaction, while working husband group reported the lowest score of satisfaction. The effect of employment status on reported satisfaction was considered by El Haj (2008), who found no statistical significant differences in

satisfaction score based on employment status. Similary, Abu Shuoaib (2005), found no statistically significant differences regarding employment status. A study by Goodman (2003), showed that women who had childbirth preparation, expectations for labour met, a higher level of education and employment had higher level of satisfaction with the childbirth experience. The researcher attributes these findings is that those of higher financial status have the facilities and opportunities to present themselves adequately to the service providers

Table 4.9: Differences in mean satisfaction scores based on household monthly income

Dep. Variable Satisfaction Domains	Monthly Income	N	Mean	Std. Deviation	t	Sig
General satisfaction	Less than2000 NIS	245	3.57	.481	6.202	.001*
	More than 2000 NIS	165	3.25	.557		
Technical competency	Less than 2000 NIS	245	3.39	.458	4.700	.001*
	More than 2000 NIS	165	3.15	.577		
Availability and responsiveness of services	Less than 2000 NIS	245	3.44	.467	6.140	.001*
	More than 2000 NIS	165	3.14	.504		
Information and communication	Less than 2000 NIS	245	2.47	.460	.059	.953
	More than 2000 NIS	165	2.46	.623		
Interpersonal manner	Less than 2000 NIS	245	3.38	.445	4.066	.001*
	More than 2000 NIS	165	3.18	.527		
Physical environment	Less than 2000 NIS	245	2.93	.591	10.314	.001*
	More than 2000 NIS	165	2.35	.484		
Overall satisfaction	Less than 2000 NIS	245	3.20	.367	6.849	.001*
	More than 2000 NIS	165	2.92	.413		

***Statistically significant**

The results in the previous table revealed that women who have a household monthly income of less than 2000 NIS reported a higher mean score of satisfaction than women with household income more than 2000 NIS. Differences between the two groups

were statistically significant at 0.05 level. This result is not consistent with Mousa (2000) study, who revealed no statistically significant differences between the economical status regarding to the satisfaction level .In contrast to our findings Al hindi (2002) , found that respondents with higher financial status tend to be more satisfied than respondents with lower financial status.

The effect of income on reported satisfaction was explored in a literature review of 14 studies. It was not significant in nine cases. Higher income was associated with greater satisfaction with doctors' and people with lower incomes have been observed to report more problems with in-hospital stays (Rogut et al, 1996). In two investigations, set in the USA, higher income groups were more likely to want to change their health plan (Kerr et al, 1998). The researcher attributes the findings of this study to the assumption that those with higher financial status have the facilities and opportunities to present themselves adequately to the service providers so the patient who have higher income tend to have higher expectation.

Table 4.10: Differences in mean satisfaction scores based on women marriage age

Dep. Variable Satisfaction Domains	Marriage age	N	Mean	Std. Deviation	t	Sig
General satisfaction	15 – 18	223	3.48	.541	1.549	.122
	over 18	187	3.40	.527		
Technical competency	15 – 18	223	3.31	.499	.511	.610
	over 18	187	3.28	.550		
Availability and responsiveness of services	15 – 18	223	3.36	.476	2.130	.034*
	over 18	187	3.26	.531		
Information and communication	15 – 18	223	2.40	.455	-2.517	.010*
	over 18	187	2.54	.603		
Interpersonal manner	15 – 18	223	3.34	.455	2.047	.041*
	over18	187	3.24	.523		
Physical environment	15 – 18	223	2.78	.629	3.236	.001*
	over 18	187	2.59	.587		
Overall satisfaction	15 – 18	223	3.11	.400	1.542	.124
	over 18	187	3.05	.417		

***Statistically significant**

Table shows differences in mean satisfaction scores in terms of women marriage age groups, the results of t- test indicate there was statistically differences between two groups regarding "Availability and responsiveness of services", "Information and communication" ," Interpersonal manner", "Physical environment" and "Overall satisfaction" dimenstions where p-value was less than or 0.05.

Brown and Lumley found no association between maternal age, marital status or country of birth and satisfaction with intra partum(Brown & Lumley 1994).

Abu shuaib (2005) study, revealed significant statistical differences only between the age at first marriage and counseling and in contrast analysis. The findings showed that those women who were married at age more than 32 years tend to be more

satisfied while the women who married at age 23-27 years reported the lower level of satisfaction .

Table 4.11: Differences in satisfaction score according to admission time

Dep. Variable Satisfaction Domains	Admission time	N	Mean	Std. Deviation	t	Sig
General satisfaction	8 – 14	248	3.52	.499	3.486	.001*
	After 14	162	3.33	.570		
Technical competency	8 – 14	248	3.36	.483	3.117	.002*
	After 14	162	3.20	.565		
Availability and responsiveness of services	8 – 14	248	3.38	.485	3.105	.002*
	After 14	162	3.22	.517		
Information and communication	8 – 14	248	2.48	.540	.667	.505
	After 14	162	2.44	.517		
Interpersonal manner	8 – 14	248	3.33	.439	1.761	.079
	After 14	162	3.25	.555		
Physical environment	8 – 14	248	2.73	.611	1.293	.197
	After 14	162	2.65	.625		
Overall satisfaction	8 – 14	248	3.13	.378	2.893	.004*
	After 14	162	3.01	.443		

***Statistically significant**

Table (11) shows that the overall mean satisfaction score of women who were admitted during morning shift was higher than women who were admitted after 2 PM. The differences between two groups were statistically significant in all satisfaction dimensions (P- value =<0.05). The researcher attributes this study result to the large number of team work at the morning shift compared to the afternoon shift. The physical environment is cleaner than the afternoon shift and finally the monitoring and follow up are given more attention than the afternoon shift.

Table 4.12: Differences in satisfaction scores by delivery periode

Dep. Variable Satisfaction Domains	Delivery periode	N	Mean	Std. Deviation	t	Sig
General satisfaction	within 8 hrs	240	3.5929	.43052	6.873	.001
	More 8 Hrs	170	3.2429	.60067		
Technical competency	within 8 hrs	240	3.4238	.43851	5.807	.001
	More 8 Hr	170	3.1309	.58248		
Availability and responsiveness of services	within 8 hrs	240	3.4566	.45093	6.812	.001
	More 8 Hr	170	3.1299	.51462		
Information and communication	within 8 hrs	240	2.5310	.55040	2.884	.004
	More 8 Hr	170	2.3815	.49188		
Interpersonal manner	within 8 hrs	240	3.4158	.46573	5.748	.001
	More 8 Hr	170	3.1441	.47976		
Physical environment	within 8 hrs	240	2.7519	.58342	2.013	.049
	More 8 Hr	170	2.6277	.65778		
Overall satisfaction	within 8 hrs	240	3.1953	.35043	6.456	.001
	More 8 Hr	170	2.9429	.44022		

Table (12) shows that the overall mean satisfaction score of women who gave birth within 8 hrs was higher than women who delivered in more than 8 hrs. The differences between two groups were statistically significant in all satisfaction dimensions (P- value =<0.05). This result is consistant with Abu Shuaib (2005), who found that the women who delivered in period less than 6 hours, were more satisfied than thoes who delivered in period more than 48 hours from admission. The explanation of this finding might be related to waiting time, waiting is difficult in normal situation, this difficulty is increased when the woman is waiting for her baby, with times she fears from unknown about her baby and her health condition. Also, this dissatisfaction could be related to lack of reassurance, bad interactions and communication from health providers.

