

Deanship of Graduate Studies

Al-Quds University



**Evaluation of Natal-Care Services Provided by Governmental
Hospitals in Gaza Governorates**

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**Evaluation of Natal-Care Services Provided by Governmental
Hospitals in Gaza Governorates**

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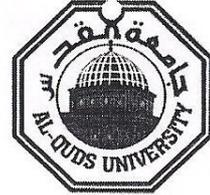
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Thesis approval

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in Gaza Governorates**

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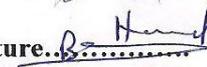
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Dedication

This work is dedicated

To my parents, who raised me on the love of reading and respect for learning.

To my husband, Dr. Adel Al Hakim, without his caring support, it would not have been possible.

To my children, Omar, Ali, and Doha, for their encouragement and patience ,who are the most precious to me.

To my sisters and brothers for the wonderful things they shared with me and supporting me all the way.

I would like to dedicate this work for all of you with love.

Sahar Abdel Wahhab Shalabi

Declaration

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

Signed

.....

Sahar Abdel Wahhab Shalabi

Date:

.....

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Sahar Abdel Wahhab Shalabi

Abstract

Birth is an occasion that changes life. It is a natural process, and there must be a good reason to interfere with this natural process in order not to expose women to high rates of intervention, unfamiliar personnel, lack of privacy and other situations that may be felt as harsh. The overall aim of the study is to evaluate the natal care services provided by governmental hospitals in Gaza Governorates.

The design of this study is a quantitative, descriptive, analytical, cross-sectional one and was conducted in governmental maternity hospitals in Gaza Governorates. Data were collected from forty low- risk women during labour and birth using an observational checklist that was prepared to assess the practices for normal childbirth in relation to evidence-based childbirth care and to obtain a rough estimate of the frequency of certain practices. And another checklist for medical records to evaluate the quality of documentation of medical records in terms of completeness, and accuracy. Data were analyzed using Statistical Package for the Social Sciences, Version 17.0.

The results indicated that non-evidence-based practices are commonly used to support, and manage birth in Gaza Governorates. High levels of obstetric interventions were observed giving evidence of their inappropriate or routine use, and largely deviated from the well-known best practice recommended by World Health Organization for normal birth. It was found that Intra Venous fluids were used for 60% of the observed women, fetal heart sounds were checked during the 2nd stage of labour in 37.5% , 66.7% of them by continuous Cardiotocograph Partogram was filled in 35% of cases, labour was augmented with oxytocin in 62.5% of cases and with artificial rupture of membranes in 77.5% of them. Birthing women were not always treated with respect and their privacy was violated many times, with frequent lack of communication with health care providers and lack of support from health care providers and family members.

There were clear differences between observation, and documentation. Augmentation of labour was used commonly by oxytocin (62.5 %), but it was less documented in medical records (52.5%). Blood pressure was measured in the observation only in 37.5% of cases

but documented in 72.5%. The overall completeness of records was found to be poor (46.4%). The completeness of demographic information (67.5%) was good in general. But it was for some items very poor, such as general examination and vital signs (12.5%), abdominal examination (10%), vaginal examination (2.5%), and Partograms filling (20%). Incomplete and inaccurate documentation of health records were detected indicating poor quality of care which stresses the need to increased attention for documentation of medical records.

This study provides recommendations to support evidence-based practices and encourage normal deliveries, and standardization of medical records among governmental hospitals.

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List of Abbreviations

AMTS	Active Management of the Third Stage of labour
BP	Blood Pressure
CS	Caesarean Section
CBR	Crude Birth Rate
G.Gs	Gaza Governorates
HCPs	Health Care Providers
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
NGOs	Non Governmental Organizations
PCBS	Palestinian Central Bureau of Statistics
PNA	Palestinian National Authority
TFR	Total Fertility Rate
UN	United Nations
UNRWA	United Nations Relief and Work Agency
WHO	World Health Organization

Chapter 1

Introduction

1.1 Background

Birth is a life-changing occasion, and the care given to women during labor has an ability to affect their physical and emotional status for short and long period. Childbirth is an essential occasion in the lives of families and in the formation of communities; it should remain so, but it must be made safe also (World Health Organization, WHO, 2005). The majority of women obtain maternity care at health facilities, but this does not mean that women will receive high- quality maternity care. About 40% of maternal mortality is related to bad quality of maternity care services (WHO, 2003). In every generation, 10 million women and more die from pregnancy-related causes (Family Care International, 2008), which could be prevented mainly by skilled care during childbirth (WHO.2009a).

