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The Quality of Immediate Postnatal Care in the Northern Area of West Bank: Mothers' Perspectives

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Dedication

My parents and every other family member who created the way for my accomplishment are honored in my thesis. To every midwife in Palestine who genuinely exemplifies commitment to their vocation and pursues advancement and creativity. The martyrs and all the Palestinians who gave their life for Palestine and religious sanctities across the nation are also honored in this thesis.

Saja Asri Mohammad Fayyad

Declaration

I therefore declare that, with the exception of those cases in which the contributions of others are expressly recognized, my thesis is entirely original with no submissions for consideration for any other degree at Al- Quds University or any other institution.

Signed.....

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Abstract

Introduction: The first 24 hours after childbirth are critical, with complications like hemorrhage and sepsis responsible for up to 45% of maternal deaths. Immediate postnatal care, provided within the first 24 to 48 hours, is essential for stabilizing the mother, supporting the newborn's transition, initiating breastfeeding, and reducing maternal and neonatal morbidity and mortality.

Aim: The purpose of study is to assess the perceived quality of the immediate postpartum care components offered to mothers and their newborns at childbirth facilities in the Northen area of West Bank from the mother prospective.

Methods: This research utilized a descriptive - cross-sectional design to assess the perceived quality of immediate postpartum care in the northern area of West Bank from mothers' perspectives. The main maternal and child health clinics associated with MOH in the northern region of the West Bank, Palestine, namely in Nablus, Jenin, Tubas, Qalqilya, Tulkarm, and Salfit, were the sites of this study. Data was gathered using a paper questionnaire between October 2024 and December 2024. Convenient sampling method was used among women who fulfilled the inclusion criteria to achieve the purpose of the study. Sample size was 338. The analysis was conducted using both descriptive and inferential statistical methods. Descriptive statistics summarized with frequency, percentage, means and standard deviations. For inferential analysis, an independent t test and one-way ANOVA were performed with post-hoc Bonferroni test applied for significant findings. Pearson's correlation analysis was used to examine relationships between continuous variables.

Results: Most participants were aged 24–29 years, held university degrees, and were unemployed, with most residing in urban areas. The average number of pregnancies was three, with 84.6% reporting no complications during pregnancy. More than half of the mothers experienced a normal delivery with episiotomy, and nearly half practiced exclusive breastfeeding.

The perceived quality of postpartum care during the first hour after delivery was rated positively (mean = 3.8), particularly in vital signs monitoring and bleeding checks. Care after the first hour received a slightly lower score (mean = 3.5), with strengths in pain management but weaknesses in emotional and family support. Newborn care during hospitalization also scored positively (mean = 3.8), while health education provided before discharge was rated neutral (mean = 3.2), reflecting gaps in family planning, postpartum exercise, and warning signs education. Overall maternal satisfaction was positive (mean = 3.9), with higher ratings for clinical care than for educational components.

Statistical analysis showed significant associations between higher income, number of children, hospital type, and length of hospital stay with perceived care quality. No significant correlation was found between care quality and breastfeeding continuation.

Conclusion: the clinical aspects of postpartum care are generally well-perceived, educational and supportive components remain insufficient. The study recommends enhancing staff training, improving educational interventions, and considering socioeconomic factors to improve maternal and newborn care outcomes in the region.

Key Words: Immediate Postpartum Care; Perceived quality of Care; West Bank; Mothers' Perspectives

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List of Abbreviations and Definitions

Abbreviation	Definitions
ANC	Antenatal Care
CINAHL	Cumulative Index to Nursing and Allied Health Literature
Df	Degrees of Freedom
et al	And Others
IPNC	Immediate Postnatal Care
IPPC	Immediate Postpartum Care
(IRB-AAUP committee)	Institutional Review Board of Arab American University committee
M	Mean
MOH	Ministry of Health
N	Frequency
PNC	Postnatal Care
p-Value	Probability Value
R	Correlation
SD	Standard Deviation
Sig.	Significance
SPSS	Statistical Package for the Social Sciences
UNICEF	The United Nations International Children's Emergency Fund
WHO	World Health Organization

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Chapter One:

Introduction

1.1 Background

The postnatal period, defined as the six weeks following childbirth, begins immediately after delivery. This period is widely recognized as a critical phase during which both mothers and newborns face the highest risk of mortality and morbidity. Comprehensive postnatal care (PNC) encompasses a range of services including immunization, breastfeeding support, routine health assessments, mental health screening for mothers, and guidance on infant care practices (World Health Organization [WHO], 1998).

Immediate postnatal care (IPNC) refers to the care provided during the first 24 to 48 hours after birth, a time frame crucial for the survival of both mother and newborn. The objectives of IPNC include ensuring effective neonatal breathing and thermoregulation, initiating breastfeeding, monitoring for maternal and neonatal complications, and supporting early maternal recovery. Key components involve continuous monitoring of vital signs, early skin-to-skin contact, and timely initiation of breastfeeding (Lawn et al., 2017).

International health authorities underscore the significance of IPNC in improving survival outcomes. According to WHO and UNICEF, all mothers and newborns—regardless of birth setting—should be monitored for a minimum of 24 hours following delivery to detect and manage potential complications. Quality care during this window has been shown to reduce preventable deaths and to promote better long-term health outcomes for both mother and child (UNICEF, 2018; WHO, 2022).

Proper management of common postnatal complications such as postpartum hemorrhage, sepsis, and psychological distress requires prompt and effective postnatal care. Emotional support, counseling on breastfeeding, and education on newborn care are integral to effective postnatal management. When implemented appropriately, postnatal care has been shown to significantly reduce the incidence of maternal complications such as infection, hemorrhage, and postpartum depression (Bhutta et al., 2014).

The postnatal period is therefore not only critical for physical health but also for facilitating neonatal adaptation to extrauterine life and for establishing maternal-infant bonding (WHO, 2022). PNC plays a central role in maternal and neonatal health systems, as it enables early identification and intervention for emerging health issues throughout the postpartum period (WHO, 2013).

Despite its recognized importance, inadequate utilization and poor quality of postnatal care services remain significant challenges, particularly in low-resource settings. Evidence suggests that approximately two-thirds of maternal deaths occur during the postnatal period (Chama et al., 2000; Ronsmans & Graham, 2006), and nearly 50% of

neonatal deaths occur within the first 24 hours postpartum—figures that highlight the urgent need for timely and high-quality postnatal interventions (WHO, 2017).

To address these challenges, WHO recommends a structured schedule for postnatal follow-up, advising health assessments at six hours, six days, six weeks, and six months after delivery (WHO, 1998). Nonetheless, in many developing countries—including Palestine—access to and utilization of postnatal care services remain limited, contributing to avoidable maternal and neonatal mortality (United Nations Population Fund [UNFPA], 2021).

The perceived quality of postnatal care (PNC) plays a critical role in ensuring positive health outcomes for mothers, newborns, and infants, as well as in sustaining the continuity of care. High-quality PNC contributes significantly to the reduction of maternal morbidity and mortality—an ongoing global public health challenge that is particularly severe in developing countries. Moreover, the achievement of many reproductive, maternal, and child health targets outlined in the Sustainable Development Goals (SDGs) depends heavily on the availability and quality of postnatal services aimed at preventing maternal and neonatal deaths. In this context, maternal health is understood to encompass the full continuum of pregnancy, childbirth, and the postpartum period (Lavender, 2016; El-Khawaga et al., 2019).

In Palestine, elevated maternal and neonatal mortality rates have been linked to poor perceived quality of PNC for both mothers and their infants (Albarqouni et al., 2018). The *National Maternal Mortality Report* (2020) revealed that approximately 45% of maternal deaths in Palestine occur during the postpartum period. Furthermore, a study conducted in the West Bank indicated that PNC coverage remains inadequate, with only one-third of women reportedly receiving postnatal services (Dhaher et al., 2008). In addition, research on the quality of life among postpartum Palestinian women has highlighted a generally low perceived quality of care during the postnatal period ("In Search of Health: Perceived Quality of Life among Postpartum Palestinian Women").

Given these findings, this study aims to evaluate the perceived quality of PNC components delivered to mothers and their newborns at childbirth facilities in the districts of Jenin and Nablus. The results of this evaluation are expected to provide insights into service delivery gaps and inform future interventions to improve maternal and neonatal outcomes.

1.2 Problem Statement

Despite global efforts to reduce maternal mortality, a significant proportion of maternal deaths continue to occur in the postnatal period, particularly within the first 24 to 48 hours after delivery. According to the World Health Organization (WHO), approximately two-thirds of maternal deaths occur after childbirth, with the majority taking place within the first week postpartum (WHO, 2014). In Ethiopia, for instance, 65.1% of maternal deaths were reported to have occurred during the postnatal period, with postpartum hemorrhage cited as the leading cause (Demissie et al., 2023).

This high rate of postnatal mortality is closely associated with the poor quality and low utilization of immediate postnatal care services. Inadequate assessment and delayed detection of complications such as hemorrhage, sepsis, and hypertension contribute substantially to these preventable deaths. Evidence shows that the first 24 hours postpartum are the most critical, yet many health systems fail to provide timely and effective interventions during this period (Campbell et al., 2016).

The persistent gap in the quality of immediate postnatal care highlights the urgent need for strengthened health systems, improved provider training, and consistent adherence to evidence-based postnatal care protocols to reduce maternal mortality.

As important as PNC is for the mother and newborn, it is often overlooked by mothers and health care professionals alike. Problems may arise from insufficient instruction at the time of discharge. Adequate education coupled with enhanced maternal understanding improves self-efficacy, thereby reducing postnatal training morbidity and mortality. Though mothers are expected to receive education on personal and neonatal care, barriers like fatigue, lack of support, and mental health issues may prevent access to care. These complications highlight the need for uncomplicated and effective postpartum care (Ahmadinezhad et al., 2022; Sacks et al., 2022).

The perceived quality of immediate postpartum care in the West Bank is affected by many factors, one of which is the socioeconomic status, healthcare setting, and availability to healthcare services. Evidence indicates that it is possible to offer maternal health services but has not received follow-up care, quality, or accessibility as an issue, mostly within rural and impoverished categories. Major complaints are such as high prevalence rates of postpartum problems, poor patient education, and shortages of postnatal follow-up (Alkasseh etal., 2020).

Evaluation of the perceived quality of postnatal care provided to mothers and newborns is necessary to discern gaps within the care delivery processes and create concrete solutions to remedy the health of mothers and infants. The study was implemented to assess the perceived quality of the immediate postpartum care components provided to mothers and their newborns in birthing hospitals in the Northern region of West Bank from the mother prospective.

1.3 Significance of the Study

Postnatal care continues to be a research priority in Palestine, especially in light of national efforts since 2023 to improve maternal and neonatal health outcomes. Despite growing interest, significant gaps remain in the perceived quality and consistency of postnatal care provided to mothers and newborns, particularly in the West Bank. This study shed light on the current situation and identified critical areas for intervention to enhance postnatal care.

The assessment of perceived quality by evaluating these components is a step for the evaluation of postnatal care for several reasons. First, and most importantly, postnatal care is essential for the health of new mothers and their babies. Postnatal care assists with the detection of infections and postpartum depression and other problems related to childbirth so that intervention can be instituted for managing these conditions.

Assessment of postnatal care perceived quality will also help delineate certain areas that need improvement. Such access, coverage, and perceived quality of services, as well as client satisfaction, are some of the important areas to address. Improvement areas can then be prioritized in their policy improvements so that mothers and newborns can benefit from improved quality.

The findings of this study, particularly the evaluation of perceived quality of postnatal care and its associated factors have the potential to inform evidence-based policy decisions and guide future investments in maternal and child health. By identifying gaps in service quality and areas of greatest need, stakeholders can allocate resources more effectively, ultimately contributing to improved health outcomes for both mothers and their newborns**.**

1.4 Aims of the Study

The purpose of study was to assess the perceived quality of the immediate postpartum care components offered to mothers and their newborns at childbirth facilities in the Northen area of West Bank. (Nablus, Jenin, Tubas, Qalqilya, Tulkarm, Salfit).

1.4.1 Specific Objectives

1. To evaluate the perceived quality of the immediate postpartum care provided to women during the first hour post-delivery in the Northen area of West Bank. (Nablus, Jenin, Tubas, Qalqilya, Tulkarm, Salfit)
2. To assess the level of the perceived quality of immediate postpartum care provided to mother after the first hour post-delivery in the Northen area of West Bank.
3. To assess the perceived quality of care provided to newborn during hospitalization in the Northen area of West Bank. (Nablus, Jenin, Tubas, Qalqilya, Tulkarm, Salfit)
4. To determine the relationships between sociodemographic and obstetric data with the perceived quality of the immediate postpartum care in the Northen area of West Bank. (Nablus, Jenin, Tubas, Qalqilya, Tulkarm, Salfit)
5. To identify the level of information and teaching provided to mothers before discharge from hospital in the Northen area of West Bank. (Nablus, Jenin, Tubas, Qalqilya, Tulkarm, Salfit)
6. To investigate the relationships between with place of delivery, time of discharge, type of delivery, duration of hospital stays, complications and the perceived quality of the immediate postpartum care newborn in the Northen area of West Bank. (Nablus, Jenin, Tubas, Qalqilya, Tulkarm, Salfit)
7. To assess women's level of satisfaction with the postpartum care provided to them and to their newborns the Northen area of West Bank. (Nablus, Jenin, Tubas, Qalqilya, Tulkarm, Salfit)
8. To identify the relationship between the perceived quality of postnatal care and continuity of breast feeding newborn in the Northen area of West Bank. (Nablus, Jenin, Tubas, Qalqilya, Tulkarm, Salfit)
9. To develop evidence-based recommendations for decision-makers to identify and address areas requiring improvement in postnatal care services.

1.4.2 Research Questions

1. What is the level of the perceived quality of immediate postpartum care provided to mother during the first hour post-delivery in the Northen area of West Bank?

2. What is the level of the perceived quality of immediate postpartum care provided to mother after the first hour post-delivery in the Northen area of West Bank?
3. What is the level of the perceived quality of immediate postpartum care provided to newborns during hospitalization time in the Northen area of West Bank?
4. Is there any association with the sociodemographic, obstetric and childbirth facilities characteristics with the perceived quality of immediate postpartum?
5. To what extent do the postpartum mothers receive information before discharge from the hospital?
6. Is there any association with the place of delivery, time of discharge, type of delivery, duration of hospital stays, complications and the perceived quality of the immediate postpartum care?
7. Are the mothers satisfied with the immediate care provided to them and to their newborns and teaching received during hospitalization in the Northen area of West Bank?
8. Is there a relationship between the perceived quality of postnatal care and continuity of breast feeding?
9.

1.4.3 Study Hypotheses

1. There is no association between the sociodemographic, obstetric and childbirth facilities characteristics with the perceived quality of care provided to mother and newborns.
2. There is no association with the place of delivery, time of discharge, type of delivery, duration of hospital stays, complications and the perceived quality of the immediate postpartum care.

Chapter Two:

Literature Review

2.1 Introduction

This chapter presents a review of the literature on the postnatal care, evaluation of the perceived quality of immediate postpartum care in the northern West Bank from the viewpoints of mothers. The search was conducted using the CINAHL, Google Scholar, and Pub-Med databases. Use the following keywords and Boolean operators to find pertinent English literature (qualitative, quantitative, mixed-methods, and systematic reviews) published between 2014 and 2025:

("Perceived quality of care" OR evaluation OR assessment OR satisfaction) AND ("postpartum care" OR "immediate postnatal care" OR "care after delivery") AND (mothers OR women OR maternal) AND ("West Bank" OR Palestine) ("postnatal care" OR "postpartum services") AND (mothers' perceptions OR "patient satisfaction") AND ("Northern West Bank" OR Palestine OR Palestinian Territories).

2.2 Postnatal Period, Definition, Components and Importance

Postnatal care (PNC) refers to the comprehensive care provided to both the mother and the newborn following childbirth. It encompasses monitoring and supporting the mother's recovery while simultaneously addressing the growth, development, and health needs of the newborn. Postpartum care, a closely related concept, focuses specifically on the mother's physical and psychological recovery after delivery. Its objectives include the prevention of complications, the promotion of optimal breastfeeding practices, support for maternal mental health, and the facilitation of physical healing. In both clinical and research contexts, the terms "postnatal care" and "postpartum care" are often used interchangeably to describe the range of services delivered during the critical six-week period following childbirth (World Health Organization [WHO], 2022).