Table 4.13: Differences in satisfaction scores by women prior experience of giving birth at Shifa Hospital

Dep. Variable Satisfaction Domains	First time at Shifa	N	Mean	Std. Deviation	t	Sig
General satisfaction	Yes	177	3.25	.591	-6.712	.001*
	No	232	3.59	.436		
Technical competency	Yes	177	3.15	.563	-5.025	.001*
	No	232	3.41	.462		
Availability and responsiveness of services	Yes	177	3.16	.525	-5.662	.001*
	No	232	3.44	.455		
Information and communication	Yes	177	2.44	.599	-.916	.360
	No	232	2.49	.475		
Interpersonal manner	Yes	177	3.18	.541	-4.293	.001*
	No	232	3.39	.427		
Physical environment	Yes	177	2.56	.593	-3.871	.001*
	No	232	2.80	.618		
Overall satisfaction	Yes	177	2.96	.450	-5.757	.001*
	No	232	3.18	.345		

***Statistically significant**

Table (13) shows that the overall mean satisfaction score of women with previous childbirth experience was higher than women with first time at Shifa Hospital. The differences between two groups were statistically significant in all satisfaction dimensions (P- value =<0.05).

This results are in agreement with a recent study carried out by El-Haj (2008) who found that patients who were admitted for more than one time elicited higher levels of overall perceptions. Similarly this study is consistent with Abu Saleek (2004) findings that clients who were hospitalized previously in other hospitals were more satisfied

than clients who were not hospitalized in other hospitals (patient comparison in experience between different hospitals).

The result of this study could be attributed to experience and knowledge receiving during the past childbirth will help the women to understand the hospital staff and the place becomes familiar.

Table 4.14: Differences in satisfaction scores by delivery mode

Dep. Variable Satisfaction Domains	Delivery mode	N	Mean	Std. Deviation	T	Sig
General satisfaction	Normal	280	3.43	.543	-.801	.424
	CS	130	3.47	.520		
Technical competency	Normal	280	3.28	.554	-1.207	.228
	CS	130	3.34	.445		
Availability and responsiveness of services	Normal	280	3.29	.469	-1.478	.141
	CS	130	3.37	.569		
Information and communication	Normal	280	2.42	.50	-2.548	.011
	CS	130	2.56	.583		
Interpersonal manner	Normal	280	3.29	.523	-.647	.518
	CS	130	3.32	.409		
Physical environment	Normal	280	2.63	.643	-3.528	.001
	CS	130	2.84	.531		
Overall satisfaction	Normal	280	3.05	.409	-2.262	.024
	CS	130	3.15	.402		

Table (14) shows that the overall mean satisfaction score of women who had Caesarean Section was higher than women who gave birth normally. The differences between two groups were statistically significant in all satisfaction dimensions (P-value =<0.05). Regarding mode of delivery, Abu Shuaib (2005) found there was statistically significant association between delivery mode and perceptions with childbirth services,

The researcher attribute these findings which are inconsistant with literature to the fact that the working team in the operation rooms have a long experience in the field

and they have a good human relationship with clients. Additionally, the physical environment in the post operative section is better than the other sections

4.3.1 Women description of staff during labour and childbirth experance:

Adjective checklists have been used to describe the hospital staff who cared for them during labour and child birth. The list used in the survey consisted of six pairs of positive and negative terms designed in an unbiased way. Respondents could select as many terms as they wished in describing the staff who cared for them. In this way, the checklist facilitates the emergence of a more detailed picture of obstetric care from the woman's point of view, while asking all women the same question.

Table 4.15: Positive terms selected by women to describe the staff

Adjective	Number of responses	Percent
Considerate	129	31.4%
Humorous	6	1.5%
Supportive	150	36.6%
Informative	28	6.8%
Kind	54	13.2%
Polite	54	13.2%

- Respondent could choose more than one term

The percentage of women who selected the term 'supportive' to describe the staff who looked after them during labour and birth was 36.6%. A similarly proportion selected the term 'Considerate 31.4%. The terms 'Humorous' and 'Informative' were selected less often (1.5% and 6.8).

Table 4.16: Negative terms selected by women to describe the staff

Adjective	Number of responses	Percent
Rushed	112	27.3%
Rude	27	6.6%
Unhelpful	42	10.2%
Bossy	83	20.2%
Inconsiderate	82	20%
Offhand	1	0.2%

- Respondent could choose more than one term

The more negative descriptors of care were chosen ‘Rushed’’ 27.3%, followed by ‘bossy’ 20.2%. Much smaller numbers of women perceived staff as ‘off-hand’ 0.2% or ‘Rude’ 6.6%. Overall, women selected a much higher proportion of positive terms compared to negative terms. Looking on the findings showed in the table assures that the level of staff communication with patient is less than the acceptable level especially in the style of treatment with patients. The researcher attributes this to the lack of training on skills of comunication and management. Therefore, it's recommended that future training should concentrate upon these spheres.

chapter (5)

Conclusions and recommendations

Chapter 5

Conclusions and Recommendations

5.1 Conclusions:

The current study was conducted to investigate women level of satisfaction with obstetric care received during hospitalization for delivery at Shifa Hospital. Moreover, the study aimed to identify socio-demographic and service related factors most likely to influence satisfaction. Knowledge gained from this study can help to understand patient expectations, knowing what the patients want, identifying gaps and deficiencies in delivery services, designing services to meet the needs, setting performance indicators and standards and set the direction to achieve hospital management goals. The study explored the main dimensions of women satisfaction with childbirth experience. Moreover, determined hospital, socio-demographic, economic status and women characteristics related factors most likely to affect women satisfaction. The high response rate (96.5 %) could be attributed to the approach utilized by the researcher and the convenience of the research instrument. The reliability analysis of study instrument was high with Alpha Cronbach 0.93.

The overall satisfaction level was 61.8 scores on a scale of 100, the overall women satisfaction with obstetric contains six different dimensions contributing to global satisfaction with child birth experience. This includes women views on technical competency, availability and responsiveness of services, information and communication, interpersonal manner and physical environment.

Looking at different dimensions of care instead of a single global measure illustrates a multifaceted picture of care evaluation. In different satisfaction dimensions, the level of satisfaction about obstetric care received at Shifa Hospital ranges from 49.3% to 69%. The dimension of information and communication had the lowest score meaning

that there is a bad need for improvement (49.3%). Also, women reported a low level of satisfaction toward physical environment (54%).

The study showed significant differences in women's level of satisfaction related to socio-demographic factors. Older women rated their satisfaction with child birth experience more highly than younger ones. Women with low educational level (Less than bachelor) was more satisfied than women with university degrees.