In countries of the Middle East, access to a skilled health care provider for childbirth care is not considered a limitation, the majority of women now deliver with doctors or midwives in institutional settings (WHO, Department of Reproductive Health and Research, 2008), with a growing uptake of medical technology in maternity services (Kabakian, et al. 2012).

The main reason for hospitalization of birthing women across the world has been that birth is safer if it takes place centrally where resources are presented. And because of the importance of natal care and maternity health, many international agencies developed guidelines and protocols for that purpose. But the lack of reliable data and analysis, are important limitation to develop maternal and newborn health in order to monitor the achievement of the service (WHO, 2009a).

There is a gap between what we know and what we do (Pang, 2010). And because of that, data on hospital normal labor practices in developing countries with high maternal mortality levels are lacking. Little is known about normal labor facility practices (Khalil, et. al.2005).

The main objectives of care during labour and childbirth are to protect the lives of the mother and newborn, to support normal labour, to detect and treat complications in timely way and, finally, to support the best currently available evidence responding to the needs of the woman, her partner and family during labour and childbirth (WHO,1996).

In 1996, the World Health Organization pronounced that childbirth is a natural process and there must be a clear reason to interfere with this natural process. Also it supported practices that are evidence-based. But many countries have been slow to fully execute evidence-based practice in maternity care (Shaban, et al.2011).

In the hospital many procedures are used to control the objectives of care during labour process. These procedures are done routinely, but there is evidence that some of the procedures used during labour do not actually offer any benefit to women. And certain procedures are not always needed but we continue to use them, they can be uncomfortable, wasteful of resources, and even harmful, which may leave women vulnerable to environmental effects (Better Births Initiative, 2002,Hodnett, et. al.2011). And might affect her health, autonomy, access to her baby, and the natural process of birth and infant health (Wick, et al.2004).

Providing all women with care from a skilled attendant is a major concern facing Ministries of Health, health managers, professional organizations and individual skilled attendants especially in the most resource-limited settings (WHO, 2004).A skilled birth attendant can shape the difference between life and death (WHO, 2007a). All over the world, women during birth expect to receive a specific type of care. This could be from female companions, family members, or midwives. But in some areas, it takes the form of a full medical team within the advanced and well-sterilized environment of hospitals (Farahat, 2010). In the Eastern Mediterranean countries the basic education of health care providers is insufficient and the health system is overloaded with a continuing need to increase and update the knowledge and skills of health care providers (WHO, 2009a).

Providing good quality and respectful care will not only enhance the reputation of the service, but it will also encourage women to attend in good time. This in turn will play a part in improving overall maternal and perinatal health (Better Births Initiative, 2002).

In addition, frequent practices require a patient record system that assists HCPs to structure their thoughts and make appropriate decisions, which acts as a helping diary for them during consultations, and makes information available to others who are involved in the care of the same patient (The Department of Health, 2005).

Therefore, evaluation of natal-care services is important to collect data for guiding policies and services and to point the gaps in the service that need to be recognized. So, there is a need for periodic review of maternity services to ensure that women are getting good obstetric care with least probable complications, and to improve the provided quality of care (Hunyinbo, et al. 2008).

1.2. Research Problem

Pregnancy and birth are special events for every woman and that experience will last for the rest of her life. The fifth millennium development goal was improving maternal health, and the target was to reduce maternal mortality by 75 % between 1990 and 2015. A little progress in developing countries was achieved, as maternal deaths were 480 per 100,000 births in 1990 compared with 450 deaths in 2005. In addition, an improvement was achieved in the availability of skilled health workers to attend deliveries (UN, 2009).

In Palestine, medicalized interventions during natal care are widely adopted, and the majority of births took place in hospitals. Almost all births are attended by skilled attendants (97.1%) and 72.6% of deliveries in Gaza Governorates (G.Gs) took place in governmental hospitals (Abdul-Rahim, et al. 2009a). The high fertility rate among Palestinians and the large proportion of population being of childbearing age means that there is a significant increasing demand for maternity services. This may challenge health care providers when they are planning and providing care.