The postnatal period lasts for up to 6 weeks after childbirth. It involves three sets of interrelated activities: care for mothers, care for newborns, and health education. In other words, the postnatal period lasts up to 6 weeks or 42 days after the birth of the baby, the most important time for mothers. Maternal mortality is high in the postnatal period in many developing countries. While approximately 60% of maternal deaths occurred

within the postnatal period, 45% of all deaths occurred in the first 24 hours after birth, >65% within 1 week, and >80% within 2 weeks. In developing countries, 80% of all deaths postpartum arising from obstetric causes occurred within a week. The identified aspects of PNC provided to mother, care provided to newborn, and health systems and health promotion interventions (WHO, 2022).

WHO (2024) elaborated that the importance of PNC is accentuated by the fact that women and newborns require support and close monitoring post-delivery. The first six weeks after birth are the most poorly funded in the delivery of high-perceived quality care for mothers and newborns and consequently carry the most deaths among mothers and babies.

PNC services prevent diseases, promote healthy practices, and treat complications to improve maternal and child health. Postnatal care further provides a constellation of services intended to create a favorable environment for sustaining the health, social, and developmental requirements of the woman, the newborn, and the family unit. The PNC services are paramount.

2.3 Perceived quality of Postnatal Care

The perceived quality of postnatal care was assessed by qualitative and quantitative studies from the mothers and providers prospective.

In a cross-sectional study that conducted by Maryam Ahmadinezhad (2022) to evaluate the mothers' perceptions of the provided postnatal care and the associated factors. The study was conducted on 160 mothers. The mothers' mean score of perception was 69.84±16.04; most mothers rated the provided postnatal care and their relationship with the personnel as good or excellent. The mean total scores of the mothers' perceptions were not different based on their satisfaction with postnatal care (P=0.646) and time of the first referral after birth (P=0.251), but they were significantly different according to the number of referrals (P=0.023) and their satisfaction with the health personnel (P<0.001). The study results revealed that mothers had a good perception about postnatal care provided by health center staff. Hence, it is necessary to educate all health staff in this regard to provide high- quality postnatal care to all mothers who refer to these centers.

Another quantitative study conducted by Mercy Pindani (2020) that used a sample of 58 midwives to assess the perceived quality of postnatal care at three selected health facilities. A structured questionnaire, an observation tool and a facility checklist were used to collect data. The study found that the percentages reported by midwives regarding client monitoring varied and were below the 80% threshold. Midwives did not always follow the reproductive health standards on client examination so that less than 75% of midwives inspected perineal wounds (52.2%), checked vital signs of neonate (66.7%) and mother (62.2%), and inspected lochia drainage (30.4%). Most midwives (91.3%) never assessed the emotional state of the mother. Midwives covered a range of topics during health education and counselling. However, some topics, including immunizations (31.1%), were never taught. The study has suggested that the postnatal care offered by midwives at three health facilities was generally substandard and midwives do not always monitor, assess and counsel postnatal clients.

In a cross-sectional study conducted by Selvaraj and Ramya (2021) to evaluate the postnatal care (PNC) services that mothers and neonates received. Just 37.4% of 227 postpartum mothers received sufficient counseling on important subjects like breastfeeding, immunizations, diet, hygiene, contraception, and baby care. Only 48.1% of normal deliveries and 72.4% of cesarean births experienced early breastfeeding initiation within the recommended timeframe, despite the fact that 99.1% of neonates received cord care and 88.5% had their nursing postures examined. Postnatal home visits were very inadequate, with only 20.7% of mothers and newborns receiving even one visit and none receiving care adhering to the Indian Public Health Standards. In addition, registration under JSY benefits covered just 46% of those eligible, with 20.6% of the non-registered claiming to be unaware of the scheme. Further, 14.1% of births were low birth weight, whereas very low birth weight accounted for 1.3%. The study, however, reveals a marked disparity in the implementation and provision of postnatal care services despite good prenatal care, indicating a need for pointed interventions and active support from the health system.

Women's evaluations of postpartum treatment at a Swedish hospital in 2006 and 2017 were compared in this study. Shorter hospital stays and a change in discharge procedures were seen in 2017 based on data from 366 women in 2006 and 342 in 2017. With advancements in the majority of care areas, overall satisfaction with postnatal care rose dramatically over time. Nonetheless, several women reported knowledge and support deficiencies, particularly those who were multiparous, over 35, or had cesarean sections. In order to further improve postnatal care experiences, the study emphasizes the necessity of ongoing improvement and the investigation of novel care models (Öhrn et al., 2020).

2.**4** Immediate Postpartum Care

The postnatal care is the aspect of maternity care that women are least satisfied with. In a longitudinal qualitative study that conducted in England, including 32 first-time mothers, the results showed that the degree to which each mother's specific postpartum needs were met had a greater impact on her confidence and degree of satisfaction than did the realization of her expectations. (McLeish et al., 2020).

While in a qualitative study that was conducted to explore how new mothers felt about receiving obstetric care through virtual care. The interviews were completed through conducting interviews with 15 women by using video conferencing. Participants expressed great pleasure, citing ease of communication, comfort, and convenience as the main advantages. Virtual care promoted trust and an emotional bond with providers despite being remote. The study comes to the conclusion that virtual care can improve follow-up care compliance, but more investigation is required to fully comprehend how social variables affect patients' experiences. (Saad et al., 2021)

Moreover, another qualitative study investigated the expectations and desires of first-time mothers in England regarding PNC, as well as the sources of their information and if it is adequate. Six major themes emerged from interviews with 40 expectant mothers: a system under stress, a need for nonjudgmental, woman-centered care, and incomplete and fragmented information. Mothers requested further information, particularly about their personal health and discharge decision-making. According to the study's findings,

antenatal education on PNC that is comprehensive, easy to understand, and available in all care settings can help first-time mothers feel less anxious (McLeish et al., 2020).

A previous cross sectional study that was conducted in Tabriz among 334 postpartum women, aimed to assess the respectful care. The results of the study showed that more than 75% of the women who participated in the study reported receiving disrespectful maternity care, particularly in the form of limitations on their mobility and labor positions. The risk of such mistreatment was considerably elevated when giving birth during night. Supportive interventions, such as having spouses close by, receiving treatment from private physicians, or using midwives, significantly decreased this risk. The results emphasize the necessity of measures to support considerate and compassionate maternity care, such as improved staffing and ethical training (Hajizadeh et al., 2020).

The first 24 hours following childbirth are very critical because complications may occur such as sepsis and hemorrhage contributing to up to 45% of maternal mortality during this period. In low- and middle-income countries, postnatal checks are frequently disregarded, and women who are at risk are provided with minimal care prior to discharge, despite the fact that earlier detections and immediate interventions are effective in mitigating these risks. (Clarke-Deelder et al., 2023). Numerous tensions and difficulties typically overwhelm primiparous women who lack expertise and knowledge of child care. Although primiparas require professional assistance (Nan et al., 2020).

2.**5** Satisfaction with Postnatal Care

The health of mothers and their newborns is greatly at risk during postnatal care. A cross-sectional study was to assess how women at the health centers of Sirik city, in the Iranian province of Hormozgan, felt about the postnatal care they received and the characteristics that were related to it. According to the results, the mothers' average perception score was 69.84±16.04; the majority of them gave the postpartum care they received and their interactions with the staff a good or exceptional rating. The mothers' perceptions' mean total scores did not differ according to their satisfaction with postnatal care ($P=0.646$) or the time of their first postpartum referral ($P=0.251$); however, they did differ significantly based on the number of referrals ($P=0.023$) and their satisfaction with the medical staff ($P<0.001$). According to the study's findings, mothers thought well of the postpartum care that the health center staff offered. Therefore, it is essential to train all medical personnel in this area so they can offer all mothers who refer to these institutions excellent postnatal care (Ahmadinezhad et al., 2022).

A longitudinal observational study involving 381 women found that 94.54% were satisfied with their childbirth experience. Higher satisfaction was linked to natural delivery, skin-to-skin contact, and low anxiety levels. Dissatisfaction was more common among women separated from their babies or whose birth plans were unmet. The study highlights the importance of respectful childbirth practices and emotional support for mothers (Blanco López et al., 2021).

At King Khalid Hospital in Jeddah, Saudi Arabia, a cross-sectional research of 300 postpartum women evaluated the discrepancy between satisfaction with postnatal services and the perceived quality of maternity care. Women's satisfaction was moderate (mean 3.20), with a reported disparity of -1.27, despite their high rating of service

perceived quality (mean 3.73). Satisfaction and care perceived quality were found to be significantly positively correlated. Despite women's general satisfaction, the study found that more compassionate care is required. It is advised that providers receive more communication and empathy training and undergo regular reviews (Al-Hussainy et al., 2022).

One important metric in the evaluation of healthcare quality worldwide is patient satisfaction. Mothers' use of the available medical facilities is influenced by their happiness with the services they receive, which they use to evaluate the perceived quality of the perinatal care they receive. The primary level of care, which is the first point of contact for the bulk of the population, has a scarcity of literature on consumers' satisfaction with the services provided. So a study was set out to investigate maternal satisfaction with perinatal care received in selected primary health centers in Ibadan. The study was a cross-sectional survey involving 66 women receiving postpartum care from five randomly selected primary health centers in Ibadan north-west local government using a 72-itemed questionnaire with $p \leq 0.05$. According to this study, 94% and 98% of mothers were satisfied with the facilities and services, respectively, and 98.5% thought their perinatal care was of excellent quality. However, problems including the unfavorable hospital atmosphere, water scarcity, staffing shortages, expense, and mistreatment led to discontent. Future care use and satisfaction were shown to be significantly correlated ($\chi^2 = 13.306$; $p = 0.0001$). While overall satisfaction was very high, the study found that in order to sustain and improve maternal use of healthcare services and promote progress toward the third Sustainable Development Goal, it is imperative to address the issues that were highlighted (Odetola & Fakorede, 2018).

2.6 Postnatal Care in Palestine

Postnatal care (PNC) in Palestine is a vital yet often neglected component of maternal and newborn healthcare. The first six weeks following childbirth represent a critical period for both maternal recovery and neonatal development. However, access to and utilization of PNC services in Palestine remains limited. Studies have reported that only around one-third of women in the West Bank receive any form of postnatal care, and even fewer receive care that meets global standards (Dhaher et al., 2008). According to the National Maternal Mortality Report (2020), approximately 45% of maternal deaths in Palestine occur during the postpartum period. Contributing factors include limited awareness of postnatal care benefits, cultural and social barriers, financial constraints, and restricted access to healthcare facilities—particularly in conflict-affected and rural areas (Albarqouni et al., 2018; UNFPA, 2021).

In response to these challenges, national and international stakeholders have introduced targeted initiatives aimed at strengthening PNC in Palestine. The United Nations Population Fund (UNFPA), in collaboration with the Palestinian Ministry of Health, has developed and implemented national obstetric guidelines and labor ward protocols to standardize and improve maternal and newborn care practices (UNFPA, 2024). In Gaza and other underserved regions, midwife-led models of care and home-based postnatal visits have demonstrated success in improving maternal outcomes, reducing rates of postpartum complications, and increasing rates of exclusive breastfeeding (UNICEF, 2022; The Lancet, 2019). These initiatives underscore the importance of coordinated, context-specific interventions to enhance the quality and accessibility of postnatal care and ultimately reduce maternal and neonatal morbidity and mortality in Palestine.

In a cross sectional study conducted in West Bank among postpartum women (N = 264) who had given birth during the previous 15 months, the aim of this study was to evaluate factors associated with a lack of postnatal treatment, as well as women's reasons for not receiving it and attitudes toward its value. This study was conducted in three clinics; Jenin in the north, Ramallah in the center, and Hebron in the south. The results of this study showed (66.1%) of women considered postnatal care necessary. only 36.6% of women obtained postnatal care. The most frequent reason for not obtaining postnatal care was that women did not feel sick and therefore did not need postnatal care (85%), followed by not having been told by their doctor to come back for postnatal care (15.5%). use of postnatal care was higher among women who had experienced problems during their delivery, had a cesarean section, or had an instrumental vaginal delivery than among women who had a spontaneous vaginal delivery (Dhaher et al., 2008).

A cross-sectional study involving 200 postpartum women in Gaza was conducted to assess their perceptions of the quality of postnatal care received during the early postpartum period. The study found no statistically significant differences in perceived quality of care based on factors such as number of pregnancies, number of deliveries, mode of delivery, age, or family income. However, significant differences were observed with respect to education level and place of delivery. These findings highlight the importance of postnatal care in addressing maternal and neonatal morbidity and mortality, particularly within the context of the Gaza Strip (Alkasseh et al., 2020).

2.7 Sociodemographic and Health- System Determinants of PNC Utilization

Almost all adverse outcomes for mothers and babies occur in the postnatal period. Good care during her time can help prevent these incidents. Interview mothers about the perceived qualityof care they receive from your program and you'll get useful insights into how to improve it-and also its results over time in. A cross-sectional survey conducted in specialized facilities in Colombo, Sri Lanka, evaluated mothers' opinions regarding routine postnatal care. The median score was 108 (IQR 96–114) overall, with ward facilities scoring 32, interpersonal care scoring 33, and technical care scoring 43. Early breastfeeding, Kangaroo Mother Care, pain medication during suturing, being between the ages of 20 and 35, receiving care in teaching hospitals, and getting health advice were all strongly associated with positive opinions. Ward facilities ranked worse, although the majority of mothers had positive opinions of care. It is advised to conduct regular evaluations to direct quality enhancements (Wickramasinghe et al., 2019).

Only half of Ugandan women use early postnatal care (EPNC), and there is still a lack of awareness about this service. The study discovered that the most significant predictor of EPNC use is the delivery of health facilities, based on data from 5,471 women in the 2016 Uganda Demographic and Health Survey. Education, income, prenatal care, and media availability are further influences. Even with increased usage of EPNC at medical facilities, many people continue to be left out, underscoring the need to improve facility-based care and focus on vulnerable populations, particularly women with lower levels of education and home births (Ndugga et al., 2020).

The sample for a population-based cross-sectional study covered 36 sub-Saharan African countries 286,255 women using Demographic and Health Surveys (DHS) 2006 to 2018 data. Care utilization among PNC women came to 52.48% on average, the results

suggested. Treat the highest percentage in Central Africa (73.51%) and the lowest in East Africa (31.71%). Those that live in rural areas, are young, have little to no education, no job, are totally cut off from the outside world, have one new child or give birth by themselves and don't go to antenatal care all have quite a few factors associated with their exclusion from healthcare (Tessema et al., 2020).

Since there is a significant chance of maternal death during the postpartum phase, warning sign education is essential. According to a poll of 80 Black women, only 54.4% said they had received this kind of instruction, and 25% of them were unable to recognize any warning indications. The level of education varied, and 25% of participants reported having unmet needs. Income, the hospital of delivery, and whether or not education was provided prior to discharge were all substantially correlated with knowledge (Adams & Young, 2022).

An ethnographic study looked at how new mothers combine traditional postpartum care methods with biomedical ones. Participants talked about obtaining injectable treatments from private providers and cultural customs such as steaming, heat applications, and "heating" of food. Three main ideas emerged from the thematic analysis: the changing postnatal care environment, the relative importance of conventional vs biomedical techniques, and the variety of sources of information. In order to preserve cultural traditions for the future health of both themselves and their unborn children, mothers reported employing both systems simultaneously. In order to provide high-quality, culturally appropriate postnatal care that recognizes and incorporates changing behaviors like injections, the study emphasizes the necessity for stakeholders (Bazzano et al., 2020).

Between 2006 and 2016, Uganda experienced a significant improvement in maternal health services, with facility birth rates increasing from 44.6% to 75.2%, and immediate postnatal care (PNC) coverage rising from 35.7% to 65.0% among facility deliveries. The median time to the first maternal check postpartum also decreased from 4 hours to just 1 hour. A cross-sectional analysis identified key predictors of receiving timely postnatal care: cesarean delivery (Adjusted Odds Ratio [aOR] 2.93), attending four or more antenatal care visits (aOR 2.34), infant weighing at birth (aOR 1.84), and exposure to media (aOR 1.38). Despite this progress, the study emphasized the continued need to integrate maternal and newborn health services and involve both parents to ensure universal, high-quality immediate postnatal care (Dey et al., 2021).