The study explained the effect of women economic status factors on reported satisfaction scores. Working women showed a lower satisfaction rate than housewives. Women with unemployed husbands have a higher level of satisfaction than working husband group. Women with a lower household monthly income had a greater satisfaction level. Additionally, the study pointed to the differences in womens satisfaction level regarding hospital admission time (Shift). Women who were admitted during morning shift reported a higher level of satisfaction than women who were admitted during evining and night shifts. Moreover, the study revealed asignificant differences in womens level of satisfaction according women prior experience of giving birth at Shifa Hospital. Women with previous childbirth experience were more satisfied than women with first time at Shifa Hospital.The study showed significant differences in women's satisfaction level related to delivery mode. Women who had Caesarean Section (CS) were more satisfied than women who gave birth normally.

Finally , the study revealed that women selected a much higher proportion of positive terms compared to negative terms to describe the attitudes of medical staff who looked after them during labour and birth.

5.2 Recommendations

- The study concluded six important dimensions that influence women satisfaction level with hospital services generally and obstetric care practically. Health policy makers, planners and managers need to consider these factors.
- There is a need to reinforce information and communication aspects through continous education and training stratigies on interpersonal skills that appreciate patient's rights and promot patient centered or oriented services and high quality of care. It means to open the communication chanels in two ways , recognizing that the patients represent the center of health care delivery and involving them in health care designation making process.
- Physical environment is another weak point that require further attention through creating and maintaining supportive environment (privacy, quiet ... etc)
- More attention should be paid to interpersonal manner aspects as a key compnent in satisfaction framwork. It implies that health care providers should listen , dissucss ,advise, give enough time , and respond to the needs and desires of patients with respect and humanity.
- Technical competency had a low satisfaction score. It is important for obstatrics services to develop clearly defined strategies regarding the assessment of the woman and her unborn baby, the diagnosis of labour, the criteria for admission, the type and timing of medical procedures performed during labour, and the support that is provided to women throughout this time.
- Patient satisfaction is a multifaceted and complex phonomena, requiring full co-operation of hospital mangers , practitioners and policy makers. Promoting

high standards of services quality which should be culturally approved and accepted.

- Every woman should be allowed to choose her own primary source of social support (one family member) to provide encouragement, advice and information supporting her during labour
- There is a need to pay more attention to younger women and render psychological support during child-birth experience. Also, increasing the level awarneness and information helps much in reaching a respectable dergree of acceptance and satisfaction.
- Since women with first hospital experince have high expectation regarding health services, increasing the level of comunication with this type of patients in addition to the respectable level of respect humanity and patience, all of these type will raise the level of satisfaction.
- More research should be applied upon the level of staff satisfaction about delivery services. In other words, we need to apply research to explore the factors that affect the low degree of comunication from the staff viewpoint.

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Annexes

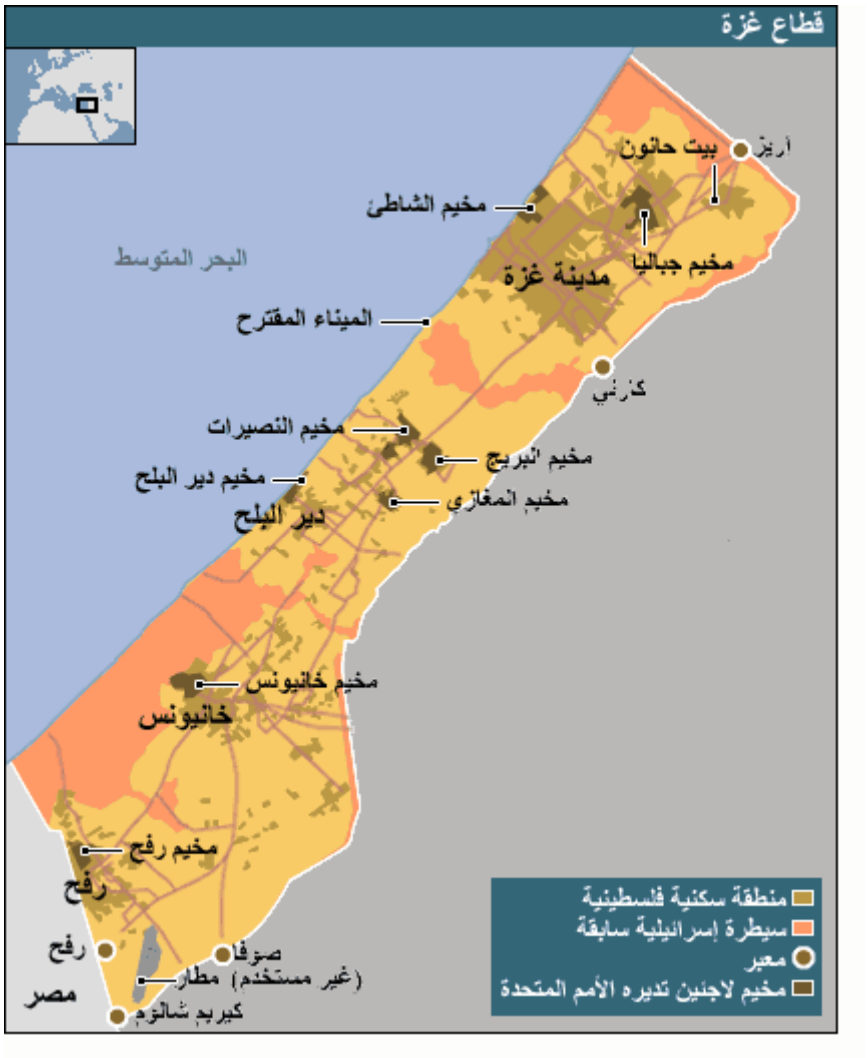
Annex 1

Map of Palestine

Source: MOH, 2000

Annex 2

Map of Gaza strip



Source :BBC Arabic
http://news.bbc.co.uk/hi/arabic/middle_east_news/newsid_5125000/5125266.stm

Annex 3

Al-Quds University
Jerusalem
School of Public Health

جامعة القدس
القدس
كلية الصحة العامة

2008/7/19

الأخ الدكتور / محمد الكاشف المحترم
مدير عام المستشفيات بوزارة الصحة
تحية طيبة وبعد،،،

الموضوع: مساعدة الطالبة عطاف أحمد

تقوم الطالبة المذكورة أعلاه بإجراء بحث بعنوان:

"Women Satisfaction About Delivery Services Provided at Shifa Hospital"

كمتطلب للحصول على درجة الماجستير في الصحة العامة-مسار إدارة صحية و عليه نرجو التكرم للإيعاز لمن تروه مناسب لتسهيل مهمة الطالبة في جمع البيانات اللازمة حيث تشمل عينة الدراسة النساء اللواتي يتلقين خدمات الولادة في مستشفى الشفاء علما بأن المعلومات ستكون متوفرة لدى الباحثة و الجامعة فقط.