Since 2000, very few doctors, nurses or technicians have been able to leave the Strip for training necessary to update their clinical skills or to learn about new medical technology. This has severely reduced their abilities to provide quality health care (Palestine Monitor, 2010).

Living conditions have become worse since 2006 when siege was forced, resulting in unprecedented levels of Palestinian unemployment, poverty, and internal conflict and increasing limitations to health care access (Abdul-Rahim, et al. 2009b). The last war on G.Gs has resulted in a severe deterioration of the already unstable living situation of the people, and has further worsened the weakened health system. The quality of health care has been further affected by deterioration in the use-ability of medical equipment due to the shortage of maintenance and spare parts, as well as by shortages of drugs and medical supplies and restricted training opportunities for medical staff that were already at poor levels before the disaster (WHO, 2009b). Almost all physicians received their education outside of the country, as there was no medical schools in Palestine till 1994 when a school of medicine established first at Al-Quds university then five years later two other campus were established in G.Gs and at Annajah national university (Dudin,2008). The effect is that they have been trained in a very assorted way, which has implications for the challenges in standardizing practices and ensuring quality care (Wick, et al.2004).

In 2008, during the health strike, about 1750 doctors, nurses, and non-clinical staff went to strike and many of their jobs were filled by new people (WHO, 2010). It is essential that health care providers try and make the woman's experience of labour as comfortable and respected as possible (Better Births Initiative, 2002). Normal labor is by definition free of problems, and good care should always be based on practices that have been justified by systematic research. However, data on routine normal labor practices in developing countries with high maternal mortality levels are inadequate (Khalil, et. al.2005). G.Gs are not an exception; little is known of normal labor facility practices. Despite the frequency of childbirth and its importance as a serious time in the life of the mother and the newborn, the characteristics of routine childbirth care in G.Gs have never been assessed.

1.3. Justification of the study

About two thirds of deliveries in G.Gs take place in hospitals of, about 65 % of deliveries were assisted by a doctor and 32 % by a trained midwife or nurse (Maram, 2003). Because of the increasing numbers of women giving birth in facilities, and with skilled providers, it is necessary to evaluate the quality of service, in terms of medical care, and the levels of comfort associated to interpersonal relations with the health care providers.

A situation of rising poverty, interrupted health care services, limited human and financial resources and political uncertainty necessitates to notify decision-makers to develop specific strategies to reduce unnecessary and unfair interventions (Abdul-Rahim, et al. 2009a). Therefore, by looking at where we are in natal- care, we might be able to guess deeply about the future trends of childbirth services, and provide local evidence through an organized collection of clinical experience to guide more effective practice. The studies that evaluate natal care services must be evidence-based, and do not depend only on the perceptions and experience of the ladies who received these services.

Despite the importance of natal care in the Palestinian society, little is known about common normal labour hospital practices in G.Gs or of their relationship to evidence-based obstetrics. Routine practices have never been evaluated specially to the researcher best knowledge. This study will highlight practices of natal care at governmental hospitals in G.Gs. And will assess the current natal care services according to WHO recommendations and evidence-based medicine, explore the reality in documenting these practices in medical records and provide recommendations that might help in improving maternal health.

1.4. Aim of the Study

The overall aim of the study is to evaluate natal care services provided by governmental hospitals in Gaza Governorates.

1.5. Objectives of the study

1. To assess the technical and humanistic practices for normal childbirth in the light of evidence-based childbirth care practices.
2. To evaluate the quality of documentation of medical records in terms of completeness, and accuracy.
3. To provide a set of recommendations that could promote the health of Palestinian women.

1.6. Research Questions

1. What are the technical and humanistic natal-care practices provided by governmental hospitals?
2. How far do technical and humanistic natal-care practices match with WHO recommendations?
3. What is the level of completeness and accuracy for natal-care medical records documentation?
4. What are the recommendations that can be developed from the study to promote the health of Palestinian women?

1.7. Study Context

The study will be conducted at governmental hospitals in G.Gs. The following paragraphs will provide some information about Palestinian population, and health care system.