In contrast, traditional postpartum practices continue to shape care in other contexts, such as China's "Zuo yue zi" or "doing the month," a cultural ritual emphasizing maternal rest, diet, and recovery. While modern maternity care facilities have adapted this tradition by offering interdisciplinary, holistic support within hospital settings, challenges remain. These include issues of social isolation, unmet psychological needs, and mismatches between institutional care and women's personal expectations (Zhang et al., 2025). These contrasting approaches highlight the importance of culturally sensitive and evidence-based strategies in shaping effective postnatal care worldwide.
A study by Jones et al. (2020) demonstrated that targeted, low-cost mobile messaging interventions have the potential to empower mothers during the critical postpartum period and possibly contribute to life-saving outcomes, even though they did not significantly alter routine check-up attendance or care-seeking behaviors for newborns.

Morbidity and death among mothers and newborns continue to be significant worldwide health concerns, particularly in sub-Saharan Africa, where the burden is greatest following childbirth. Data regarding the standard of postnatal care and the application of evidence-based therapies catered to the requirements of both mothers and infants are scarce. The impact of courteous versus rude care on women's decisions to seek PNC is also little understood. In order to better understand how women's perspectives, experiences, and access to postnatal care in sub-Saharan Africa are influenced by the perceived quality of treatment, this review will examine qualitative data. The findings indicated that data from 985 women who were questioned in-person in eight different countries were included in 15 studies. Kindness, support, and attention to women's needs were all described as aspects of respectful care. Women expressed a preference for medical treatments where the staff had courteous and considerate communication. Disrespectful treatment was described as involving power disparities between women and medical professionals as well as verbal and/or physical abuse. When some women went to a medical facility after giving birth at home, they were refused postnatal treatment. Disrespectful care is more likely to be given to vulnerable women, such as adolescents, women with low socioeconomic level, and women living with HIV, according to data (Lythgoe et al., 2021).

2.8 Summary of this Literature Review

The literature says high quality, respectful and individualized postnatal care (PNC) is key to better maternal and newborn outcomes. While many studies show increased maternal satisfaction over time, concerns remain around lack of emotional support, fragmented information and disrespect – especially for vulnerable groups like multiparous women, adolescents and those with lower socio-economic status. Care that is responsive to individual needs, including virtual and culturally sensitive services, has been shown to improve satisfaction, confidence and breastfeeding.

Structural and systemic factors like staffing, facility resources, provider communication and health education play a big role in shaping PNC experiences. Sociodemographic factors like education, income and place of delivery also impact access and perception of care. Innovative strategies like mobile messaging and maternal role adjustment programs show that we can scale up interventions to improve outcomes. Overall the evidence is calling for continuous evaluation, training and integration of respectful, inclusive and evidence based postnatal care models to meet the diverse needs of mothers and babies.

Chapter Three:

Conceptual Framework of the Study

3.1 Introduction

The conceptual framework supporting the study "The Perceived quality of Immediate Postpartum Care in the Northern Area of West Bank: Mothers' Perspectives" is presented in this chapter. The conceptual framework offers the structural underpinnings for comprehending how many factors interact to affect mothers' assessments of the perceived quality of immediate postpartum care. It provides a methodical framework to direct the investigation, gathering, processing, and interpretation of data. Important theoretical concepts pertaining to patient satisfaction, maternal health, and care perceived quality are included in the framework. It shows how the elements of postpartum care, mothers' experiences and expectations, and the elements influencing their general level of satisfaction are related to one another.

3.2 Variables of the Study

Figure (3.1) shows the relationship between dependent and independent variables.

3.2.1 Dependent Variables

- Perceived quality of the immediate postnatal care:
    - The immediate care provided to mother at first hour after delivery.
    - The care provided to mother during the first 24 hours.
    - The immediate Care provided to newborn.
    - Education and teaching given to mothers before discharge.
    - Satisfaction of care provided to mothers and their newborns and the education provided to the mothers.

3.2.2 Independent Variables

- Socio-demographic variables such as age, the level of education, and monthly income, residency.
- Place of delivery: private, governmental hospital.
- Mode of delivery: vaginal with episiotomy/ tear, vaginal without episiotomy/ tear.
- Time of delivery: Morning, Evening.

- Time of discharge. Morning, Evening.
- Duration of hospital stay post-delivery.
- Complications

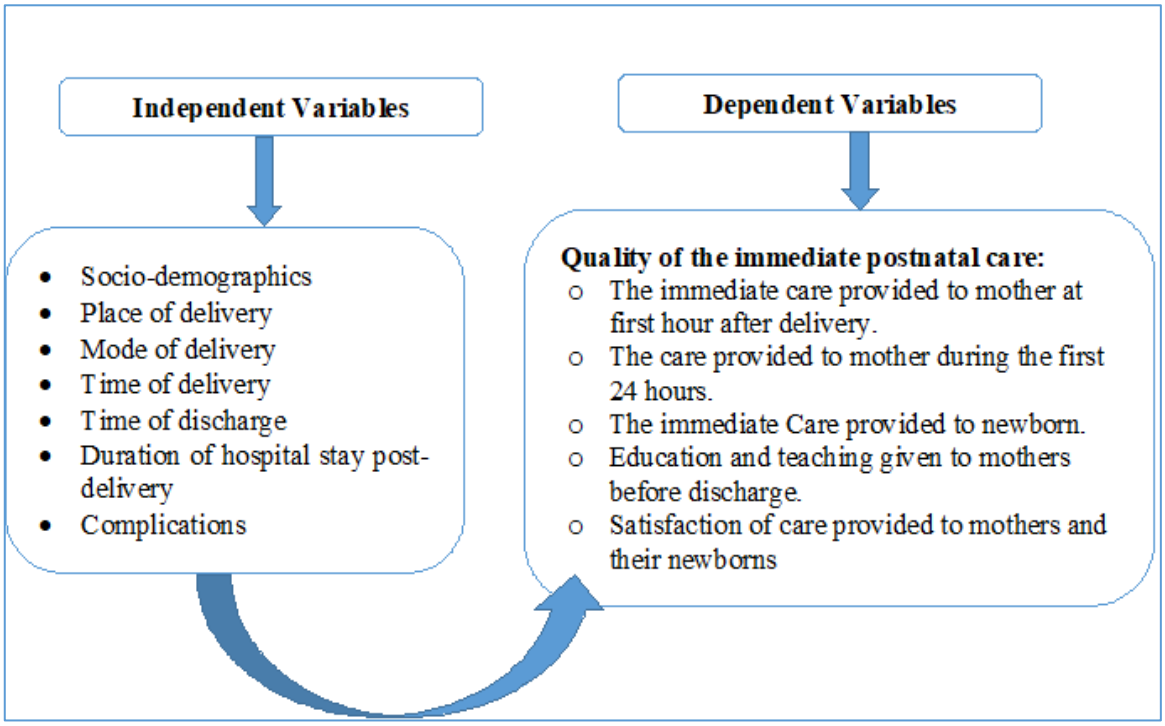


Figure 3.1. The Conceptual Framework of the Study

3.2.3 The Conceptual and Operational Definitions

The following key concepts are integrated into the framework:

3.2.3.1 Immediate Postpartum Care

The first 24 hours following childbirth are known as the "immediate postnatal period," during which the infant's physiology adjusts and the mother's risks and other serious morbidities are at their peak. Mothers receive care throughout the first twenty-four hours following delivery. Physical examination, emotional support, instruction on nursing and caring for a newborn, and problem-spotting are all included in this period (Bekele et al., 2022).

3.2.3.2 Mothers' Perspectives

Subjective evaluation by postpartum women of the care they received, including their satisfaction, unmet needs, and expectations. Mothers may receive proper information at this stage concerning the health conditions of both themselves and their infants. Information as primary caregivers will be needed by mothers regarding neonatal care; such as feeding, hygiene, vaccinations, and signs of a sick baby. Also, mothers should be educated about the importance of looking after their own health. This relevant care could significantly reduce morbidity and mortality among mothers and includes the following

topics: vaginal bleeding, infections, warning signs, nipple care, and general cleanliness. Even though it has been highly recommended, patients should be referred to health clinics for postnatal care (Ahmadinezhad et al., 2022).

3.2.3.3 Perceived quality of Care

Efforts to improve PNC must go beyond coverage and survival alone to include perceived qualityof care in order to lower mortality and improve the health and survival of women and newborns during the postnatal period. For the prevention and early identification of numerous possible causes of obstetric problems and newborn mortality, including maternal anemia and neonatal hypothermia, high- quality PNC is essential. Evaluated using metrics related to structure, procedure, and results that demonstrate both technical proficiency and patient-centeredness (Zhao et al., 2023).

A valid and reliable questionnaire was used to operationally evaluate the variables in this investigation. The quality of immediate postnatal care was assessed in a number of important areas. The care given to the mother during the first hour after delivery and throughout the first 24 hours after giving birth were included in this. The evaluation also covered the mother's health education and counseling before discharge, as well as the immediate care given to the infant. As a final measure of the quality of postnatal care, women' general happiness with the treatment they and their babies received—as well as the caliber of instruction provided—was also assessed.

3.3 Summary

The conceptual framework that underpins the investigation into the perceived quality of immediate postpartum care in the Northern Area of the West Bank from the viewpoints of mothers was described in this chapter. It draws attention to important factors such maternal satisfaction, health education prior to discharge, and care for the mother and newborn during the first 24 hours following birth. These elements were evaluated using an established and trustworthy questionnaire. The framework ensures a thorough understanding of the factors impacting mothers' opinions of the quality of postpartum care by offering a clear structure for data collection, analysis, and interpretation.

Chapter Four:

Methodology

4.1 Introduction

The study design, demographics, place and setting, sample size and sampling procedure, eligibility requirements, data collection process, instruments, validity and reliability, ethical considerations, and data analysis were all covered in length in this chapter.

4.2 Study Design

This research utilized a descriptive - cross-sectional design to assess the perceived quality of immediate postpartum care for the mothers who had given birth vaginally in the northern area of West Bank from mothers' perspectives.

4.3 Study Location and Setting

The main maternal and child health clinics associated with MOH in the northern region of the West Bank, Palestine, namely in Nablus, Jenin, Tubas, Qalqilya, Tulkarm, and Salfit, were the sites of this study. Data was gathered using a paper questionnaire.

4.4 Study Duration

The whole study commenced between October 2024 and December 2024**.**

4.5 Population and Sample

The study's participants were women over the age of eighteen who had just given birth vaginally and who visited family planning, postnatal care, and child immunization clinics for a period of no more than 2 months after childbirth. Additionally who they reside in the North West Bank (Nablus, Jenin, Tubas, Qalqilya, Tulkarm, and Salfit); 114 women from Nablus, 98 from Jenin, 20 from Tubas, 36 from Qalqilya, 51 from Tulkarm, and 25 from Salfit. Questionnaires that are self-administered and on paper.

4.6 Inclusion Criteria

- Women who delivered vaginally within 2 months duration before the study were included in the study sample and visited the main clinics the postnatal care and child immunization clinics and family planning clinics in the Northen area of West Bank (Nablus, Jenin, Tubas, Qalqilya, Tulkarm, and Salfit) who met the inclusion criteria**.**
- Women age above 18 years.
- Normal vaginal delivery.

4.7 Exclusion Criteria

- Women unable to understand or read the Arabic questionnaire.
- Women who were out of the Northen area of West Bank.
- Women who had stillbirth, or neonatal death during last childbirth.
- Woman who gave birth by caesarean section.

4.8 **The Sampling Method and Sample Size**

4.8.1 Sampling Method

This study employed convenience sampling after proportional allocation by strata. Convenient sample from women who visit the main maternal and child health clinics belong to Ministry of Health which located in the Northen area of West Bank (Nablus, Jenin, Tubas, Qalqilya, Tulkarm, Salfit). The purpose of choosing convenient sampling methods was to save the time and cost and minimize the difficulties in data collection and achieve the needed sample size.

4.8.2 Sample Size

The estimated sample size calculation was done by using single proportion formula considering the prevalence rate of postnatal care, based on previous study in Palestine (Dhaher et al., 2008), the prevalence rate was 33.3%, 95% confidence interval, and 5% error margin (absolute precision level).
The calculation of sample size done as the following:
$n = (z/\Delta)^2 p(1-p)$
Z value based on 95% CI = 1.96
Absolute precision (Δ) = 5%(0.05)
P = prevalence rate for postnatal care = 33.3%
$n= (1.96/0.05)\ ^2 0.296(1-0.333) = 339.$
A total of 339 women will be included in the sample (Table 4.1).

Table 4.1. Sampling Method

North of West Bank strata	No delivery, 2022 (Health annual report) (strata population size)	Strata Sample size calculated by Sample size/ population size x stratum size
Jenin	8967	98
Nablus	11081	114
Tubas	1725	20
Qalqilya	3664	36
Tulkarm	5136	51
Salfit	2331	25
Total	32904	339

4.9 Research Tool

4.9.1 Modification of an Existing Questionnaire

A pre-existing self-administered questionnaire was adopted from a study in Gaza, modified and updated to meet the study's goals, which included evaluating the standard of immediate postnatal care in the northern region of the West Bank, Palestine (Alkasseh & Mwafy , 2019). A thorough analysis of pertinent literature and previously approved instruments served as the basis for the changes, which made sure the instrument was appropriate for the study's objectives and contextually relevant.

A review of qualitative and quantitative research on the standard of postnatal care was the first step in the process. Examining current surveys to determine crucial domains, important items, scaling strategies, and validation techniques was part of this.

Prevalence of postnatal care, perceived quality of postnatal care, postnatal care for mothers, and postnatal care for babies, and satisfaction with postnatal care were among the keywords selected in the literature search. The Cochrane Library, PubMed, Scopus, and Google Scholar were among the databases consulted.

The original questionnaire was modified to meet the unique requirements and circumstances of the research population in light of this evidence. There are six components in the final Arabic-language questionnaire:

4.9.2 Demographic and Obstetric Information

This section gathers details on maternal age, educational level, place of residence, occupation, economic status, pregnancy and childbirth history, complications during or after birth, birth setting, timing of delivery and discharge, duration of hospital stay, and current newborn feeding practices.

4.9.3 Care Provided During the First Hour after Normal Delivery

This section contains 7 items adapted from the Ministry of Health (MOH) obstetric emergency protocols, assessing maternal care in the immediate postpartum period. Responses are measured on a 5-point Likert’s scale (strongly agree to strongly disagree).

4.9.4 Care in the Postpartum Department after the First Hour

Ten items in this section assess continued maternal care during the postpartum hospital stay. These items are also derived from MOH protocols and use the same 5-point Likert's scale.

4.9.5 Postnatal Care for the Newborn

This section includes 14 items addressing newborn care. Several items were adopted from previous studies, while others were formulated in consultation with clinical experts. Responses are measured using a 5-point Likert's scale.

4.9.6 Health Education and Counseling before Hospital Discharge

Comprising 11 items, this section evaluates the extent and perceived quality of health education and counseling provided to mothers prior to discharge. Items were drawn from existing literature and expert input, using the same Likert's scale.

4.9.7 Overall Satisfaction with Postnatal Care

The final section includes 6 items assessing the mother's satisfaction with the care received. This section uses a 5-point satisfaction scale (very satisfied to very dissatisfied).

To interpret responses, mean scores were categorized into five levels based on the guidelines of (Vagias, 2006):

- 1.00–1.80: Very positive perception
- 1.81–2.60: Positive perception
- 2.61–3.40: Neutral perception
- 3.41–4.20: Negative perception
- 4.21–5.00: Very negative perception

To guarantee clarity and cultural suitability, every item was translated and modified into Arabic. Two bilingual (English and Arabic) language specialists examined and edited the translation. The Appendix contains the completed Arabic version of the survey.

4.9.8 Validity of the Questionnaire

4.9.8.1 Content validity

To ensure the validity of the questionnaire items, after development of the questionnaire achieved, the Arabic version of the questionnaire was sent to 6 experts of midwives and nurses and consultant for maternal and child health care and Faculty of Nursing and midwifery department at Al-Quds university and Bethlehem University. Expert validation was conducted to ensure the validity of the instruments. The experts were emailed the questionnaire with the objectives of the study after their agreement to participate in the validity process. These experts were asked first, to review the domains and their items and provide feedback on each item if possible. One of the experts suggested to add more items in the health education and counseling for maternal care before hospital discharge part, so more items were added. Another expert asked to clarify some items to be clearer

in the questionnaire such as the meaning of the "vital sign" point was clarified, all comments from the experts were valuable and enrich the content and clarity of the questionnaire items, and all are taken into consideration to refine the domains and their items.