و اقبلوا فائق التحية و الاحترام،،،

د. بسام أبو حمد
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Annex 4

Consent Form

Dear participant

You are selected as participant in the research " Women Satisfaction About Delivery Services Provided At Shifa Hospital.

, this study self funded is part of the requirements of the master degree of public health AL-Quads University –Palestine.

You are selected because you met the criteria for participation. The aim of this study to To assess women's level of satisfaction with obstetric care received during hospitalization for delivery at Shifa Hospital in order to improve maternity services

The time required self administered questionnaire not excess fifteen (15) minutes

There's no any risk or discomfort as result of your participation , and all information will used for the purpose of scientific research ,and will be kept confidential and anonymity will maintained , and you have the freedom to withdrawal from participation at any time.

Please answer all the questions as your opinion appropriate as there are no correct answers and wrong answers, and I will be located in the place during the data collection and ready for any question

Thank you for your participation It's very effective

Researcher: Etaf Ahmed

Annex 5

Questionnaire No ….....

Personal and socio demographic data:

Age ……. Date of admission…….

Time of admission: …….. Time of delivery: ……

Province: 1. North 2. Middle 3. Gaza City 4. khanyouns 5. Rafah.

Residency place: …….

Educational level : prep. or Elementary ☐ secondary ☐ Bachelor ☐

Work status: Yes ☐ No ☐

Husband work stats: working ☐ not working ☐ temporary working ☐

Family income:…….

Obstetrics History:……..

Age at marriage:…….. Years of marriage:…….....

Number of pregnancies …….. Number of living children:……

Is it your first delivery here: Yes ☐ No ☐

Mode of current delivery Spontaneous vaginal ☐ Forceps ☐ Ventose ☐ Cs ☐

Episiotomy Yes ☐ No ☐

Past history of cesarean delivery Yes ☐ No ☐

Number of cesarean delivery:……..

Sex and weight of newborn ☐ male ☐ female ☐ Weight

Reason for selecting shifa hospital (please check one)

Your doctor is working there ☐ Close to your home ☐ Compulsory referral

Recommendation from others ☐ Previous experience ☐ Other reasons

- Please record the level of your agreement or disagreement with each of the following statements by placing a check mark (√) in the appropriate box.
- **1- strongly disagree** 2- **disagree** 3- **undecided, 4- agree** 5- **Strongly agree**

NO	**Items**	1	2	3	4	5
1	In the general, the health service you received was satisfactory.					
2	In general, you are satisfied with the health care and services in stages before the actual delivery.					
3	. You were satisfied with the service and care during the delivery.					
4	You were satisfied with the care provided in the postnatal ward.					
5	some aspects of the health service need further improvement.					
6	. according to health service you received you will recommended the hospital to your friends or relatives.					
7	You received the appropriate health care you expected					
8	. Your delivery was easy / uneventful.					
9	. You were satisfied with the gender of the staff who looked after you.					
10	You felt you were cared for by honest and faithful staff.					
11	The staff of labor rooms was interested in your case and its findings at the the time of admission (complete medical care					
12	You were helped at the beginning of labor pains.					
13	During labor continuous medical and clinical, observations were performed.					
14	The medical staff did every thing possible to alleviate your pain.					
15	You and your fetus have been observed continuously.					
16	You had unbearable pain during labor.					
17	The recent delivery is letter and easier that the previous ones.					
18	After delivery you have been transferred to the postnatal ward in a dignified way.					
19	You felt waiting for long at admission and entry procedures.					
20	The doctors were available, with enough manpower to cope with your needs when required.					
21	The nursing staff was available, with enough manpower to cope with your needs when required.					

22	When you asked for a help you got it with a reasonable time					
23	The examination and the medical procedures were carried out in the appropriate time.					
24	when you needed help at night, the medical staff was always present and helpful.					
25	You've got all the necessary medications for your case during your stay in hospital.					
26	When you asked for a pain killer, the working staff answered you positively.					
27	You have noticed, sometimes there was a difference of opinion regarding you case.					
28	You have noticed the staff worked as a team for a better health service (fruitful teamwork)					
29	The doctors spent enough time with you explaining and answering your questions and enquiries.					
30	The staff was listening to you carefully, not ignoring your questions.					
31	The treating staff have introduced themselves to you.					
32	You have been helped by the doctor to understand clearly and of your enquiries about your case the doctor was thoughtful.					
33	The nursing staff have answered you questions fully and clearly.					
34	The doctor or nurse has informed about the results of the laboratory requests done for you, and clearly were understood.					
35	One of the staff has explained to you why you take the drugs, and the possible side effects.					
36	One of the staff has told how to recognize early warning dangerous signs regarding the postnatal period at home.					
37	One of the medical staff has told you when you can resume you daily usual work.					
38	The nursing and medical staff provided enough information about your case to your relatives to help you recover.					
39	The doctors used medical terms talking to you and didn't explain it to you.					
40	The doctor has told you about the treating obstetric procedures prior to their performance.					
41	You were informed prior to cutting and suturing the episiotomy (the tear in the perineum).					
42	You were kept informed about the progress of your labor.					

43	You were informed in advanced (prior) to any managing procedure, relating to your case.					
44	You were treated with respect and appreciation by the doctors.					
45	You were treated with respect and appreciation by the nursing staff.					
46	The labor room staff was kind and helpful.					
47	The staff was supportive, encouraging, and providing psychological and moral assistance during the delivery.					
48	You enjoyed or liked the managing doctor explaining and industring new doctors regarding your operative delivery.					
49	You have had the respectful privacy measures during the examination (presence of partition or separate room for examination).					
50	You have had your own opinion about your medical management which was respected at acted upon					
51	They have been abusive and/or offensive (using rude and insulting language).					
52	The staff favor some people for financial benefits or personal relationships.					
53	You had the feeling that the staff are careless regarding your case.					
54	The ward was always tidy and clean.					
55	The ward was prepared for rest and sleep.					
56	The ward provides privacy.					
57	The toilets were clean.					
58	The ward was wide enough with available places for sitting or resting.					
59	Hospital food was good regarding taste, temperature and variety.					
60	Linen was clean, changed regularly, and obtainable when needed.					
61	The drinking water was clean and available.					
62	Room temperature and ventilation were good.					
63	The night noise level was acceptable.					
64	Timed and restricted visiting hours					

Based on your experience: please choose either positive or negative one or more adjectives that could be related to the medical staff

==========

Adjective		Adjective	
Rushed		Considerate	
Rude		Humorous	
Unhelpful		Supportive	
Bossy		Informative	
Inconsiderate		Kind	
Offhand		Polite	

65. State more things that got your appraisal in the obstetric department

66. . State more things that you dislike in the obstetric department

67. List things that should bi improved in obstetric department to upgrade the level of health services' quality.

طلب الموافقة

الأخوات الفاضلات أرجو التكرم بالإجابة على أسئلة الاستبيان الذي تم إعداده لجمع المعلومات اللازمة لتقويم الخدمات الصحية المقدمة في أقسام النساء و الولادة في مستشفى الشفاء بغزة .