1.7.1. Geographic location

Palestine lies on the eastern extremity of the Mediterranean Sea. It is bounded to the north by Lebanon and Syria, to the east by Jordan, to the west by the Mediterranean Sea,

and to the south by Gulf of Aqaba and the Egyptian Sinai peninsula. The land area of the historical Palestine is; 26,323 km², from which the remained Palestinian territory (West Bank and G.Gs) consists from 6,020 km², with the G.Gs total land about 365 km² (PASSIA, 2008).

1.7.2. Demographic context

According to the Palestinian Central Bureau of Statistic (PCBS) statistical review in 2012, the mid-year population of G.Gs was 1.64 million of total population in Palestine, 835 thousand males and 809 thousand females (PCBS, 2012).

1.7.3. Births

In-spite of the progressive decline over years in the number of live births per 1,000 of total population per year, the number is still high in Palestine compared with other countries. The Crude Birth Rate (CBR) in G.Gs dropped from 45.4 to 36.8 then increased to 39.2 births per 1,000 population in 1997, 2009 and 2010 respectively (MOH, 2010b, 2011a).

1.7.4. Fertility

The Total Fertility Rate (TFR) which is defined as the average number of children born to women at age of 15- 49 years old was estimated to be 4.6 births per woman in the Palestinian Territory (PCBS, 2007), 5.7 births per woman in G.Gs (MOH, 2011a). The percentage of women of childbearing age of total population was estimated to be 23.4 % (MOH, 2011a).

1.7.5. Maternal Mortality Ratio

Maternal Mortality Ratio (MMR) is one of the most important indicators to determine the health status of women. Globally, 70% of all maternal mortality is caused by five factors: hemorrhage, infection, unsafe abortion, high blood pressure, and obstructed labor (WHO, 2006). In Palestine, in spite of the fact that institutionalized deliveries are improved, there are still many risk factors including unstable political situation that raises questions about the quality of natal care. The reported MMR is 20 per 100,000 live births among women aged 15-49 years in G.Gs in 2004 (MOH, 2005), This increase may suggest poor quality of natal-care services, or poor documentation, or both of them. Due to weaknesses in documentation and reporting maternal deaths.

1.7.6. Childbirth in Palestine

In November 1994, the Palestinian MOH took over responsibility for the Palestinian health services and adopted childbirth policy of encouraging hospital birth by reducing the fees of maternity care in governmental hospitals and by addressing linking safe childbirth and the declining infant mortality rate with hospitalization of birth. In addition, the MOH established new maternity hospitals, with the idea of increasing access to hospital care. The institutionalization of normal childbirth approach resulted in that hospital becoming the routine place of birth in Palestine. This change was a result of a range of reasons, including the number of services and of physicians, the marketing of childbirth technology, and women's health-seeking behaviors (Wick, et al.2004). Up to date, normal or operative delivery in governmental hospitals is free of charge, and more and more women use this sector for that reason.

Human resources in maternal health, show that the number of physicians per 1000 individuals in the Palestinian territory (2.1) is similar to that in Jordan (2.0), the UK (2.3), and Canada (2.1). But there is a shortage of nurses (1.7) and midwives (0.1) (MOH, 2008). And the quality of care in the public sector is in general recognized as being poor (World Bank, 2006).

In 2007 the percentage of Palestinians in G.Gs who lived under the national poverty line was 51.8 % compared to 24 % in 1998. In G.Gs, the severe effects of the Israeli siege on economic and social conditions are shocking. In 2007 unemployment in Palestine was 26 %, in G.Gs was estimated at 40.6 % compared with approximately 19 % in the West Bank (MOH, 2010a). Many services and specialist and life-saving treatments are not available to Palestinians inside G.Gs, and when the siege began, access to medical care in hospitals outside G.Gs decreased. This situation forced a lot of women and their families to seek medical services in governmental hospitals, as they have a low socioeconomic position and a corresponding low quality of life increasing the load on weakened health system (MOH, 2010a).

The commonest disasters or emergencies in Palestine are all related to the political environment to the extent that there is a continuing state of emergency due to the Israeli military occupation, siege, and attacks. On the other hand, the reduction, and sometimes total stoppage, of the supply of fuel to G.Gs for days has led to a decrease in the quality of medical services. The lack of medical equipment and medicines and serious shortage of replacement parts for equipment and of disposable items in G.Gs is increasing gradually.