4.9.8.2 Face Validity

After the content validity step achieved with the experts and the questionnaire items have improved, the revised draft of the questionnaire was gone through face validity. Face Validity also done with 20 women from different ages to ensure understandability and clarity of the items of the questionnaire. Women were also asked to provide any verbal or written comments related to questionnaire items. The questionnaire items were understandable and clear.

4.9.8.3 Pilot Study and Reliability of the Questionnaire

Pilot study was conducted to examine for suitability of the item, and reliability of the questionnaire as well as to evaluate the procedures for participants' recruitment, usability of the scale, duration and data collection processes, and cost before implementing the full scale in order to decrease the chance of failure in a final study. Pilot testing was conducted to test the research approach with 30 women met the study criteria. The snowball method was used to collect the data at this stage and the questionnaire was sent to them electronically by messenger, WhatsApp and Gmail. They were asked about the clarity of the questionnaire items, time needed to fill the questionnaire, any technical problems or difficulties with the questionnaire form. Feedback from the women was taken into account. The reliability coefficients ranged from 0.80 to 0.88, indicating strong internal consistency across all scales.

4.10 Data Collection

The process of data collection started after it had been permitted by the ministry of health officer and the letters of permission is sent to in the main maternal and child health clinics related to MOH in the Northen area of West Bank, Palestine mainly at (Nablus, Jenin, Tubas, Qalqilya, Tulkarm, Salfit); in order to facilitate the process of data collection. Data collection was done by the main researcher through using the new developed questionnaire. The women who accept to participate in this study and meet the including criteria were included in this study; 339 women fulfilled the paper questionnaire.

As for the data collection in in the main maternal and child health clinics related to MOH in the Northen area of West Bank, Palestine mainly at (Nablus, Jenin, Tubas, Qalqilya, Tulkarm, Salfit); around 339 self-administered questionnaires distributed by the main researcher to the women who seek care in main clinics the postnatal care and child immunization clinics and family planning clinics in the Northen area of West Bank, Palestine. The participant take space to answer the questions in complete privacy. The purpose of the study was explained to the participants before starting the data collection. Moreover, the aim of the study and its criteria were present within the questionnaire. The self-administered questionnaire took around 12 minutes to be filled.

4.11 Data Analysis

The analysis was applied with SPSS version 26. The main variables were approximately normal distributed. The analysis was conducted using both descriptive and inferential statistical methods. Descriptive statistics summarized with frequency, percentage, means and standard deviations. For inferential analysis, an independent t test and one-way ANOVA were performed with post-hoc Bonferroni test applied for significant findings. Pearson's correlation analysis was used to examine relationships between continuous variables. A significance level of $p < 0.05$ was applied to all statistical tests.

4.12 Ethical Consideration

4.12.1 Consent and Voluntary Participation

Verbal informed consent from all participants sought throughout the research. Voluntary participation through all the study phases was ensured, the participants assured their right to withdraw from the research at any time with no consequences or embarrassment and participants knew that there was no harm on them from non-participation in this study. Explanation of research objective in simple language was done for the participants, the research information sheet includes the purpose of the study was available on the top of the questionnaire.

4.12.2 Confidentiality

Participant information was secured, the participant knew previously that the search result was being used without using the individual name. The data is secured and used for scientific purposes only. All data (during analysis) were stored in password-protected computer files. Paper copies of the questionnaires were stored securely in a locked cabinet. The names were not written in the questionnaire, no personal information was recorded at all.

4.12.3 Ethical Approval

Ethical approval for this proposal was obtained from the Ethical Committee at Al-Quds University. Permission was obtained from the ministry of health for the data collection that conducted at (Nablus, Jenin, Tubas, Qalqilya, Tulkarm, and Salfit) main clinics (Appendix 1; Appendix 2).

Chapter Five:

Results

5.1 Introduction

This chapter presents the analysis of the data which was collected. In this chapter the data collected were thoroughly edited, tabulated, analyzed, and interpreted to provide a comprehensive understanding of the perceived quality of the immediate postpartum care components offered to mothers and their newborns at childbirth facilities in the Northern area of West Bank.

5.2 Reliability of the Scales

The reliability coefficients range from 0.84 to 0.96, indicating strong internal consistency across all scales, as seen in (Table 5.1).

Table 5.1. Cronbach's Alpha for the Study Scales

Scale	**Items**	**Cronbach's Alpha**
Care provided to the mother during the first hour after normal delivery	7	0.84
Care provided to the mother in the postpartum department, i.e. after the first hour of birth	10	0.87
Postnatal care and instructions for taking care of the baby	14	0.92
Health education and counseling for maternal care before discharge from hospital	11	0.96
Overall satisfaction with postnatal care	6	0.94

5.3. Participants' Characteristics

Three hundred and thirty-eight mothers participated in the study. The analysis revealed that majority of participants 144 (42.6%) were aged between 24-29 years. More than half 184 (54.4%) had a university degree and most participants 273 (80.8%) were not employed. In terms of residence, the majority 260 (76.9%) lived in cities. The largest proportion of participants 196 (58.0%) reported a family monthly income between 1,800-3,000 NIS, as seen in (Table 5.2).

Table 5.2. Distribution of Socio Demographic Characteristics (N=338)

Variable		F	(%)
Age	18- 23 years	74	21.9
	24- 29 years	144	42.6
	30-35 years	97	28.7
	36 years and above	23	6.8
Educational level	Primary	20	5.9
	Secondary	128	37.9
	University	184	54.4
	Other	6	1.8
Work	Yes	65	19.2
	No	273	80.8
Place of residence	Village	52	15.4
	Camp	26	7.7
	City	260	76.9
Family monthly income	Less than 1800 NIS	61	18.0
	1800- 3000 NIS	196	58.0
	3000 NIS and above	81	24.0
Data based on Frequencies (F) and Percentages (%)			

5.4 Distribution of Information Related to Pregnancy and Childbirth History

The study showed that the mean number of live births was 2.60 (SD = 1.38), and the mean number of pregnancies was 3.01 (SD = 1.81), as indicated in (Table 5.3). There were an average of 0.41 (SD = 0.93) miscarriages and 0.04 (SD = 0.25) child deaths yearly. About half of the participants, 169 (50.0%), had two to three children. Furthermore, 286 (84.6%) of the participants said they had no health issues or challenges during their pregnancy. The participants also reported that it had been 20.1 days (SD = 19.9) since the birth of their last child.

Table 5.3. Distribution of Information Related to Pregnancy and Childbirth History (N=338)

Variable		F	(%)	M	SD
Number of pregnancies				3.0059	1.80995
Number of live births				2.6036	1.38117
Number of miscarriages				0.4053	0.93318
Number of deaths				0.0385	0.24664
Number of children	One child	86	25.4		
	2-3 children	169	50.0		
	4 and above	83	24.6		
Health problems or complications during pregnancy	Hypertension or Preeclampsia	5	1.5		
	Diabetes or gestational diabetes	12	3.6		
	Anemia (HB less than 11)	35	10.4		
	Nothing	286	84.6		
How many days have passed since you gave your last child				20.1	19.9
Data based on Frequencies (F), Percentages (%), Mean (M) and Standard Deviation (SD)					

5.5 Distribution of Information Related to Childbirth

The analysis revealed that 181 (53.6%) of participants had a normal delivery with vaginal episiotomy. Most participants 297 (87.9%) reported no complications during or after childbirth. In terms of hospital type, 170 (50.3%) of childbirth was in governmental hospitals. The majority of births 213 (63.0%) occurred in the morning (7 AM – 3 PM) and 176 (52.1%) of participants leaving the hospital in the morning. Also, more than half of the participants 192 (56.8%) spent between 6-12 hours in the hospital post-delivery. In terms of infant feeding practices, 162 (47.9%) of mothers exclusively breastfed their babies, as seen in (Table 5.4).

Table 5.4. Distribution of Information Related to Childbirth (N=338)

Variable		F	(%)
Type of last delivery	Normal delivery without vaginal episiotomy	157	46.4
	Normal delivery with vaginal episiotomy	181	53.6
Complications during or after the last birth	No complications at all	297	87.9
	Complications for the mother	14	4.1
	Complications for the child	20	5.9
	Complications for the mother and child	7	2.1
Hospital	Governmental	170	50.3
	Non-governmental	168	49.7
Birth was in	Morning (7 am -3 pm)	213	63.0
	Evening (after 3 pm)	125	37.0
Time of discharge from the hospital	Morning (7 am -3 pm)	176	52.1
	Evening (after 3 pm)	162	47.9
Number of hours you spent in the hospital after birth	Less than 6 hours	81	24.0
	6-12 hours	192	56.8
	More than 12 hours	65	19.2
Current breast-feeding	Limited to breastfeeding only.	162	47.9
	A combination of breastfeeding and formula milk	153	45.3
	Only formula milk	23	6.8
Data based on Frequencies (F) and Percentages (%)			

The analysis revealed that 50.3% of mothers reported that their childbirth was in governmental hospitals, as seen in (Figure 5.1).

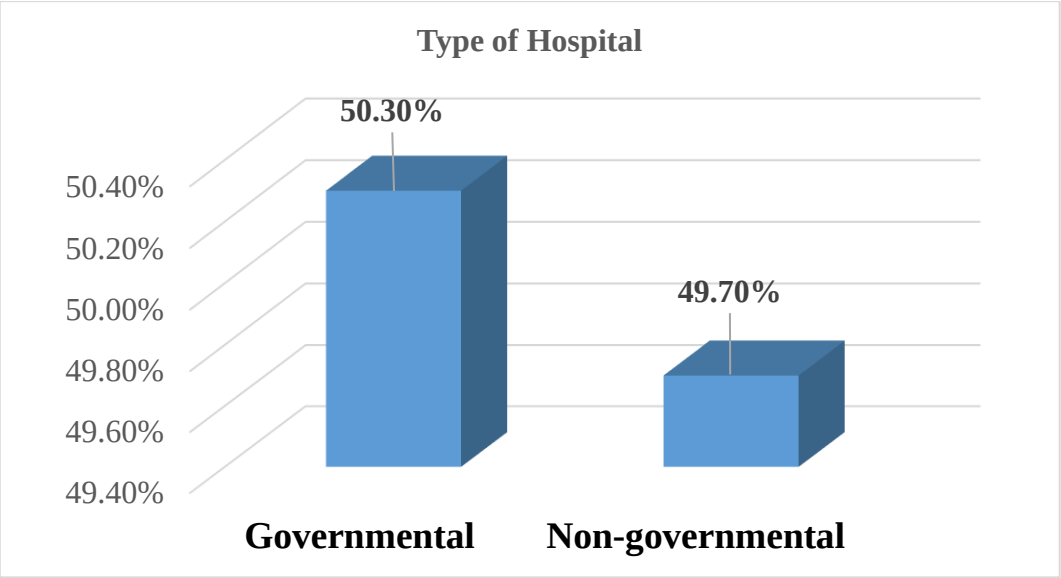


Figure 5.1. Distribution of the Participants Regarding Hospitals (N=338)

5.6 Research Questions Answers

5.6.1 Research Question One

What is the level of the perceived quality of immediate postpartum care provided to mother during the first hour post-delivery in the Northern area of West Bank?

A generally positive view of care was shown by the study, which showed that the mother's overall mean score for the perceived qualityof immediate postpartum care received during the first hour after birth was 3.8 (SD = 0.8).

The midwife/nurse checking vital signs immediately after birth and every quarter hour during the first hour was the item with the highest rating, according to the items analysis (M = 4.1, SD = 1.0). Likewise, a mean score of 4.0 (SD = 1.1) was obtained for keeping an eye out for bleeding symptoms and making sure uterine contractions were routinely evaluated. High marks were also given to the midwife/nurse who kept the woman in the delivery room for at least an hour after the birth (M = 4.0, SD = 1.1). Assistance with personal care, such as helping the mother dress and shower (M = 3.3, SD = 1.4) and emptying her bladder (M = 3.8, SD = 1.2), was associated with lower scores.

Table (5.5) shows that encouragement and support for immediate breastfeeding had a modest score (M = 3.9, SD = 1.1).

Table 5.5. Distribution of Participants Regarding Perception of Perceived qualityCare Provided to the Mother during the First Hour after Normal Delivery (n=338)

	Item	M	SD
1	The midwife/nurse kept me in the delivery room for at least an hour after the birth	4.0	1.1
2	The midwife/nurse checked my vital signs such as blood pressure and pulse immediately after the birth and every quarter of an hour during the first hour after my birth	4.1	1.0
3	The midwife/nurse make uterus massage every quarter of an hour after the birth.	3.9	1.2
4	The midwife/nurse monitored for signs of bleeding such as the amount of blood after the birth and the contractions of the uterus every quarter of an hour.	4.0	1.1
5	The midwife/nurse helped me go to the bathroom to empty my bladder	3.8	1.2
6	I breastfed my baby immediately within the first hour after the birth with the help and encouragement of the midwife/nurse	3.9	1.1
7	The midwife/nurse helped me to shower and dress myself	3.3	1.4
Total Mean		**3.8**	**0.8**
Data based on Mean (M) and Standard Deviation (SD)			

5.6.2 Research Question Two

What is the level of the perceived quality of immediate postpartum care provided to mother after the first hour post-delivery in the Northern area of West Bank?

A generally positive opinion of care was shown by the study, which showed that the mother's overall mean score for the perceived quality of the immediate postpartum care she received after the first hour after giving birth was 3.5 (SD = 0.83). According to the items analysis, the most highly rated postpartum care items were encouraging regular bladder emptying (M = 4.1, SD = 1.0), checking blood pressure and pulse hourly for the first four hours (M = 4.1, SD = 1.0), and giving painkillers when necessary (M = 4.2, SD = 0.9). But according to (Table 5.6), the statement that was rated the lowest was talking about the husband's or family's role in supporting the mother (M = 2.6, SD = 1.4). This was followed by checking the breasts for engorgement or cracking (M = 2.8, SD = 1.4) and encouraging the mother or husband to have a companion (M = 3.1, SD = 1.5).

Table 5.6. Distribution of Participants Regarding Perception of Perceived quality Care Provided to the Mother after the First Hour Post-Delivery (n=338)

	Item	M	SD
1	The midwife/nurse monitored my blood pressure and pulse every hour for the first 4 hours after birth	4.1	1.0
2	The midwife/nurse encouraged me to empty my bladder frequently	4.1	1.0
3	The midwife/nurse checked my vaginal wound, if any, approximately every 8 hours	3.3	1.2
4	The midwife/nurse gave me painkillers when needed	4.2	.9
5	The midwife/nurse helped me to breastfeed	3.9	1.2
6	The midwife/nurse examined my breasts to check for engorgement and cracking	2.8	1.4
7	The midwife/nurse discussed the role of the family, especially the husband, in supporting the mother after birth	2.6	1.5
8	The midwife encouraged me to have someone I wanted to accompany me, such as my husband or mother	3.1	1.5
9	The midwife/nurse encouraged early mobilization after birth	3.4	1.5
10	The hospital provided me with a meal after birth	4.0	1.1
Total Mean		**3.5**	**0.8**
Data based on Mean (M) and Standard Deviation (SD)			

5.6.3 Research Question Three

What is the level of the perceived quality of immediate postpartum care provided to newborns during hospitalization time in the Northern area of West Bank?

The results of the study showed that the perceived quality of the immediate postpartum care given to neonates during their hospital stay had a mean score of 3.8 (SD = 0.9), which is generally positive. The items analysis revealed that the most highly rated newborn care items were the following: monitoring vital signs such as temperature and pulse (M = 4.3, SD = 0.7), doctor-led examinations before discharge (M = 4.1, SD = 1.1), and the application of identification bands and immediate post-birth baby checks (M = 4.3, SD = 0.8). Table (5.7), however, reveals that the vaccine booklet and explanation of immunizations were rated lowest (M = 3.3, SD = 1.4), followed by tips for umbilical care (M = 3.5, SD = 1.4), infant warming and airway clearance (M = 3.4, SD = 1.4), and vaccinations.