يتم هذا البحث بالتنسيق مع وزارة الصحة و جامعة القدس و ذلك كمتطلب تخرج لإنهاء درجة الماجستير في الإدارة الصحية . إن تعاونكم و موافقتكم على المشاركة و الإجابة على أسئلة الاستبيان سيكون له أهمية بالغة لانجاز هذا البحث و كذلك للارتقاء بالخدمات الصحية في مستشفى الشفاء . كما أن المعلومات الخاصة بكم و نتائج البحث ستكون في سرية تامة و لكم مطلق الحرية في المشاركة أو عدم المشاركة دون أن يكون هناك أي ضرر يلحق بكم في حال عدم المشاركة أو أي عائد مادي للمشاركة

شاكرين تعاونكم

الباحثة : عطاف أحمد

استبانه

رقم مسلسل .....

1. العمر بالسنوات ----------
2. تاريخ دخول المستشفى ؟----------
3. ساعة الدخول----------
4. المدة التي استغرقتها الولادة منذ الوصول حتى الولادة ----------
5. المحافظة/مكان السكن:

أ.شمال ب.غزة ج.الوسطى د.الجنوب

6.اسم الحي ----------

7.المستوى التعليمي

أ. إعدادي فاقل ب.ثانوي ج.دبلوم د.جامعي

8. عمل السيدة

أ.تعمل ب.لا تعمل

9.طبيعة عمل الزوج

أ.يعمل بشكل دائم ب.يعمل بشكل متقطع ج.لا يعمل

10.معدل الدخل الشهري للأسرة بالشيكل --------

11.السن عند الزواج----------

12. عدد سنوات الزواج----------

13.عدد مرات الحمل----------

14.عدد الأبناء الأحياء----------

15.هل هذه أول ولادة لك في مستشفى الشفاء

أ. نعم ب. لا

16.طبيعة الولادة الحالية

أ.طبيعي ب. قيصرية ج. شفط د. بالملقط

17. هل سبق أن ولدت ولادة قيصرية

أ. نعم ب. لا

18.عدد مرات الولادة القيصرية --------

19.جنس المولود

أ.ذكر ب.أنثى

20.وزن المولود----------

21. شق العجان Episiotomy (غرز)

أ.نعم ب. لا

22.سبب اختيار المستشفى

أ.طبيبك الخاص يعمل فيه ب.قريب من بيتك

ج.توصية من الآخرين د.تجربة سابقة

ه.تحويل إجباري و.سمعة المستشفى

ز.وجود طاقم مميز س.اخرى حددي ----------

v من فضلك اكتبي مستوي اتفاقك واختلافك مع العبارات التالية بوضع علامة (√) في الخانة المناسبة :
1- غير موافق بشدة 2- غير موافق 3- لاإرادي / متردد 4- موافق 5- موافق بشدة

الرقم	العبـــــارة	1	2	3	4	5
1	بشكل عام الخدمات التي تلقيتيها كانت مرضية .					
2	بشكل عام ، كنت راضية عن الخدمات والعناية التـــي قدمت لك في مرحلة ما قبل الولادة.					
3	كنت راضية عن الخدمات والعناية التي قدمت لك فـــي اثناء الولادة					
4	كنت راضية من الخدمات والعناية التي قدمت لك مـــا بعد الولادة (القسم)					
5	هناك بعض الأمور بحاجة إلى تحســين فـــي الخدمـــة الصحية التي تلقيتها.					
6	بناء على الخدمة الصحية التي قـــدمت لـــك ، ســـوف تنصحين باستخدام هذه الخدمات لصديق أو احد أفـــراد عائلتك.					
7	تلقيت الخدمة التي كنت تتوقعينها.					
8	تعتبرين أن ولادتك تمت بشكل سهل/ سلس.					
9	كنت راضية عن جنس مقدم الخدمة (ذكر / انثى)					
10	شعرت انك بين ايدٍ امينة					
11	عندما دخلت المستشفى كان الطاقم الطبـــي فـــي قســـم الولادة مهتما بفحص كل ما هو متعلق بحالتك الصحية					
12	الطاقم الطبي في قسم الولادة ساعدك في مرحلة بـــدء الطلق					
13	اثناء الولادة كنت تحت رقابة طبية مستمرة .					
14	الطاقم الطبي في قسم الولادة عمل كل شيء لتخفيـــف آلامك أثناء الولادة.					
15	اثناء الولادة تمت مراقبة الجنين بصفة مستمرة.					

16	واجهك ألم لا يحتمل أثناء عملية الولادة.					
17	الولادة الحالية أفضل وأسهل من الولادات السابقة.					
18	بعد الولادة تم نقلك الى القسم بطريقة لائقة.					
19	شعرت انك انتظرت وقت أكثر من اللازم أثناء إجراءات الدخول					
20	كان الأطباء متواجدين و متوفرين عند الحاجة إليهم بشكل كافي.					
21	كان التمريض متواجدين و متوفرين عند الحاجة إليهم بشكل كافي.					
22	عندما تطلبين المساعدة كنت تحصلين عليها في وقت معقول.					
23	الفحوص والإجراءات الطبية تمت في الوقت المناسب و بدون تأخير					
24	عندما احتجت إلى المساعدة في الليل كان الطاقم الطبي متوفر دائما.					
25	تمكنت من الحصول على كل الأدوية و العلاج اللازم لوضعك الصحي أثناء وجودك في المستشفى					
26	عندما طلبت مخففاُ للألم استجاب لك الطاقم العامل					
27	في بعض الأحيان شعرت أن هناك اختلاف في أراء الطاقم الطبي حول حالتك الصحية.					
28	كان الأطباء والتمريض مع بعضهم يعملون كفريق واحد لتقديم الخدمة الأفضل لك.					
29	الأطباء أمضوا وقت كاف معك للإجابة عن استفساراتك					
30	كان الفريق يصغي لك باستمرار ولم يتغاضى عن أسئلتك					
31	قام الطاقم المعالج بتقديم نفسه .					
32	إذا كان لديك استفسار عن حالتك وتوجهت به للطبيب هل قام الطبيب بالإجابة على هذه الأمور بطريقة تفهمينها.					
33	إذا كان لديك استفسار عن حالتك وتوجهت به للتمريض هل قام التمريض بالإجابة على هذه الأمور بطريقة تفهميها.					
34	قام الطبيب أو التمريض بشرح نتائج الفحوص المخبرية لك بطريقة تفهميها.					