1.7.7. Health care system context

After Oslo agreement was signed, the Palestinian national authority (PNA) took the responsibility for the health in GGs. Since that time, MOH started programs focused on ensuring continuity of health services to reform existing system, infrastructure, and equipment. Today there is a wide net of health care centers run by MOH with other partners who share in providing health-care services: UNRWA, NGOs, Military Medical services, and private services providers.

1.7.8. Hospitals

MOH is responsible for an important portion of secondary health care delivery system. In G.Gs there are 13 hospitals and 2 specialized centers with a capacity of 1593 beds, and total number of 4764 employees; 1261 physicians, 1594 nurses, 528 technicians, and 1101 administrators (MOH, 2009).

There are only 4 hospitals that provide child birth and delivery services which will be the locality of this study with capacity of 52 beds for delivery. The total number of deliveries in 2008 at governmental hospitals was 33,813. Increased in 2010 to 39,238 . Out of them 7685, were by caesarean section (C.S.) forming 19.6% of total deliveries (MOH, 2009, MOH, 2011b). In G.Gs, all maternity care hospitals are using Paper-based Medical Records as the primary source of medical information. All information regarding the treatment of patient is written by hand on the sheets. Each record is kept at the Medical Records archive at the hospital and is retrieved for use when the patient is admitted for inpatient care.

1.7.9. Locality of the study

1.7.9.1. Shifa Hospital

Shifa hospital is the largest medical establishment in PNA that provides health care services for more than 846,546 populations and also provides tertiary services for all G.Gs population. It is localized in the western region of Gaza City on 42,000 square meters, it was established in 1946, and passed many stages of improvement.

In 2008, the hospital contained 500 beds distributed in many departments. The Department of obstetrics and gynecology in Shifa hospital offers comprehensive services and meets the needs of all problems related to women's health. Services are provided with hospitalization unit, specialty clinic and the women's emergency room. It provides care services for women after normal vaginal delivery, high risk pregnancy, and genecology

surgeries. The department of obstetrics and gynecology consists of 117 beds; the staff consists of 84 physicians and 120 nurses (MOH, 2009).

1.7.9.2. Shohadaa Al-Aqsa Hospital

This hospital was established at the beginning of Intifada in 2001, to provide health care services to 226,778 populations in the Mid Zone Governorate. It was established on 4,000 square meters, and contains 392 employees. In 2008, the hospital contained 103 beds distributed in many departments. The department of obstetrics and gynecology consists of 13 beds, and the staff consists of 20 physicians and 18 nurses (MOH, 2009).

1.7.9.3. Nasser Hospital

Nasser hospital was established in 1958 in Khanyounis city. It is considered the second largest hospital in G.Gs. The hospital provides health care services to more than 296,438 individuals on 5,000 square meters. In 2008, the hospital contained 260 beds, and 742 employees. The department of obstetrics and gynecology consists of 44 beds, and the staff consists of 31 physicians and 33 nurses (MOH, 2009).

1.7.9.4. Al- Helal Al-Emiratee Maternity Hospital

This hospital is specialist for obstetrics and gynecology. It was established in 2006 in Rafah Governorate to provide maternal health services for about 192,144 of population. In 2008, the hospital contained 40 beds, and 219 employees 20 of them are physicians and 33 are nurses (MOH, 2009).

1.8. Definitions

Evaluation: Is the systematic collection, analysis, and reporting of information about a program/ service to assist in decision- making (Baker, et. al.2000).

Process evaluation: Investigates the process of delivering the program or technology, including alternative delivery procedures.

Technical care: Throughout labour and delivery the woman's physical and emotional well-being should be regularly assessed. This implies measuring of temperature, pulse and blood pressure, checking fluid intake and urine output, assessing pain and need of support. This monitoring should be maintained until the conclusion of the birthing process (WHO, 1996).

Normal labour Is divided into three stages:

- **First stage:** starts from the beginning of the uterine contractions and is divided to two phases;
 - **Latent phase** starts with painful contractions and some cervical effacement and dilatation up to 4 cm.
 - **Active phase** starts when there are regular painful contraction and progressive cervical dilatation from 4 cm.
- **Second stage:** starts when the cervix is fully dilated until the birth of the fetus.
- **Third stage:** it begins after the birth of the baby and ends at complete expulsion of the placenta (WHO, 1996, NICE, 2007, MOH, 2004).