Table 5.7. Distribution of Participants Regarding Perception of the Perceived qualityof Immediate Postpartum Care Provided To Newborns during Hospitalization (N=338)

	Item	M	SD
1	The midwife/nurse checked the baby immediately after birth and sure identification bands are apply	4.3	0.8
2	The midwife/nurse checked the baby's vital signs such as temperature and pulse	4.3	0.7
3	The midwife/nurse made sure that the baby had urinated and defecated before discharge.	3.9	1.1
4	The midwife/nurse provided me with the necessary instructions for caring for the umbilical area	3.5	1.4
5	The midwife/nurse explained to me about the risk factors for the baby that require a referral to a health center to the hospital such as jaundice, lethargy.	3.6	1.4
6	The doctor encouraged me to start and continue breast-feeding	4.0	1.1
7	The doctor examined the baby after birth	3.8	1.2
8	The midwife/nurse explained to me about vaccinations and the vaccination booklet	3.3	1.4
9	The doctor examined my baby before leaving the hospital	4.1	1.1
10	The doctor gave me an appointment for a follow-up if necessary	3.7	1.3
11	The midwife/nurse explained to me about the PKU examination	3.7	1.3
12	The midwife/nurse provided me with the necessary instructions such as keeping the baby warm and keeping the airway clear.	3.4	1.4
13	The midwife/nurse provided me with the necessary instructions for the breastfeeding process	3.5	1.4
14	The instructions I was given about caring for the baby were sufficient for caring for the baby after leaving the hospital	3.6	1.2
Total Mean		**3.8**	**0.9**
Data based on Mean (M) and Standard Deviation (SD)			

5.6.4 Research Question Four

To what extent do the postpartum mothers receive information before discharge from the hospital?

According to the analysis, postpartum mothers who received information prior to being released from the hospital achieved a mean score of 3.2 (SD = 1.2), which indicates a neutral perception. The items analysis revealed that the highest-rated health education items were instructions on how to take care of perineal and sutures (M = 3.6, SD = 1.2), food and hydration intake guidelines (M = 3.4, SD = 1.5), and iron supplementation after childbirth (M = 3.4, SD = 1.5). Table (5.8) shows that the categories with the lowest ratings were postpartum exercise and movement education (M = 2.7, SD = 1.5), family planning and contraceptive counseling (M = 2.7, SD = 1.5), and information on risk factors that required medical care (M = 3.0, SD = 1.5).

Table 5.8. Distribution of the Postpartum Mothers Receive Information before Discharge from the Hospital (n=338)

	Item	M	SD
1	I received the necessary instructions on the necessity of self-care and hygiene.	3.3	1.5
2	I received the necessary instructions on perineal care and stitches care.	3.6	1.2
3	I received the necessary instructions on the importance of diet and fluid intake after childbirth	3.4	1.5
4	I received the necessary instructions to educate me on the importance of getting enough rest after childbirth and adequate sleep.	3.2	1.5
5	I received instructions on caring for my breasts before and after breastfeeding	3.0	1.5
6	The midwife/nurse explained to me the necessary exercises to restore my health after childbirth and the importance of movement	2.7	1.5
7	I received the necessary information on the risk factors that require me to go to the hospital such as (dizziness, fever, headache, blurred vision)	3.0	1.5
8	I received sufficient information on the importance of family planning and contraceptives and how to obtain them	2.7	1.5
9	I received instructions on the necessity of visiting the primary health care center after 6 days and 6 weeks after childbirth to check on my health after childbirth	3.2	1.5
10	The midwife/nurse explained the necessity of taking iron pills after childbirth	3.4	1.5
11	The information provided to me was sufficient for me to take care of myself after childbirth	3.2	1.4
Total Mean		3.2	1.2
Data based on Mean (M) and Standard Deviation (SD)			

5.6.5 Research Question Five

Are the mothers satisfied with the immediate care provided to them and to their newborns and teaching received during hospitalization in the Northern area of West Bank?

Mothers expressed the highest satisfaction with the care they received during the first hour after birth (M = 4.1, SD = 1.1) and in the postpartum department, i.e., after the first hour after birth (M = 4.1, SD = 1.1), while they were less satisfied with the health education they received for themselves (M = 3.6, SD = 1.3) and their newborns (M = 3.6, SD = 1.3), according to the analysis, which showed a total mean score for satisfaction of 3.9 (SD = 1.0), indicating a generally positive perception of postnatal care (Table 5.9).

Table 5.9. Distribution of the Mothers' Perception Regarding Satisfaction with Postnatal Care (n=338)

Item	M	SD
The care I received during the first hour after birth	4.1	1.1
The care I received in the postpartum department, i.e. after the first hour after birth	4.1	1.1
The care I received for my child after birth	4.0	1.1
The health education I received for me after birth	3.6	1.3
The health education I received for my child after birth	3.6	1.3
The overall care I received after birth	3.9	1.2
Overall satisfaction	**3.9**	**1.0**
Data based on Mean (M) and Standard Deviation (SD)		

5.6.6 Research Question Six

Is there any association with the sociodemographic, obstetric and childbirth facilities characteristics with the perceived quality of immediate postpartum?

According to the study, there were no statistically significant differences in the perceived quality of immediate postpartum care within the first hour after delivery between age, educational attainment, employment status, and place of residence ($p>0.05$). However, there was a statistically significant difference between the perceived quality of treatment and family monthly income ($F = 9.588$, $p = 0.000$). According to Table (5.10), mothers who earned 3,000 NIS or more per month ($M = 4.1$, $SD = 0.8$) reported significantly higher feelings of care perceived quality than mothers who made less than 1,800 NIS ($M = 3.5$, $SD = 0.8$, $p = 0.000$) or between 1,800 and 3,000 NIS ($M = 3.8$, $SD = 0.8$, $p = 0.010$).

Table 5.10. Differences between sociodemographic characteristics and the perceived quality of immediate postpartum care during the first hour post-delivery

Variable		N	M	SD	Test	P. Value	Pair comparisons
Age	18- 23 years	74	3.7	0.8	F= 1.548	0.202	Not sig. for all
	24- 29 years	144	3.9	0.9			
	30-35 years	97	3.9	0.7			
	36 years and above	23	3.7	0.7			
Educational level	Primary	20	3.9	0.9	F= 0.894	0.444	Not sig. for all
	Secondary	128	3.9	0.8			
	University	184	3.8	0.8			
	Other	6	4.2	0.9			
Work	Yes	65	3.9	0.9	t= 0.168	0.867	
	No	273	3.8	0.8			
Place of residence	Village	52	3.8	0.8	F= 2.040	0.132	Not sig. for all
	Camp	26	4.2	0.7			
	City	260	3.8	0.8			
Family monthly income	Less than 1800 NIS	61	3.5	0.8	F= 9.588	0.001	C1–C2=0.062 C1-C3=0.000 C2-C3=0.010
	1800- 3000 NIS	196	3.8	0.8			
	3000 NIS and above	81	4.1	0.8			

Note: C1= less than 1800 NIS, C2 1800- 3000 NIS, C3=3000 NIS and above

Age and educational attainment did not significantly affect the perceived quality of immediate postpartum care beyond the first hour after birth, according to the analysis ($p > 0.05$). Work status, however, was a significant factor; mothers who were employed reported higher-perceived quality care ($M = 3.8$, $p = 0.013$) than mothers who were not employed ($M = 3.5$). Additionally, there was a significant difference ($P<0.05$) in the perceived quality of treatment between residences. Interestingly, there were no significant differences in pair comparisons between mothers from the village, camp, and city ($P>0.05$). Finally, there was a substantial difference ($p =< 0.001$) between reported care perceived quality and family monthly income. As shown in Table (5.11), mothers who earned more than 3,000 NIS ($M = 3.7$) reported higher-perceived quality care than mothers who earned less than 1,800 NIS ($M = 3.2$).

Table 5.11. Differences between Sociodemographic Characteristics and the Perceived qualityof Immediate Postpartum Care after the first hour Post-Delivery

Variable		N	M	SD	test	p. value	Pair comparisons
Age	18- 23 years	74	3.3	0.9	F= 1.862	0.136	thirty-eight
	24- 29 years	144	3.7	0.9			
	30-35 years	97	3.6	0.8			
	36 years and above	23	3.6	0.8			
Educational level	Primary	20	3.8	0.8	F= 0.972	0.406	Not sig. for all
	Secondary	128	3.5	0.9			
	University	184	3.5	0.8			
	Other	6	3.6	0.9			
Work	Yes	65	3.8	0.8	t= 2.501	0.013	
	No	273	3.5	0.8			
Place of residence	Village	52	3.7	0.7	F= 3.563	0.029	Village –camp = 1.0 Village –city= 0.126 Camp –city= 0.153
	Camp	26	3.8	1.0			
	City	260	3.5	0.8			
Family monthly income	less than 1800 NIS	61	3.2	0.8	F= 7.444	0.001	C1 –C2=0.062 C1-C3= <0.001 C2-C3=0.010
	1800- 3000 NIS	196	3.6	0.9			
	3000 NIS and above	81	3.7	0.7			

Note: C1= less than 1800 NIS, C2 1800- 3000 NIS, C3=3000 NIS and above

The analysis revealed had an average number of weak positive correlations with the number of pregnancies this year (r=0.038) which was also most not at all significantly related to the perceived quality of immediate postpartum care during the first hour after delivery (p=0.491). The same weak correlation held for number of live births (r=0.018, p=0.745) and number of miscarriages (r=-0.014, p=0.791) and the perceived quality of care. The number of deaths were weakly positively correlated (r=0.068) but not statistically significant (p=0.210) as in Table (5.12).

Table 5.12. Association between obstetric history and the perceived quality of immediate postpartum care during the first hour post-delivery

Variable	r (p. value)
Number of pregnancies	0.038 (0.491)
Number of live births	0.018(0.745)
Number of miscarriages	-0.014(0.791)
Number of deaths	0.068(0.210)

The findings suggest that the three groups differ significantly in their perceived qualityof immediate postpartum care at the first hour after birth on the basis of the number of children. The mean perceived quality of care for women with one child (M = 3.6, SD = .8) was rated lower than (M = 4.0, SD = 0.8) for mothers of two-three children and (M = 3.9, SD = 0.8) for mothers with four or more children. The pairwise comparisons indicated that mothers with one child received significantly poorer care than mothers with two to three children (p = 0.001) and mothers with four or more children (p = 0.023). In fact, according to the statistical analysis, important funding disparities exist (F = 6.743, p = 0.001). For mothers without diabetes, gestational diabetes, or anemia as potential complications, differences were not statistically significant (F = 1.271, p = 0.284) as illustrated in Table (5.13).

Table 5.13. Differences between obstetric history and the perceived quality of immediate postpartum care during the first hour post-delivery

Variable		N	M	(SD)	test	p. value	Pair comparisons
Number of children	One child	86	3.6	0.8	F= 6.743	0.001	C1 –C2=0.001 C1-C3=0.023 C2-C3=1.00
	2-3 children	169	4.0	0.8			
	4 and above	83	3.9	0.8			
Health problems or complications during pregnancy	hypertension or Preeclampsia	5	4.4	0.8	F= 1.271	0.284	Not sig. for all
	Diabetes or gestational diabetes	12	3.8	1.1			
	Anemia (HB less than 11)	35	3.7	0.9			
	Nothing	286	3.9	0.8			

Note: C1= One child, C2= 2-3 children, C3=4 and above

There was no discernible relationship between the quantity of pregnancies and the standard of immediate postpartum care beyond the first hour after birth, according to the analysis (r = 0.001, p = 0.982). The number of live births and postpartum care did not significantly correlate (r = 0.033, p = 0.542). The number of miscarriages and the standard of postpartum care had a weakly negative connection (r = -0.080, p = 0.141), although this was not statistically significant. While there was a weak positive connection between the number of deaths and the perceived quality of postpartum care (r = 0.089, p = 0.103), Table 5.14 shows that this relationship was not statistically significant.

Table 5.14. Association between obstetric history and the perceived quality of immediate postpartum care after the first hour post-delivery

Variable	r (p. value)
Number of pregnancies	0.001 (0.982)
Number of live births	0.033 (0.542)
Number of miscarriages	0.080 (0.141)
Number of deaths	0.089 (0.103)

Following the first hour following delivery, the number of children exhibited a significant difference in the perceived quality of immediate postpartum care, according to the study ($F = 4.1$, $p = 0.017$). Mothers with one kid and those with two to three children ($p = 0.047$) and mothers with one child and those with four or more children ($p = 0.026$) differed significantly, according to post-hoc pairwise comparisons. Mothers with two to three children and those with four or more children did not, however, vary significantly ($p = 1.00$). Pregnancy-related health issues or complications did not significantly affect the perceived quality of postpartum treatment ($P>0.05$), as shown in (Table 5.15).

Table 5.15. Differences between obstetric history and the perceived quality of immediate postpartum care after the first hour post-delivery

Variable		N	M	(SD)	test	p. value	Pair comparisons
Number of children	One child	86	3.3	0.8	F= 4.108	0.017	C1 –C2=0.047 C1-C3=0.026 C2-C3=1.00
	2-3 children	169	3.6	0.9			
	4 and above	83	3.7	0.8			
Health problems or complications during pregnancy	hypertension or Preeclampsia	5	4.2	0.4	2.034	0.109	Not sig. for all
	Diabetes or gestational diabetes	12	3.9	1.1			
	Anemia (HB less than 11)	35	3.6	0.9			
	Nothing	286	3.5	0.8			

Note: C1= One child, C2= 2-3 children, C3=4 and above

5.6.7 Research Question Seven

Is there any association with the place of delivery, time of discharge, type of delivery, duration of hospital stays, complications and the perceived quality of the immediate postpartum care?

Postpartum care given to mothers during the first hour after delivery did not vary significantly with respect to the kind of delivery, any complications during or after the last delivery, time of delivery and discharge, or current breastfeeding practices, according

to the analysis (p > 0.05). Mothers in non-governmental hospitals reported that better postpartum care perceived quality was delivered (M = 4.0, SD = 0.7) than in governmental hospitals (M = 3.7, SD = 0.9; p = <0.001). This indicates that hospital type indeed had a statistically significant difference. Also, a significant difference was noted in hours spent in the hospital post-delivery (p<0.05). There were significant differences between mothers who were less than 6 hours and 6-12 hours in the hospital (p =< 0.001), whereas pairwise comparisons shown in Table (5.16) indicate no significant difference between those in the hospital for 6-12 hours and greater than 12 hours (p = 0.060).

Table 5.16. Differences between childbirth characteristics and perceived qualityof immediate postpartum care provided to mothers during the first hour post-delivery

Variable		N	M	(SD)	test	p. value	Pair comparisons
Type of last delivery	Normal delivery without vaginal episiotomy	157	3.9	0.8	t= 0.168	0.682	
	Normal delivery with vaginal episiotomy	181	3.8	0.8			
Complications during or after the last birth	No complications at all	297	3.9	0.8	F= 1.526	0.208	Not sig. for all
	Complications for the mother	14	4.1	0.7			
	Complications for the child	20	3.5	0.9			
	Complications for the mother and child	7	3.8	0.7			
Hospital	Governmental	170	3.7	0.9	t= 4.319	<0.001	
	Non-governmental	168	4.0	0.7			
Birth was in	Morning (7 am -3 pm)	213	3.9	0.8	t= 1.756	0.080	
	Evening (after 3 pm)	125	3.7	0.8			
Time of discharge from the hospital	Morning (7 am -3 pm)	176	3.9	0.8	t= 1.263	0.207	
	Evening (after 3 pm)	162	3.8	0.9			
Number of hours you spent in the hospital after birth	Less than 6 hours	81	3.5	0.8	F= 14.912	<0.001	C1 – C2=0.000 C1-C3=0.071 C2-C3=0.060
	6-12 hours	192	4.0	0.8			
	More than 12 hours	65	3.8	0.8			
Current breastfeeding	Limited to breastfeeding only.	162	3.9	0.8	F= 1.718	0.181	Not sig. for all
	A combination of breastfeeding and formula milk	153	3.8	0.8			
	Only formula milk	23	3.8	1.0			

Note: C1= Less than 6 hours, C2= 6-12 hours, C3= More than 12 hours

No significant variations in perceived quality were evident from the analysis conducted on the immediate postpartum care of the mothers after delivery from one hour onward, with respect to type of delivery, complications during or after the last birth, time of delivery, and time of discharge, current breastfeeding practices. When taking into account the type of hospital, there is indeed a difference statistically in the perceived quality of postpartum care offered to mothers who delivered in private hospitals (M = 3.71, SD = 0.67) as compared to those in public institutions (M = 3.36, SD = 0.94), with a level of significance of $p < 0.05$. The number of hours spent in the hospital post-delivery was significant: mothers who spent 6-12 hours in the hospital reported that the perceived quality of postpartum care available for them was the best (M = 3.73, SD = 0.86), while those who had shorter or longer hospital stays were less satisfied postoperatively ($p< 0.05$) with the results of inter-group comparisons shown in (Table 5.17).