35	قام احد أفراد الطاقم الطبي بشرح الغرض من الأدوية التي تلقيتها بشكل واضح من حيث أهميتها و أعراضها الجانبية.					
36	قام احد أفراد الطاقم الطبي بإخبارك عن علامات الخطر المحتملة بعد ذهابك للبيت.					
37	أخبرك احد أفراد الطاقم الطبي متى يمكن أن تزاولي أعمالك العادية.					
38	قدم التمريض أو الأطباء معلومات كافية لأحد أفراد أسرتك لمساعدتك على الشفاء.					
39	في بعض الأحيان استخدم الأطباء مصطلحات طبية في حديثهم معي بدون شرح المعنى .					
40	حدثك الطبيب عن الإجراءات الطبية التي سوف يقوم بها قبل القيام بعملية الولادة					
41	في حال احتجت إلى عمل غرز كشق العجان أخبرك الطبيب بذلك.					
42	زودك الفريق بمعلومات مستمرة حول تقدم عملية ولادتك.					
43	اخبرك الطاقم عن أي اجراء قبل عمله.					
44	تم التعامل معك من قبل الأطباء بتقدير و احترام.					
45	تم التعامل معك من قبل التمريض بتقدير و احترام.					
46	كان الطاقم الطبي أثناء عملية الولادة لطيف.					
47	كان الطاقم الطبي أثناء عملية الولادة يقدم الدعم النفسي ويشجعك.					
48	أعجبك ان يقوم الطبيب المشرف بالشرح للأطباء الجدد حول عملية ولادتك.					
49	توفر لديك الحد الأدنى من الخصوصية أثناء إجراء الفحص الطبي مثل وضع ستارة عازلة أو الكشف في غرفة مستقلة					
50	كان لك رأي في إجراءات علاجك و شاركت بالقرارات المتعلقة بوضعك الصحي					
51	تعرضت لألفاظ غير مستحبة من قبل الطاقم العامل					
52	طاقم المستشفى يفضل بعض المرضى عن غيرهم لاعتبارات مالية أو علاقات شخصية					
53	كان لديك إحساس بعدم مبالاة الطاقم الطبي بحالتك.					

54	كان القسم نظيفا دائما .					
55	كان القسم مهيأ للراحة والنوم .					
56	بيئة القسم توفر خصوصية جيدة للمريض					
57	القسم واسع و توجد فيه أمـــاكن مختلفـــة للجلـــوس و الراحة.					
58	المراحيض كانت نظيفة.					
59	كان الغذاء المقدم لك من قبل القسم جيد من حيث الطعم و الحرارة و التنوع					
60	كانت الشراشف و الأغطية و المساند نظيفـــة و تغيـــر باستمرار و تحصل عليها عند الحاجة					
61	كانت مياه الشرب نظيفة و متوفرة					
62	درجة الحرارة / تهوية غرفتي كانت جيدة.					
63	كان مستوى الضوضاء في الليل مقبولا.					
64	كان في القسم مواعيد و فترات محددة للزائرين					

اختاري صفة أو أكثر من هذه الصفات التي تشعرين أنها مناسبة للطاقم العامل

الرقم	الصفة	الاختيار
65	يهتم و يراعي مشاعر الآخرين	
66	ظريف وضحوك	
67	مساند ومشجع	
68	يرشد ويعطي معلومات توضيحية	
69	لطيف و ودود	
70	مؤدب ومهذب	
71	مندفع ومتسرع ولا يترك فرصة للاستفسار	
72	غير مهذب / بذيء	
73	غير متعاون وغير مساعد	
74	يتصرف كمدير	
75	لا مبالي	
76	لا يعمل شيء(مكتوف الأيدي)	

1. اذكر ما هي الأشياء التي نالت إعجابك في قسم و خدمات الولادة ؟.

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2. اذكر ما هي الأشياء السيئة في قسم و خدمات الولادة ؟.0

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3. ما هي الأمور داخل قسم الولادة التي بحاجة لتحسين لرفع مستوى جودة الخدمة الصحية المقدمة؟.

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No	statement	Strongly disagree/ Disagree	Uncertain	Agree /Strongly Agree
1	In the general, the health service you received was satisfactory.	20.0%	14.4%	65.6%
2	In general, you are satisfied with the health care and services in stages before the actual delivery.	15.9%	14.6%	69.5%
3	You were satisfied with the service and care during the delivery.	22.0%	10.0%	68.0%
4	You were satisfied with the care provided in the postnatal ward.	23.7%	14.9%	61.5%
5	some aspects of the health service need further improvement.	4.4%	13.4%	82.2%
6	according to health service you received you will recommended the hospital to your friends or relatives.	22.0%	23.9%	54.1%
7	You received the appropriate health care you expected	40.5%	17.6%	42.0%
8	. Your delivery was easy / uneventful.	43.2%	20.2%	36.6%
9	. You were satisfied with the gender of the staff who looked after you.	16.6%	7.3%	76.1%
10	You felt you were cared for by honest and faithful staff.	11.0%	22.4%	66.6%
11	The staff of labor rooms was interested in your case and its findings at the the time of admission (complete medical care).	15.6%	8.8%	75.6%

12	You were helped at the beginning of labor pains.	24.4%	21.0%	54.6%
13	During labor continuous medical and clinical, observations were performed.	16.3%	10.0%	73.7%
14	The medical staff did every thing possible to alleviate your pain.	35.5%	14.9%	49.6%
15	You and your fetus have been observed continuously.	11.5%	6.8%	81.7%
16	You had unbearable pain during labor.	12.0%	26.8%	61.2%
17	The recent delivery is letter and easier that the previous ones.	29.8%	48.8%	21.5%
18	After delivery you have been transferred to the postnatal ward in a dignified way.	9.3%	5.4%	85.4%
19	You felt waiting for long at admission and entry procedures.	75.6%	3.9%	20.5%
20	The doctors were available, with enough manpower to cope with your needs when required.	30.2%	16.6%	53.2%
21	The nursing staff was available, with enough manpower to cope with your needs when required.	9.0%	13.2%	77.8%
22	When you asked for a help you got it with a reasonable time	34.9%	21.2%	43.9%
23	The examination and the medical procedures were carried out in the appropriate time.	3.9%	14.1%	82.0%
24	when you needed help at night, the medical staff was always present and helpful.	35.1%	30.2%	34.6%
25	You've got all the necessary medications for your case during your stay in hospital.	16.1%	12.7%	71.2%
26	When you asked for a pain killer, the working staff answered you positively.	37.3%	11.0%	51.7%
27	You have noticed, sometimes there was a difference of opinion regarding you case.	53.5%	13.2%	33.3%
28	You have noticed the staff worked as a team for a better health service (fruitful teamwork)	4.6%	45.4%	50.0%
29	The doctors spent enough time with you explaining and answering your questions and enquiries.	48.8%	20.7%	30.5%