Table 5.17. Differences between childbirth characteristics and perceived quality of immediate postpartum care provided to mothers after the first hour post-delivery

Variable		**N**	**M**	**(SD)**	**test**	**p. value**	
Type of last delivery	Normal delivery without vaginal episiotomy	157	3.6	0.8	t= 0.759	0.384	
	Normal delivery with vaginal episiotomy	181	3.5	0.9			
Complications during or after the last birth	No complications at all	297	3.5	0.8	F= 2.458	0.063	Not sig. for all
	Complications for the mother	14	3.8	0.7			
	Complications for the child	20	3.3	0.8			
	Complications for the mother and child	7	4.2	0.8			
Hospital	Governmental	170	3.4	0.9	t= 3.965	<0.001	
	Non-governmental	168	3.7	0.7			
Birth was in	Morning (7 am -3 pm)	213	3.6	0.8	t= 0.771	0.441	
	Evening (after 3 pm)	125	3.5	0.8			
Time of discharge from the hospital	Morning (7 am -3 pm)	176	3.6	0.8	t= 1.846	0.066	
	Evening (after 3 pm)	162	3.4	0.8			
Number of hours you spent in the hospital after birth	Less than 6 hours	81	3.3	0.7	F= 12.520	<0.001	C1–C2= 0.000 C1-C3= 1.00 C2-C3= 0.002
	6-12 hours	192	3.7	0.9			
	More than 12 hours	65	3.3	.8			
Current breastfeeding	Limited to breastfeeding only.	162	3.5	.8	F= 0.050	.951	Not sig. for all
	A combination of breastfeeding and formula milk	153	3.5	.9			
	Only formula milk	23	3.5	1.1			

Note: C1= Less than 6 hours, C2= 6-12 hours, C3= More than 12 hours

5.6.8 Research Question Eight

Is there a relationship between the perceived quality of postnatal care and continuity of breast feeding?

The analysis of the relationship between the perceived quality of postnatal care and the continuity of breastfeeding shows no significant correlation. The correlation coefficient (r) is 0.015 with a p-value of 0.781, indicating that the perceived quality postnatal care does not have a statistically significant relationship with the current breastfeeding practices of mothers in the study, as seen in (Table 5.18)**.**

Table 5.18. Correlation between Perception of Postnatal Care Perceived quality and Continuity of Breastfeeding

Variable	**Perception of perceived qualityof postnatal care**
	r (p. value)
Current breastfeeding	0.015 (0.781)

The analysis indicated a moderate positive correlation between satisfaction and the perceived quality of care provided to mothers during the first hour post-delivery (r = 0.371, p =< 0.001). A stronger positive correlation is observed between satisfaction and the perceived quality of postpartum care provided to mothers after the first hour post-delivery (r = 0.581, p =< 0.001). The highest correlation is noted between satisfaction and the perceived quality of immediate postpartum care provided to newborns during hospitalization (r = 0.616, p =< 0.001), suggesting that perceived high-perceived quality care for newborns is strongly associated with overall satisfaction, as seen in (Table 5.19).

Table 5.19. Relationship between Satisfaction and perception of perceived quality of Care

Variable	**Satisfaction**
	r (p. value)
Perceived quality of immediate postpartum care provided to mother during the first hour post-delivery	0.371**< (0.001)
Perceived quality of immediate postpartum care provided to mother after the first hour post-delivery	0.581**< (0.001)
Perceived quality of immediate postpartum care provided to newborns during hospitalization	0.616**< (0.001)

5.7 Summary of Results

The demographic analysis showed that most participants were aged 24–29 years (42.6%), held a university degree (54.4%), were unemployed (80.8%), and resided in urban areas (76.9%). Obstetric history revealed an average of 3 pregnancies, 2.6 live births, and 84.6% of the mothers reported no complications during pregnancy. Over half (53.6%) had normal deliveries with episiotomy, and 47.9% practiced exclusive breastfeeding.

Regarding the quality of care, the study found that during the first hour post-delivery, the mean score was (M=3.8), indicating a generally positive perception, especially for monitoring vital signs and bleeding. However, support for personal hygiene was rated lower. After the first hour, the quality score declined slightly to(M=3.5)
, with strengths in pain management and vital sign monitoring, while family involvement and breast examination received lower ratings. Care for newborns received a mean score of (M=3.8), with high ratings for clinical assessments but lower ratings for health education about vaccines and newborn care. Health education provided to mothers before discharge had a neutral average score of (M=3.2) with notable deficiencies in topics such as family planning, postpartum exercises, and awareness of warning signs.

In terms of maternal satisfaction, the overall rating was positive (3.9/5), particularly for the clinical aspects of postpartum care, though educational support was less satisfactory. Statistically significant associations were identified, showing that higher family income, greater number of children, non-governmental hospital deliveries, and a postpartum hospital stay of 6–12 hours were linked to better perceived quality of care. No significant associations were found between care quality and breastfeeding continuation, complications, education level, or maternal age.

In conclusion, while immediate postpartum care in the Northern West Bank is generally viewed positively in its clinical aspects, there is a clear need to enhance educational and emotional support for mothers, particularly in family planning and postpartum recovery. Socioeconomic and institutional factors notably influence perceptions of care quality. The study recommends focused interventions in staff training, patient education, and healthcare policies to address these gaps and improve overall maternal and newborn outcomes.

Chapter Six:

Discussion

6.1. Introduction

This chapter interprets the findings of the study in light of previous research and the broader literature on maternal satisfaction with PNC. The discussion highlights how the study contributes to existing knowledge, explores possible explanations for the results, and suggests implications for practice and future research.

6.2 Overview of Key Findings

According to the study the perceived quality of postnatal care were generally favorable, particularly during the first hour following birth and in the postpartum unit. The highest satisfaction ratings were linked to clinical monitoring and newborn care. Actions such as newborn inspections, uterine assessments, and vital sign checks were rated higher by mothers than health education and support related to personal care, family involvement, and postpartum exercise. Pregnancy issues, family income, work status, and the number of children all had a substantial impact on perceived care quality, but age, education, birth mode, and pregnancy difficulties did not. Mothers who gave birth in government institutions reported less treatment than those who gave birth in private hospitals. Furthermore, a moderate to significant positive correlation was discovered between contentment and the quality of care, especially for neonates. These findings demonstrate how important it is to improve health education, offer emotional support, and standardize care across hospitals.

6.3 Care Provided During and After the First Hour after Normal Delivery

The current study found reduced satisfaction with personal care and breastfeeding support, despite a generally high view of immediate postpartum care, especially in monitoring and observation during the first hour following birth. A structured mother role adjustment program, on the other hand, dramatically increased maternal confidence and nursing success by 12 weeks postpartum, according to a prior study that used a pretest-posttest methodology. Aspects of the program that were rated lower in the current study were addressed via rooming-in, family education, and counseling. This implies that

including these activities into postpartum care could improve maternal outcomes and satisfaction over the long run (Song et al., 2020).
The present study examined how mothers felt about immediate postpartum care and found that they were more satisfied with clinical monitoring but less satisfied with personal care and breastfeeding support. The Norwegian study, on the other hand, focused on more general factors that affect mothers' perceived quality of life, like contentment, spouse relationships, and baby sleep. Although the current study focuses on immediate therapeutic treatments, Valla et al. (2022) emphasize the significance of emotional and relational support. These two studies illustrate distinct but complimentary components of postpartum care. In order to enhance maternal well-being, they collectively recommend that complete postpartum care should incorporate both excellent clinical treatment and psychosocial support.

A previous study highlighted the gaps in postnatal information and the need for woman-centered, nonjudgmental care, but also the need for comprehensive, compassionate, and open communication to address the needs of new mothers and lessen anxiety, especially among primigravida mothers. This implies that improved education and support for new mothers should be provided both before and after giving birth in order to increase maternal satisfaction (McLeish et al., 2020).

Similar to the need for ongoing quality enhancements and more customized assistance, particularly in the areas of postpartum education and personal care, a previous study found that postnatal care satisfaction increased with time in Sweden, but that knowledge and support gaps remained, particularly for older mothers, multiparous women, and women who had cesarean deliveries (Öhrn et al., 2020).

In a study investigated virtual obstetric care (Saad et al., 2021), it discovered high satisfaction because of comfort, convenience, and emotional connection with providers, whereas this study concentrated on immediate in-person postpartum care, emphasizing strong clinical practices but weaker support in personal care and breastfeeding. Regardless of whether care is provided in-person or virtually, both research emphasize how crucial good communication and trust are to raising maternal happiness. However, also urge more research on the impact of socioeconomic variables on virtual care experiences, a topic that isn't fully covered in current study.

With high ratings for both observation and vital sign monitoring, this study found that people's perceptions of immediate postpartum care were largely favorable. According to (Hajizadeh et al., 2020), on the other hand, postpartum women frequently report receiving disrespectful maternity care, particularly when it comes to limited movement and labor positions. Nonetheless, both findings emphasize how crucial patient-centered, compassionate treatment is. While the current study points to deficiencies in breastfeeding assistance and personal care, the other study emphasize patient autonomy and ethical treatment, highlighting the larger need for responsive and respectful maternity services.

6.4 Satisfaction with Postnatal Care

Mothers were most satisfied with the care they received in the postpartum department and in the first hour after giving birth, but they were less satisfied with the health information they received for both themselves and their babies. Overall satisfaction suggests that

postnatal care is generally viewed favorably. Immediate and respectful care is well-received.

Mothers in Sirik, Iran, reported satisfactory or exceptional postnatal care experiences, which is consistent with the study's findings. However, there were differences in satisfaction depending on some parameters like the quantity of follow-up visits and the caliber of interactions with medical personnel. This implies that maternal satisfaction is greatly influenced by staff interaction and continuity of care. The significance of continuous training for healthcare professionals in preserving and enhancing the quality of care is emphasized by both studies (Ahmadinezhad et al., 2022).

According to this study, satisfaction was much raised by emotional support and considerate treatment, such as maintaining skin-to-skin contact and respecting birth plans. Higher levels of satisfaction just after birth could be a reflection of similar instances of positive emotional and physical care. Though this could be a useful area for future research, the current study did not thoroughly examine the influence of emotional characteristics or delivery styles, in contrast to a prior Spanish study (Blanco López et al., 2021).

The results of this study closely resemble those of the Gaza study, which found that women were more satisfied with rapid postpartum care and less satisfied with health education (Alkasseh & Mwafy , 2019). Despite feeling that information distribution was inadequate, mothers in both trials praised the caliber of care provided to both mothers and newborns. This suggests that improving health education for mothers and babies is a regional or systemic necessity.

Mothers in Jeddah gave excellent ratings to the perceived quality of treatment, but their satisfaction was only moderate, mostly because of a lack of empathy and communication (Al-Hussainy et al., 2022). Although participants in this study expressed greater satisfaction, both findings stress the need of empathetic communication. The Saudi results support the notion that satisfaction depends on emotional and interpersonal factors in addition to technical care quality.

Despite identifying system-level problems such staff shortages, mistreatment, and infrastructure as obstacles, the Ibadan study revealed extremely high satisfaction (over 94%) with services (Odetola & Fakorede, 2018). Although these systemic problems were not thoroughly examined in this study, the poorer health education scores might be indicative of comparable difficulties. In order to sustain contentment, the study emphasizes the necessity of structural changes, quality control, and a nurturing atmosphere.

6.5 Sociodemographic and Health-System Determinants of PNC Utilization

The research has shown that few respondents give any significant weight to the demographic factors in their assessment of PNC. Perhaps this means that mothers tend to rely more heavily on personal knowledge to judge PNC rather than on other influences, regardless of their financial condition or life experiences. Yet, the perceived quality was reported to be significantly affected by few other variables: having many children, the working status of the mother, and the presence of pregnancy complications. This could infer that when evaluating satisfaction or perceived quality of care, working women or

women with many children could be more aware of service expectations or have previous experiences with which to compare.

Interestingly, the study also established that those mothers who gave birth at government health facilities perceived quality of care as somehow lower than those who delivered in private hospitals. This cuts across findings of other studies that bring to light systemic hurdles in public health sectors, including limited resources, staff shortages, and high patient loads—all of which influence service delivery and patient satisfaction negatively.

It was shown that maternal satisfaction is moderately to strongly correlated with perceived quality neonatal care. This prioritizes newborn care as the major component that influences the overall postnatal experience. When mothers feel that their newborns are well cared for in high quality, their level of satisfaction with the health setup increases. Based on this, suggestions have been made to improve perceived quality of care in public facilities, with special attention to working mothers and those with complicated pregnancies; and neonatal care as a priority for improving maternal satisfaction and health outcomes.

These results are consistent with research conducted in Sri Lanka, which found that teaching hospitals, interpersonal care, and education led to more positive opinions. This suggests that the type of facility and informational assistance play a significant role in affecting mother satisfaction (Wickramasinghe et al., 2019). Similarly, a study revealed that while care was generally seen favorably in Gaza, health education continued to be a weak spot, which is similar to the lower satisfaction in your study with relation to education for mothers and newborns (Alkasseh & Mwafy , 2019).

According to (Dey et al., 2021; Ndugga et al., 2020)in Uganda, facility-based births, media exposure, and health counseling are all significant predictors of postnatal care utilization and satisfaction, which further supports the impact of the place of delivery. This is supported by your data, which show that private facility deliveries probably have improved privacy, communication, or continuity of treatment, all of which increase patient satisfaction.

However, current data, perceived quality did not strongly correlate with more general sociodemographic patterns like wealth and education. This stands in contrast to research by (Adams & Young, 2022; Tessema et al., 2020), which found that lower income and education levels were associated with less knowledge of postpartum warning signs and less use of PNCs. This implies that structural health-system elements (such as staff conduct and facility type) might take precedence over personal background variables in your situation.

The correlation between overall maternal satisfaction and the perceived quality of neonatal care is in line with global data that demonstrates that respectful, knowledgeable care for both mother and child is essential for successful outcomes (Blanco López et al., 2021; Lythgoe et al., 2021). According to the Lythgoe et al. review, women's trust and usage of PNC services—particularly in vulnerable groups—are significantly impacted by courteous and compassionate care.

Furthermore, Jones et al. (2020) highlight the value of easily available, empowering information, showing how a straightforward SMS campaign increased postpartum

knowledge and service adoption. The need to improve educational outreach in both public and private contexts is supported by this, especially in situations when knowledge discontent endures.

6.6 Conclusion

The findings of this study indicate that the quality of immediate postpartum care provided to mothers and their newborns in the Northern West Bank is perceived as generally positive, particularly in clinical aspects such as monitoring vital signs, managing pain, and performing newborn assessments. However, notable gaps remain in non-clinical areas, especially in the provision of health education, emotional support, and family involvement. Mothers reported lower satisfaction with educational aspects related to family planning, postpartum exercises, and warning signs.

The study further highlights that socioeconomic and institutional factor, such as family income, type of hospital, and duration of hospital stay, significantly influence perceptions of care quality. Conversely, variables such as maternal age, education level, and complications during pregnancy were not significantly associated with perceived care quality. Additionally, no meaningful correlation was found between perceived care quality and continued breastfeeding practices.

In light of these findings, there is a clear need to strengthen postpartum care beyond clinical interventions by enhancing education, counseling, and psychosocial support. It is recommended that policymakers and healthcare administrators prioritize targeted strategies such as staff training, structured discharge education, and improved postpartum follow-up, especially in governmental facilities. Addressing these gaps can contribute to a more holistic approach to maternal and newborn health and improve overall satisfaction and outcomes in postpartum care services.

6.7 Recommendations

Future research:

A similar study could be conducted on large samples in different regions in the center and the South, and include vaginal delivery and cesarian section for wider generalization. Thus, future studies can be conducted among these groups of women to obtain a clear picture of the situation in Palestine.

Health care providers:

Regularly train healthcare providers on evidence-based immediate postpartum care practices, with emphasis on communication, empathy, and responsiveness to mothers' needs during the first 24 hour after delivery.

Equip midwives and nurses with updated knowledge and skills in postpartum care to enhance their ability to meet mothers' needs effectively.

Provide continuous education and hands-on training for nurses, midwives, and neonatal staff to improve their knowledge, skills, and responsiveness in neonatal care, family planning and warning sign in postnatal period

Allocate sufficient human and material resources in maternity wards to support the effective delivery of immediate postpartum care.

Women:

Educate women and families on the importance of continued care after childbirth to increase demand for quality services and early identification of complications.