30	The staff was listening to you carefully, not ignoring your questions.	47.3%	24.9%	2738%
31	The treating staff have introduced themselves to you.	88.0%	1.2%	10.7%
32	You have been helped by the doctor to understand clearly and of your enquiries about your case the doctor was thoughtful.	32.4%	32.9%	34.6%
33	The nursing staff have answered you questions fully and clearly.	13.9%	37.8%	48.3%
34	The doctor or nurse has informed about the results of the laboratory requests done for you, and clearly were understood.	88.0%	3.9%	8.0%
35	One of the staff has explained to you why you take the drugs, and the possible side effects.	84.6%	2.4%	12.9%
36	One of the staff has told how to recognize early warning dangerous signs regarding the postnatal period at home.	90.2%	2.4%	7.3%
37	One of the medical staff has told you when you can resume you daily usual work.	93.4%	1.7%	4.9%
38	The nursing and medical staff provided enough information about your case to your relatives to help you recover.	92.9%	1.7%	5.4%
39	The doctors used medical terms talking to you and didn't explain it to you.	50.7%	13.7%	35.6%
40	The doctor has told you about the treating obstetric procedures prior to their performance.	73.2%	4.9%	22.0%
41	You were informed prior to cutting and suturing the episiotomy (the tear in the perineum).	51.2%	37.8%	11.0%
42	You were kept informed about the progress of your labor.	47.8%	19.0%	33.2%
43	You were informed in advanced (prior) to any managing procedure, relating to your case.	66.3%	5.4%	28.3%
44	You were treated with respect and appreciation by the doctors.	11.0%	24.4%	64.5%
45	You were treated with respect and appreciation by the nursing staff.	17.3%	15.9%	66.8%
46	The labor room staff was kind and helpful.	24.9%	15.4%	59.8%
47	The staff was supportive, encouraging, and providing psychological and moral assistance during the delivery.	43.9%	29.3%	26.8%

48	You enjoyed or liked the managing doctor explaining and industring new doctors regarding your operative delivery.	3.4%	1.5%	95.1%
49	You have had the respectful privacy measures during the examination (presence of partition or separate room for examination).	94.9%	1.7%	3.4%
50	You have had your own opinion about your medical management which was respected at acted upon	87.6%	2.0%	10.5%
51	They have been abusive and/or offensive (using rude and insulting language).	17.8%	32.4%	49.8%
52	The staff favor some people for financial benefits or personal relationships.	59.0%	16.1%	24.9%
53	You had the feeling that the staff are careless regarding your case.	11.0%	24.4%	64.5%
54	The ward was always tidy and clean.	17.3%	15.9%	66.8%
55	The ward was prepared for rest and sleep.	52.0%	10.2%	37.8%
56	The ward provides privacy.	69.0%	3.4%	27.6%
57	The toilets were clean.	73.9%	4.1%	22.0%
58	The ward was wide enough with available places for sitting or resting.	86.3%	4.2%	9.5%
59	Hospital food was good regarding taste, temperature and variety.	17.8%	77.6%	4.6%
60	Linen was clean, changed regularly, and obtainable when needed.	70.5%	7.6%	22.0%
61	The drinking water was clean and available.	76.6%	18.0%	5.4%
62	Room temperature and ventilation were good.	14.1%	14.9%	71.0%
63	The night noise level was acceptable.	37.1%	18.8%	44.1%
64	Timed and restricted visiting hours	9.5%	31.7%	58.8%

1. General satisfaction dimension:

No	Strongly disagree		Disagree		Uncertain		Agree		Strongly Agree		Mean	Std. Deviation
	Count	%	Count	%	Count	%	Count	%	Count	%		
1	14	3.4%	68	16.6%	59	14.4%	242	59.0%	27	6.6%	3.49	.959
2	8	2.0%	57	13.9%	60	14.6%	270	65.9%	15	3.7%	3.55	.847
3	16	3.9%	74	18.0%	41	10.0%	257	62.7%	22	5.4%	3.48	.977
4	4	1.0%	93	22.7%	61	14.9%	239	58.3%	13	3.2%	3.40	.904
5	2	.5%	16	3.9%	55	13.4%	181	44.1%	156	38.0%	4.15	.832
6	11	2.7%	79	19.3%	98	23.9%	207	50.5%	15	3.7%	3.33	.918
7	4	1.0%	162	39.5%	72	17.6%	163	39.8%	9	2.2%	3.03	.960
8	32	7.8%	145	35.4%	83	20.2%	149	36.3%	1	.2%	2.86	1.011
9	3	.7%	65	15.9%	30	7.3%	298	72.7%	14	3.4%	3.62	.816
10	12	2.9%	33	8.0%	92	22.4%	256	62.4%	17	4.1%	3.49	.959

2. Dimension of technical competency:

No	Strongly disagree		Disagree		Uncertain		Agree		Strongly Agree		Mean	Std. Deviation
	Count	%	Count	%	Count	%	Count	%	Count	%		
11	3	.7%	61	14.9%	36	8.8%	297	72.4%	13	3.2%	3.62	.801
12	8	2.0%	92	22.4%	86	21.0%	215	52.4%	9	2.2%	3.30	.908
13	4	1.0%	63	15.4%	41	10.0%	279	68.0%	23	5.6%	3.62	.846
14	16	3.9%	129	31.5%	61	14.9%	187	45.7%	16	3.9%	3.14	1.033
15	2	.5%	45	11.0%	28	6.8%	317	77.5%	17	4.2%	3.74	.726
16	1	.2%	48	11.7%	110	26.8%	177	43.2%	74	18.0%	3.67	.912
17	15	3.7%	107	26.1%	200	48.8%	84	20.5%	4	1.0%	2.89	.800
18	4	1.0%	34	8.3%	22	5.4%	342	83.4%	8	2.0%	3.77	.664

3. Dimension of responsiveness and availability of services:

No	Strongly disagree		Disagree		Uncertain		Agree		Strongly Agree		Mean	Std. Deviation
	Count	%	Count	%	Count	%	Count	%	Count	%		
19	7	1.7%	303	73.9%	16	3.9%	79	19.3%	5	1.2%	2.44	.861
20	7	1.7%	117	28.5%	68	16.6%	205	50.0%	13	3.2%	3.24	.961
21	2	.5%	35	8.5%	54	13.2%	308	75.1%	11	2.7%	3.71	.679
22	13	3.2%	130	31.7%	87	21.2%	169	41.2%	11	2.7%	3.09	.979
23	0	0	16	3.9%	58	14.1%	320	78.0%	16	3.9%	3.82	.552
24	20	4.9%	124	30.2%	124	30.2%	135	32.9%	7	1.7%	2.96	.947
25	4	1.0%	62	15.1%	52	12.7%	278	67.8%	14	3.4%	3.58	.822
26	17	4.1%	136	33.2%	45	11.0%	202	49.3%	10	2.4%	3.13	1.037
27	11	2.7%	208	50.9%	54	13.2%	117	28.6%	19	4.6%	2.82	1.028
28	3	.7%	16	3.9%	186	45.4%	190	46.3%	15	3.7%	3.48	.668
29	20	4.9%	180	43.9%	85	20.7%	118	28.8%	7	1.7%	2.79	.973

4.Dimension of information and communication:

No	Strongly disagree		disagree		Uncertain		Agree		Strongly Agree		Mean	Std. Deviation
	Count	%	Count	%	Count	%	Count	%	Count	%		
30	13	3.2%	181	44.1%	102	24.9%	106	25.9%	8	2.0%	2.79	.930
31	94	22.9%	267	65.1%	5	1.2%	43	10.5%	1	.2%	2.00	.827
32	14	3.4%	119	29.0%	135	32.9%	134	32.7%	8	2.0%	3.01	.913
33	1	.2%	56	13.7%	155	37.8%	187	45.6%	11	2.7%	3.37	.759
34	90	22.0%	271	66.1%	16	3.9%	29	7.1%	4	1.0%	1.99	.794
35	71	17.3%	276	67.3%	10	2.4%	50	12.2%	3	.7%	2.12	.860
36	98	24.0%	271	66.3%	10	2.4%	27	6.6%	3	.7%	1.94	.769
37	100	24.4%	282	68.8%	7	1.7%	19	4.6%	1	.2%	1.92	1.201
38	105	25.6%	275	67.1%	7	1.7%	19	4.6%	3	.7%	1.90	.845
39	12	2.9%	196	47.8%	56	13.7%	146	35.6%	0	0	2.82	.960
40	30	7.3%	270	65.9%	20	4.9%	85	20.7%	5	1.2%	2.43	.939
41	27	6.6%	183	44.6%	155	37.8%	41	10.0%	4	1.0%	2.54	.800
42	19	4.6%	177	43.2%	78	19.0%	129	31.5%	7	1.7%	2.82	.986
43	33	8.0%	239	58.3%	22	5.4%	110	26.8%	6	1.5%	2.55	1.017

5.Dimension of interpersonal manner:

No	Strongly disagree		Disagree		Uncertain		Agree		Strongly Agree		Mean	Std. Deviation
	Count	%	Count	%	Count	%	Count	%	Count	%		
44	4	1.0%	30	7.3%	70	17.1%	287	70.0%	19	4.6%	3.70	.713
45	3	.7%	42	10.2%	100	24.4%	248	60.5%	16	3.9%	3.59	.864
46	7	1.7%	64	15.6%	65	15.9%	257	62.7%	17	4.1%	3.52	.865
47	5	1.2%	97	23.7%	63	15.4%	227	55.4%	18	4.4%	3.38	.934
48	85	20.7%	95	23.2%	120	29.3%	102	24.9%	8	2.0%	2.64	1.124
49	1	.2%	13	3.2%	6	1.5%	374	91.2%	14	3.4%	4.11	2.394
50	156	38.0%	233	56.8%	7	1.7%	14	3.4%	0	0	1.70	.669
51	21	5.1%	338	82.4%	8	2.0%	35	8.5%	8	2.0%	2.20	.742
52	5	1.2%	68	16.6%	133	32.4%	143	34.9%	61	14.9%	3.46	.976
53	11	2.7%	231	56.3%	66	16.1%	83	20.2%	19	4.6%	2.68	.978

4. Dimension of physical environment:

No	Strongly disagree		disagree		Uncertain		Agree		Strongly Agree		Mean	Std. Deviation
	Count	%	Count	%	Count	%	Count	%	Count	%		
54	15	3.7%	129	31.5%	34	8.3%	212	51.7%	20	4.9%	3.23	1.060
55	24	5.9%	189	46.1%	42	10.2%	152	37.1%	3	.7%	2.81	1.030
56	41	10.0%	242	59.0%	14	3.4%	112	27.3%	1	.2%	2.49	1.007
57	37	9.0%	266	64.9%	17	4.1%	87	21.2%	3	.7%	2.40	.944
58	240	58.7%	113	27.6%	17	4.2%	39	9.5%	0	0	1.65	.941
59	20	4.9%	53	12.9%	318	77.6%	17	4.1%	2	.5%	2.82	.596
60	52	12.7%	237	57.8%	31	7.6%	87	21.2%	3	.7%	2.40	.981
61	208	50.7%	106	25.9%	74	18.0%	19	4.6%	3	.7%	1.79	.947
62	13	3.2%	45	11.0%	61	14.9%	280	68.3%	11	2.7%	3.56	.843
63	11	2.7%	141	34.4%	77	18.8%	173	42.2%	8	2.0%	3.06	.974
64	5	1.2%	34	8.3%	130	31.7%	232	56.6%	9	2.2%	3.50	.731

ملخص الدراسة

اكتسب رضا المرضى حديثاً اهتماماً متزايداً في الجهود المبذولة من اجل تحسين جودة الرعايـــة الصـــحية . وهذا الرضا ليس مهماً فقط من اجل فهم أعمق لوجهة نظر متلقي الخدمات فيما يتعلق بالخدمات الصـــحية و لكن أيضا كمخرج أساسي للرعاية و التي تؤثر على الأداء و الاستمرارية .

هدف هذه الدراسة هو استقصاء مستوى الرضا لدى النساء فيما يتعلق بخدمات التوليد المقدمة فـــي مستشـــفى الشفاء ، صممت هذه الدراسة كدراسة تحليلية مقطعية استخدم الباحث المقابلة بعد خروج متلقي الخدمات حيث قام الباحث بمقابلات منتظمة لعينة منتقاة من النساء و عددهم 425 حيث بلغت نسبة التجاوب 96.5% للواتي تم توليدهن خلال فترة جمع البيانات تمتع المقيـــاس بدرجـــة ثبـــات عاليـــة، بلغـــت 0.93 حســـب مقيـــاس (Cronbach's alpha)

بلغ مستوى الرضا العام 61,8% حيث كانت من أدنى المعدلات مقارنة بالدراسات التي أجريـــت فـــي هـــذا المجال في قطاع غزة . اشتمل مقياس الدراسة على ستة أبعاد تضمنت الآتي : الرضا العام ، الكفاءة المهنيـــة ، ، أسلوب التواصل بين الأشخاص ، توافر الخدمات و سرعة الاستجابة ، المعلومات و التواصـــل و أخيـــرا البيئة المادية المحيطة. حيث أظهرت الدراسة أن الأخيرتان قد سجلتا اقل الدرجات رضـــا (49.3) مقارنـــه بالأبعاد الأخرى .

أظهرت الدراسة أن النساء الأكبر سنا و النساء ذوات المستوى التعليمي المنخفض ، ربـــات البيـــوت ، ذوات الدخل الشهري المنخفض و النساء لأزواج عاطلين عن العمل كن الأكثر رضا بفارق إحصائي جوهري عـــن النساء الأخريات .

استخلصت الدراسة أيضا أن النساء اللواتي ادخلن في الفترة الصباحية و اللواتي لديهن تجربـــة ســـابقة فـــي الولادة بمستشفى الشفاء و النساء متعددات الولادة واللواتي ولدن بعملية قيصرية كـــن أكثـــر رضـــا بفـــارق إحصائي دال من تجربة ولادتهن عن الأخريات . و من بين عوامل الدراسة التي فشلت في إبراز أية دلالـــة إحصائية (مكان الإقامة ،العمر عند الزواج،جنس المولود أو جنس الشخص الذي قام بعملية التوليد.)

أخيرا قدمت الدراسة إطارا لتحسين رضا النساء عن خدمات الولادة في مستشفى الشفاء. حيث هنـــاك حاجـــة ماسة لتعزيز المعلومات و التواصل وكذلك لتحسين الوضع البنيوي (المادي) لخدمات الولادة