Policy makers:

Develop and enforce standardized guidelines for immediate postnatal care to ensure consistent quality and reduce variability in service delivery in privet hospital and governmental hospital.

Continue Follow up and monitoring for the postnatal care provided to mothers especially at governmental childbirth facilities.

Stress on that postpartum mothers, should not be discharged early after delivery. A sufficient observation period is essential to monitor for complications such as postpartum hemorrhage, infection, and issues with breastfeeding or newborn health. Early discharge may compromise the detection and timely management of these conditions. Therefore, discharge should only occur once both mother and newborn are clinically stable, have received proper education on postpartum care, and a follow-up plan is in place.

6.8 Strengths and Limitations of the Study

The study serves to enhance the corpus of PNC literature in several ways. Mainly consisting of mothers' perspectives, it provides a unique insight into their postnatal experiences. By looking through the eyes of the client, the study makes an important contribution to legislators and healthcare professionals, especially with regard to the assessment and improvement of maternity and newborn health services. Furthermore, the results reveal disparities in service provision between the public and private healthcare sectors and show the consequences of newborn care on total maternal satisfaction.

Despite the advantages just enumerated, this research suffers from some limitations. One obvious problem stemmed from difficulty in collating comprehensive and reliable data from the participants. Recall bias can interfere with the data collection method, predominated by self-reporting: mothers being asked to remember events that took place several days or weeks prior. Furthermore, some prohibited the sharing of private information about pregnancy complications, dissatisfaction with services offered, and socioeconomic issues; hence, sensitive information was probably underreported or even socially permissible answers could have been given instead.

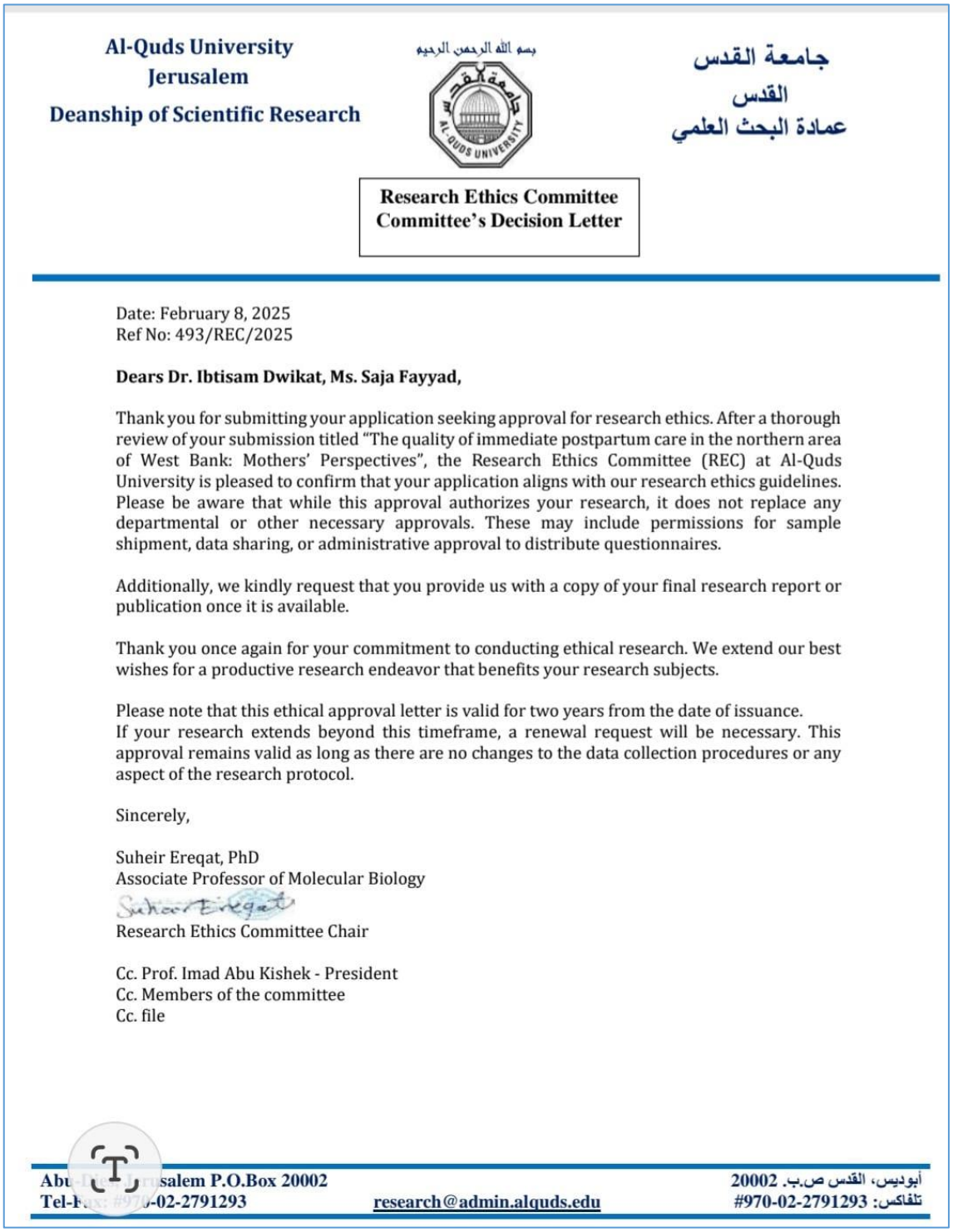
Setting up logistics was a major source of trouble. Participants were caught in slippery areas, sometimes geographically isolated, such that even the logistics of reaching them for follow-ups were beyond possibilities. There were instances when follow-ups simply could not be conducted, thereby leading to incomplete data collection. Furthermore, in some cases, participants' abilities related to reading and understanding did not extend far beyond very basic levels. Very simple wording or rephrasing of interview questions had to be carried out; this may have affected response consistency as well as data reliability.

Forthcoming constraints that might limit applicability for wider populations include the restricted geographic scope and small size of the study. In addition to that, the cross-sectional nature of the study limits the ability to assess long-term study outcomes and

does not measure change over time, hence cannot establish causal linkages. Therefore, future studies could design longitudinal investigations with follow-ups in order to be able to get a deeper understanding of maternal and neonatal outcomes. Finally, larger samples with greater variation should be included through a mixed-methods design that incorporates both quantitative and qualitative data, providing for a more holistic and nuanced view of postnatal care experiences.

Appendices

Appendix 1. IRB Approval Letter



Al-Quds University
Jerusalem
Deanship of Scientific Research

بسم الله الرحمن الرحيم

جامعة القدس
القدس
عمادة البحث العلمي

Research Ethics Committee
Committee's Decision Letter

Date: February 8, 2025
Ref No: 493/REC/2025

Dears Dr. Ibtisam Dwikat, Ms. Saja Fayyad,

Thank you for submitting your application seeking approval for research ethics. After a thorough review of your submission titled "The quality of immediate postpartum care in the northern area of West Bank: Mothers' Perspectives", the Research Ethics Committee (REC) at Al-Quds University is pleased to confirm that your application aligns with our research ethics guidelines. Please be aware that while this approval authorizes your research, it does not replace any departmental or other necessary approvals. These may include permissions for sample shipment, data sharing, or administrative approval to distribute questionnaires.

Additionally, we kindly request that you provide us with a copy of your final research report or publication once it is available.

Thank you once again for your commitment to conducting ethical research. We extend our best wishes for a productive research endeavor that benefits your research subjects.

Please note that this ethical approval letter is valid for two years from the date of issuance.
If your research extends beyond this timeframe, a renewal request will be necessary. This approval remains valid as long as there are no changes to the data collection procedures or any aspect of the research protocol.

Sincerely,

Suheir Ereqat, PhD
Associate Professor of Molecular Biology
Research Ethics Committee Chair

Cc. Prof. Imad Abu Kishek - President
Cc. Members of the committee
Cc. file

Abu Dis, Jerusalem P.O.Box 20002
Tel-Fax: #970-02-2791293
research@admin.alquds.edu
أبوديس، القدس ص.ب. 20002
تلفاكس: #970-02-2791293

Appendix 2. Facilitation Letter (MOH)

State of Palestine
Ministry of Health
Education in Health and Scientific
Research Unit

دولة فلسطين
وزارة الصحة
وحدة التعليم الصحي
والبحث العلمي

Ref.: .....
Date:.....

الرقم: ج.ص/٢٢٤٤/١٤٤٠
التاريخ: ٢٠١٨/٩/١٠م

عطوفة الوكيل المساعد لشؤون الصحة العامة وصحة الاسرة المحترم،،،

تحية واحترام،،،

الموضـــوع: تسهيل مهمة بحث

يرجى تسهيل مهمة **الطالبة: سجى عصري محمد فياض– ماجستير تمريض صحة امومة وطفولة/ جامعة القدس**، وباشراف د. ابتسام دويكات، في عمل بحث بعنوان:

جودة الرعاية الصحية المقدمة للام والطفل ما بعد الولادة في مستشفيات شمال الضفة الغربية. فلسطين

من خلال السماح للطالبة بجمع المعلومات عن طريق تعبئة استبانة من قبل النساء المراجعات، وذلك للعيادات التالية:

المحافظة	العيادة
نابلس	عيادة المخفية، العيادة المركزية، عيادة بلاطة وعيادة راس العين
جنين	عيادة البساتين
طولكرم	عيادة الصحة الشمالية
طوباس	عيادة طوباس المركزية وعيادة طوباس القديمة
سلفيت	العيادة المركزية
قلقيلية	العيادة المركزية

على ان يتم الالتزام باساليب واخلاقيات البحث العلمي، والحفاظ على سرية المعلومات.

على ان يتم تزويد الوزارة بنسخة PDF من نتائج البحث، التعهد بعدم النشر لحين الحصول على موافقة الوزارة على نتائج البحث.

مع الاحترام،،،

د. عبد الله القواسمي
رئيس وحدة التعليم الصحي والبحث العلمي

نسخة: منسق برنامج الدراسات العليا– دائرة التمريض المحترم/ جامعة القدس

Telfax.:09-2333901 scientificresearch.dep@gmail.com تلفاكس: 09-2333901

Appendix 3. Questionnaire English Version

Al-Quds University

Deanship of Scientific Research

Dear Mother
Greetings,
I am Saja Fayyad, a master's student in maternal and child health nursing at Al-Quds University. I am conducting a cross-sectional study as a graduation requirement titled: The Perceived qualityof Postpartum Healthcare Provided to Mothers and newborn in Hospitals in the Northern West Bank.
This study aims to assess the perceived qualityof healthcare provided to mothers and newborn during the first 24 hours after postnatal in hospitals in the Northern West Bank. This study targets mothers who have recently given birth normal delivery and who visit central maternity and child clinics in the North West Bank.

Dear Mother

Your participation in this research project is entirely voluntary, and you may withdraw from the study at any time without any impact on your personal or professional life. Researchers will have access to your individual responses, and no one will be able to link your identity to your answers on this questionnaire. The data collected will be securely store.
If you agree to participate in this study, please provide your answers to the questionnaire items. Completing the questionnaire will take approximately 12 minutes
If f you have any inquiries regarding this study or your rights as a participant, please do not hesitate to contact me via email: fayyadsaja5@gmail.com or phone: 0599826600.
Supervisor: Dr. Ibtisam Duweikat

Demographic information

Age:

☐18- 23 ☐ 24-29 ☐ 30-35 ☐ 36 and above

Educational level:

☐Primary ☐ Secondary ☐ University ☐ Other

Employment status:

☐Yes ☐ No

Place of residence:

☐Village ☐ Camp ☐ City

Household income:

☐Less than 1800 NIS ☐ 1800-3000 NIS ☐ 3000 and above

Pregnancy and childbirth information:

Number of pregnancies_____

Number of children: ☐ One child ☐ 2-3 children ☐ 4 and above

Number of live births_____

Number of miscarriages__

Number of neonatal deaths____

Health complications during pregnancy

☐hypertension or Preeclampsia

☐Diabetes or gestational diabetes

☐Anemia (HB less than 11)

☐Bleeding during pregnancy

How many days have passed since your last delivery _____

Type of last birth:

☐Normal delivery without perineal tear.

☐Normal delivery with perineal tear.

Complications during or after the last birth:

☐No complications

☐Complications for the mother

☐Complications for the child

☐Complications for the mother and child

Place of last birth:

☐Government hospital ☐ Private hospital ☐ Home

Time of delivery:

☐Morning period (7AM-3PM)

☐Evening period (after 3 pm)

Time of discharge from the hospital:

☐Morning period (7AM-3PM)

☐Evening period (after 3 pm)

Hours spent in the hospital after delivery:

☐Less than 6 hours

☐6-12hours

☐More than 12 hours

Current newborn feeding practice:

☐ Exclusive breastfeeding.

☐ combination of breastfeeding and formula.

☐ Formula feeding only (on breastfeeding)

Postnatal care for the mother in the first hour after normal delivery:

statement	**Strongly agree**	**agree**	**Neutral**	**disagree**	**Strongly disagree**
The midwife/nurse kept me in the delivery room for at least one hour after the birth					
The midwife/nurse checked my vital signs such as blood pressure and pulse immediately after the birth and every quarter of an hour during the first hour after my delivery.					
The midwife/nurse make uterus massage every quarter of an hour after delivery.					
The midwife/nurse monitored postnatal bleeding and uterine contractions every 15 minutes.					
The midwife/nurse assisted me in going to the bathroom to empty my bladder.					
I breastfed my baby within the first hour after delivery with the help and encouragement of the midwife/nurse.					
The midwife/nurse helped me with bathing and dressing					

Postnatal care for the mother after the first hour postpartum department.

statement	strongly agree	agree	neutral	disagree	strongly disagree
The midwife/nurse monitored my blood pressure and pulse every hour for the first 4 hours after postnatal.					
The midwife/nurse encouraged me to empty my bladder frequently.					
The midwife/nurse checked my perineal tear (if any) every 8 hours.					
The midwife/nurse gave me painkillers when needed					
The midwife/nurse assisted me with breastfeeding.					
The midwife/nurse examined my breasts for engorgement and cracking.					
The midwife/nurse discussed the role of the family, especially the husband, in supporting the mother after birth.					
The midwife encouraged a companion of my choice someone, such as my husband or mother to stay with me.					
The midwife/nurse encouraged early mobilization after birth.					
The hospital provided me with a meal after birth.					

Postnatal care and guidance for the newborn:

Statement	strongly agree	agree	neutral	disagree	strongly disagree
The midwife/nurse examined the baby immediately after birth and placed identification bracelet.					
The midwife/nurse checked the baby's vital signs including temperature and pulse					
The midwife/nurse ensured the baby had urinated and passed stool before discharge.					
The midwife/nurse provided guidance on umbilical cord care.					
The midwife/nurse explained waring sings requiring a health center visit such a jaundice, lethargy.					
The doctor encouraged me to start and continue breastfeeding					
The doctor examined the baby after birth					
The midwife/nurse explained newborn vaccinations and the vaccination record book.					
The doctor examined my baby before discharge.					
The doctor scheduled a follow-up if necessary.					
The midwife/nurse explained the newborn PKU examination.					
The midwife/nurse provided guidance on keeping the baby warm and keeping the airway clear.					
The midwife/nurse provided educated me on proper breastfeeding techniques.					
The instructions given for newborn care were sufficient for me to care for my baby after discharge.					

Health education and counseling for maternal care before hospital discharge:

Statement	**strongly agree**	**agree**	**neutral**	**disagree**	**strongly disagree**
I received the necessary instructions on the necessity of selfcare and hygiene.					
I received the necessary instructions on perineal care and stitches care.					
I received the necessary instructions on the importance of diet and fluid intake after childbirth					
I received the necessary instructions to educate me on the importance of getting enough rest after childbirth and adequate sleep.					
I received instructions on caring for my breasts before and after breastfeeding					
The midwife/nurse explained the necessary exercises for postnatal recovery and the importance of movement					
I received the necessary information on the risk factors that require me to go to the hospital such as (dizziness, fever, headache, blurred vision)					
I received sufficient information on the importance of family planning and contraceptives and how to obtain them					
I received instructions on the necessity of visiting the primary health care center after 6 days and 6 weeks after childbirth to check on my health after childbirth					
The midwife/nurse explained the necessity of taking iron supplements after childbirth					
The information provided to me was sufficient to take care of myself after childbirth.					

Overall satisfaction with postnatal care:

statement	**strongly agree**	**agree**	**neutral**	**disagree**	**strongly disagree**
The care I received during the first hour after birth					
The care I received in the postpartum department, i.e. after the first hour after birth					
The care I received for my child after birth					
The health education I received for me after birth					
The health education I received for my child after birth					
The overall care I received after birth					

If you intend to have children after this birth. Would you choose to give birth in the same hospital?

☐Yes ☐ No ☐ I do not want to give birth again

What are your recommendations to improve the perceived qualityof care provided by midwives after birth.

……

……

……

Appendix 4. Questionnaire Arabic Version

جامعة القدس

عمادة البحث العلمي

عزيزتي الأم

تحية طيبة وبعد،

أنا سجى فياض طالبة ماجستير تمريض صحة الام والطفل- جامعة القدس أقوم بإجراء دراسة مقطعية كمتطلب للتخرج بعنوان جودة الرعاية الصحية المقدمة للام والطفل ما بعد الولادة في مستشفيات شمال الضفة الغربية.

تهدف هذه الدارسة الى تقييم جودة الرعاية الصحية المقدمة للام والطفل في الـ 24 ساعة الأولى ما بعد الولادة في مستشفيات شمال الضفة الغربية.

تستهدف هذه الدراسة الأمهات حديثات الولادة اللواتي أنجبن اخر مولود بطريقة طبيعية ويترددن على عيادات الامومة والطفولة المركزية في محافظات شمال الضفة الغربية

عزيزتي الأم

مشاركتك في هذا المشروع البحثي تطوعية تمامًا ويمكنك الانسحاب من الدراسة في أي وقت تختارينه ولن تؤثر مشاركتك بأي شكل من الأشكال على حياتك الشخصية أو المهنية. ستبقى ردودك سرية ومجهولة الهوية؛ لن يطلع أي شخص آخر غير الباحثين على الإجابات الفردية ولن يستطيع أي شخص الربط بين هويتك وإجاباتك الفردية على هذا الاستبيان. سيتم الاحتفاظ بالبيانات الواردة من هذا البحث في مكان مغلق. إذا كنت توافقين على المشاركة في هذا المشروع، فيرجى تقديم إجاباتك على عناصر الاستبيان وقد يستغرق إكمال الاستبيان حوالي 12 دقيقة.

إذا كان لديك أي أستفسار حول هذا الموضوع أو فيما يتعلق بالدراسة أو حول حقوقك كمشاركة في الدراسة فلا تتردد بالسؤال عبر البريد الإلكترونيfayyadsaja5@gmail.com أو من خلال رقم الهاتف 0599826600

الدكتور المشرف: د. ابتسام دويكات

المعلومات الديموغرافية

العمر:

☐ 18-23 ☐24-29 ☐ 30- 35 ☐ 36 فما فوق

المستوى التعليمي:

☐أساسي ☐ ثانوي ☐جامعي ☐ غير ذلك

هل لديك عمل

☐نعم ☐ لا

مكان الإقامة:

☐قرية ☐ مخيم ☐ مدينة

معدل دخل الاسرة:

☐اقل من 1800 شيكل ☐ 1800-3000 شيكل ☐ 3000 فما أكثر

معلومات تتعلق بالحمل والولادة:

عدد مرات الحمل _____

عدد الأطفال: ☐ طفل واحد ☐ 2-3 أطفال ☐ 4 فما فوق

عدد المواليد الاحياء_____

عدد مرات الإجهاض ___

عدد الوفيات _____

مشاكل او مضاعفات صحية اثناء الحمل

☐ ضغط او تسمم حمل

☐ سكري او سكري حمل

☐ فقر دم (نسبة دم اقل من 11)

☐ نزيف اثناء الحمل

كم عدد الأيام التي مرت على وضعك مولودك الاخير _____

نوع الولادة الأخيرة:

☐ ولادة طبيعية بدون حدوث جرح مهبلي.

☐ولادة طبيعية مع حدوث جرح مهبلي.

مضاعفات خلال الولادة الأخيرة او بعدها :

☐ لم يحدث مضاعفات ابدا

☐ مضاعفات للام

☐ مضاعفات للطفل

☐ مضاعفات للام وللطفل

مكان الولادة الاخيرة:

☐ مستشفى حكومي ☐ مستشفى خاص ☐ البيت

الولادة كانت في

☐الفترة الصباحية (7-3)

☐الفترة المسائية (ما بعد الـ 3 مساءا)

وقت الخروج من المستشفى

☐الفترة الصباحية (7-3)

☐الفترة المسائية (ما بعد 3 مسائي)

عدد الساعات التي قضيتيها بالمستشفى ما بعد الولادة

☐ اقل من 6 ساعات

☐ 6 -12 ساعة

☐أكثر من 12 ساعة

رضاعة الطفل في الوقت الحالي

☒ تقتصر على الرضاعة الطبيعية فقط.

☐مزيج بين الرضاعة الطبيعية والحليب الصناعي.

☐ لم ارضع طفلي رضاعة طبيعية مطلقا (حليب صناعي فقط)

الرعاية المقدمة للام خلال الساعة الأولى بعد الولادة الطبيعية:

العبارة	اوافق بشدة	أوافق	لاينطبق	لا اوافق	لا أوافق بشدة
ابقتني القابلة/ الممرضة في غرفة الولادة لمدة ساعة كاملة بعد الولادة على الاقل					
تفحصت القابلة/ الممرضة العلامات الحيوية لي مثل الضغط والنبض مباشرة بعد الولادة كل ربع ساعة خلال الساعة الأولى بعد ولادتي					
قامت القابلة/الممرضة بتدليك الرحم لي كل ربع ساعة بعد الولادة					
راقبت القابلة/ الممرضة علامات النزيف مثل كمية الدم بعد الولادة وانقباض الرحم كل ربع ساعة					
ساعدتني القابلة/الممرضة عند الذهاب الي الحمام لتفريغ المثانة					
ارضعت طفلي مباشرة خلال الساعة الأولى من الولادة بمساعدة وتشجيع القابلة / الممرضة					
ساعدتني القابلة/ الممرضة بالاستحمام وارتداء ملابسي					

الرعاية المقدمة للأم في قسم ما بعد الولادة اي بعد انقضاء الساعة الأولى من الولادة

العبارة	اوافق بشدة	أوافق	لا ينطبق	لا أوافق	لا أوافق بشدة
راقبت القابلة / الممرضة ضغطي ونبضي كل ساعة خلال الـ 4 ساعات الأولى ما بعد الولادة					
شجعتني القابلة/الممرضة على تفريغ المثانة بشكل متكرر					
تفحصت القابلة/ الممرضة الجرح المهبلي ان وجدت كل 8ساعات تقريبا					
قامت القابلة/ الممرضة بإعطائي المسكنات عند اللزوم					
ساعدتني القابلة / الممرضة على ممارسة الرضاعة الطبيعية.					
قامت القابلة/ الممرضة بفحص الثدي					

لفحص الاحتقان و التشقق)					
قامت القابلة/ الممرضة بمناقشة دور الاسرة وخاصة الزوج في دعم الام بعد الولادة.					
شجعت القابله أن يكون معي شخص ممن أرغب ان يرافقني مثل زوجي أو امي					
شجعتني القابلة/ الممرضة على الحركة بعد الولادة					
وفر لي المستشفى وجبة طعام بعد الولادة					

الرعاية المقدمة للطفل ما بعد الولادة والارشادات اللازمة للعناية به

العبارة	اوافق بشدة	أوافق	لاينطبق	لا اوافق	لا أوافق بشدة
تفقدت القابلة/ الممرضة الطفل مباشرة بعد الولادة ووضع إسواره التعريف عنه					
فحصت القابلة/ الممرضة العلامات الحيوية للطفل مثل الحرارة والنبض					
قامت القابلة/ الممرضة بالتأكد ان الطفل تبول واخرج قبل الخروج من المستشفى					
قامت القابلة/ الممرضة بتقديم الارشادات الازمة للعناية بمنطقة السرة					
شرحت القابلة / الممرضة لي عن عوامل الخطورة بالنسبة للطفل التي تستدعي مرجعة مركز صحي الى المستشفى مثل الاصفرار، الخمول.					
فحص الطبيب الطفل بعد الولادة					
شجعني الطبيب على المباشرة والاستمرار بالرضاعة الطبيعية					
شرحت القابلة/ الممرضة لي عن التطعيمات ودفتر التطعيمات					
فحص الطبيب طفلي قبل الخروج من المستشفى					
اعطاني الطبيب موعد للمراجعة إن استدعى الأمر					
شرحت القابلة/ الممرضة عن فحص كعب القدم لطفلي					
قدمت القابلة/ الممرضة لي الارشادات اللازمة لي مثل إبقاء الطفل دافئ وإبقاء مجرى التنفس مفتوح.					

قامت القابلة / الممرضة بتقديم الارشادات اللازمة لي عن عملية الرضاعة الطبيعية					
كانت الارشادات التي أعطيت لي عن العناية بالطفل كافية لرعاية الطفل بعد الخروج من المستشفى					

التثقيف الصحي وتقديم المشورة للعناية بالأم قبل الخروج من المستشفى

العبارة	اوافق بشدة	أوافق	محايد	لا اوافق	لا أوافق بشدة
حصلت على الارشادات اللازمة حول ضرورة النظافة الشخصية والاستحمام					
حصلت على الارشادات اللازمة للعناية بالجرح او التمزق التلقائي في منطقة المهبل					
حصلت على الارشادات اللازمة حول أهمية التغذية السليمة وتناول السوائل ما بعد الولادة					
حصلت على إرشادات اللازمة بتوعيتي حول أهمية احذ قسط من الراحة بعد الولادة النوم الكافي.					
تلقيت ارشادات عن العناية بالصدر قبل وبعد الرضاعة					
شرحت لي القابلة/الممرضة عن التمارين اللازمة لاستعادة صحتي بعد الولادة واهمية الحركة					
حصلت على المعلومات اللازمة عن عوامل الخطورة التي تستدعي ذهابي الي المستشفى مثل (الدوخة الحرارة وجع الرأس عدم وضوح الرؤية)					
حصلت على المعلومات الكافية عن أهمية تنظيم الاسرة ووسائل منع الحمل وكيفية الحصول عليها					
حصلت على الارشادات بضرورة مراجعة مركز الرعاية الصحية الأولية بعد 6 أيام و6 أسابيع من الولادة للاطمئنان على صحتي بعد الولادة					
شرحت القابلة/ الممرضة عن ضرورة تناول حبوب الحديد بعد الولادة					
كانت المعلومات المقدمة لي كافية لاعتني بنفسي بعد الولادة					

مدى الرضى عن الرعاية المقدمة بعد الولادة بشكل عام

العبارة	راضية جدا	راضية	محايد	غير راضية	غير راضية بشكل كبير
الرعاية التي قدمت لي خلال الساعة الأولى من بعد الولادة					
الرعاية التي قدمت لي في قسم ما بعد الولادة أي بعد الساعة الأولى من بعد الولادة					
الرعاية التي قدمت لطفلي بعد الولادة					
التثقيف الصحي الذي حصلت عليه لي بعد الولادة					
التثقيف الصحي الذي حصلت عليه لطفلي بعد الولادة					
الرعاية الكلية التي قدمت لي بعد الولادة					

ان كانت لديك النية في إنجاب أطفال بعد هذه الولادة. هل ستختارين الولادة في نفس المستشفى

☐ نعم ☐ لا ☐ ليس لدي رغبة في الانجاب مرة اخرى

ماهي توصياتك لتحسين جودة الرعاية المقدمة من قبل القابلات بعد الولادة؟

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جودة الرعاية الفورية بعد الولادة في منطقة الشمال من الضفة الغربية: من وجهة نظر الأمهات

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د. ابتسام دويكات

ملخص

مقدمة: تُعدّ الساعات الأربع والعشرون الأولى بعد الولادة فترةً حرجةً للغاية، حيث يُمكن أن تُسبب المضاعفات، بما في ذلك تعفّن الدم والنزيف، ما يصل إلى 45% من وفيات الأمهات خلال هذه الفترة. تُعرف التدابير الطبية الداعمة المُقدّمة للأم والطفل خلال أول 24 إلى 48 ساعة بعد الولادة بالرعاية الفورية بعد الولادة. تُعدّ هذه الفترة الزمنية بالغة الأهمية لتعزيز التواصل المُبكر بين الأم والطفل، وخفض معدلات الأمراض والوفيات بين الأم والطفل بسرعة، وتأقلم المولود الجديد بفعالية مع الحياة خارج رحم أمه.

الهدف: الغرض من الدراسة هو تقييم جودة مكونات رعاية ما بعد الولادة الفورية المقدمة للأمهات ومواليدهن في مرافق الولادة في المنطقة الشمالية من الضفة الغربية.

المنهجية: استخدم هذا البحث تصميمًا وصفيًا مقطعيًا لتقييم جودة رعاية ما بعد الولادة الفورية في المنطقة الشمالية من الضفة الغربية من وجهة نظر الأمهات. كانت عيادات صحة الأم والطفل الرئيسية المرتبطة بوزارة الصحة في المنطقة الشمالية من الضفة الغربية، فلسطين، وهي في نابلس وجنين وطوباس وقلقيلية وطولكرم وسلفيت. تم جمع البيانات باستخدام استبيان ورقي بين أكتوبر 2024 وديسمبر 2024. تم استخدام طريقة أخذ العينات الملائمة بين النساء اللاتي استوفين معايير الإدراج لتحقيق غرض الدراسة. بلغ حجم العينة 338. تم إجراء التحليل باستخدام كل من الأساليب الإحصائية الوصفية والاستدلالية. تم تلخيص الإحصاءات الوصفية بالتكرار والنسبة المئوية والمتوسطات والانحرافات المعيارية. للتحليل الاستدلالي، أُجري اختبار t مستقل وتحليل التباين أحادي الاتجاه، مع تطبيق اختبار بونفيروني اللاحق للنتائج المهمة. واستُخدم تحليل ارتباط بيرسون لفحص العلاقات بين المتغيرات المستمرة.

النتائج: تراوحت أعمار معظم المشاركات بين 24 و29 عامًا، وحصلن على شهادات جامعية، وكن عاطلات عن العمل، ويقيم معظمهن في المناطق الحضرية. بلغ متوسط عدد حالات الحمل ثلاث حالات، ولم تُبلغ 84.6% منهن عن أي مضاعفات أثناء الحمل. وُلدت أكثر من نصف الأمهات بشكل طبيعي بعد شق العجان، ومارس ما يقرب من نصفهن الرضاعة الطبيعية الحصرية

تم تقييم جودة رعاية ما بعد الولادة خلال الساعة الأولى بشكل إيجابي (المتوسط = 3.8)، لا سيما في مراقبة العلامات الحيوية وفحوصات النزيف. حصلت الرعاية بعد الساعة الأولى على تقييم أقل

قليلاً (المتوسط = 3.5)، مع نقاط قوة في إدارة الألم ونقاط ضعف في الدعم العاطفي والعائلي. كما سجلت رعاية حديثي الولادة أثناء الإقامة في المستشفى تقييمًا إيجابيًا (المتوسط = 3.8)، بينما تم تقييم التثقيف الصحي المُقدم قبل الخروج بأنه محايد (المتوسط = 3.2)، مما يعكس وجود فجوات في تنظيم الأسرة، وممارسة التمارين الرياضية بعد الولادة، والتثقيف بشأن علامات التحذير. كان رضا الأمهات بشكل عام إيجابيًا (المتوسط = 3.9)، مع تقييمات أعلى للرعاية السريرية مقارنةً بالعناصر التثقيفية. أظهر التحليل الإحصائي ارتباطًا مهمًا بين ارتفاع الدخل، وعدد الأطفال، ونوع المستشفى، ومدة الإقامة فيه، وجودة الرعاية المُدركة. ولم يُعثر على أي ارتباط مهم بين جودة الرعاية واستمرار الرضاعة الطبيعية

الخلاصة: تُعتبر الجوانب السريرية لرعاية ما بعد الولادة جيدة بشكل عام، إلا أن الجوانب التعليمية والداعمة لا تزال غير كافية. توصي الدراسة بتعزيز تدريب الكوادر، وتحسين التدخلات التعليمية، ومراعاة العوامل الاجتماعية والاقتصادية لتحسين نتائج رعاية الأمهات والمواليد الجدد في المنطقة.

الكلمات المفتاحية: رعاية ما بعد الولادة الفورية؛ جودة الرعاية؛ الضفة الغربية؛ وجهات نظر الأمهات