Non- technical care / Humanistic care: It is the means through which natal-care decisions and practices are implemented. It is the way that HCPs and labouring women talk, discuss and understand their ethical responsibilities with one another (Simmonds, 2010).

Health Record: Means any record, or any part of a record that is held by a health care provider and containing personal information; or containing personal health information. (Australian Capital Territory, 2011).

Health Care Provider: A health professional providing services for a client or patient (Department of Health, Western Australia, 2011).

Intra natal care: The care provided during or at the time of birth. (Mondofacto medical dictionary, 2000).

Evidence based practices: The process of systematically finding, appraising and using research findings as the basis for clinical decisions (Department of Health, Western Australia, 2011). It is the careful explicit use of current best evidence in making decisions regarding the care of patients. The practice of evidence-based medicine means mixing individual clinical expertise with the best available clinical evidence from systematic research (Sackett, et al. 1996).

WHO Recommendations for Normal Delivery: A set of recommendations on interventions practiced in labour and delivery. These recommendations should be used to support the processes of normal birth with the purpose of improving outcomes for mothers and babies (WHO, 1996).

Chapter 2

Literature review

2.1. Conceptual Framework

Conceptual framework is a type of intermediate theory that attempts to connect to all aspects of inquiry, for example; problem definition, purpose, literature review, methodology, data collection and analysis. Conceptual framework can act like a map that gives unity to experimental inquiry.

The researcher constructed the theoretical framework that addresses the major aspects of this study after reviewing the available literature about the evaluation of natal-care services. The approach which uses process, output or outcome indicators, to measure the actions that prevent deaths or illness is widely used (WHO,2009a). The researcher used and focused on the process to evaluate natal care services in GG. Process evaluation assesses performance, and quality of practice or services related to the implementation of a program.

2.1.1. Technical care and interventions:

The care provided to the birthing woman during labour and delivery, in the three stages of labour.

2.1.1. 1. Care during the first stage of labour:

The first stage of labor is referred to as the "dilating "stage. It is the period from the first true labor contractions to complete dilatation of the cervix. Emotional and psychological support should be given to the women in this period, and assess her well-being, encourage her to move about, eat and adopt the most comfortable position. Also, Fetal heart assessment and monitoring the progress of labour are parts of the care.

2.1.1. 2. Care during the second stage of labour:

The second stage of labor is referred to as the "delivery or expulsive" stage. It is the period from complete dilatation of the cervix to birth of the baby. Women should be encouraged to adopt any position they feel most comfortable. It includes care of the perineum and episiotomy.

2.1.1. 3. Care during the third stage of labour:

The third stage of labor is referred to as the "placental" stage. It is the period from birth of the baby until the delivery of the placenta. It includes cord clamping, immediate care of the neonate and mother, and interventions to prevent postpartum hemorrhage.

2.1.2. Non – Technical / Humanistic care:

Interpersonal relationship between the providers and the patients including labour support, effective listening, involvement in the decision-making process and communication between providers and clients based on the development of trust, respect, and confidentiality.

2.1.2.1. Labour support:

Labour support describes the attendance of a helpful person who gives advice, information, comfort measures, and other types of touchable assistance to help a woman cope with the stress of labour and birth (Hodnett, et al.2002).

2.1.2.2. Involvement in decision making:

The aim of the participation of women in the decision making process is to establish a new pattern of a consensus and shared responsibility which involves other elements in the

process of decision-making, such as: Information, consensus and shared decision making, shared responsibility, and starting a plan of action (HealthCare, 2007).

2.1.2. 3. Communication:

Communication is the core of the relationship between provider and client, and good communication is the key to make a correct diagnosis and a successful treatment (Stein, 2006). Communication and information should be given in a form that is accessible to birthing women in an effective sensitive way (NCT, 2008).

2.1.2.4. Respect and privacy:

All women should be treated with respect and should be involved in what is happening to them. Therefore, health care providers should establish a relationship with labouring women, asking them what they want (NICE, 2007). The privacy of the labouring woman should be respected (WHO, 1996). This involves protection from unnecessary physical interventions during a physical examination, and the client must agree to any compromise of her right to privacy (PATH, 2003).

2.1.3. Documentation and Medical Records:

Medical records are flexible and accessible way to collect information. It is necessary to ensure that maternity records are complete, accurate and well kept, and the data on the management of obstetric complications is recorded correctly.

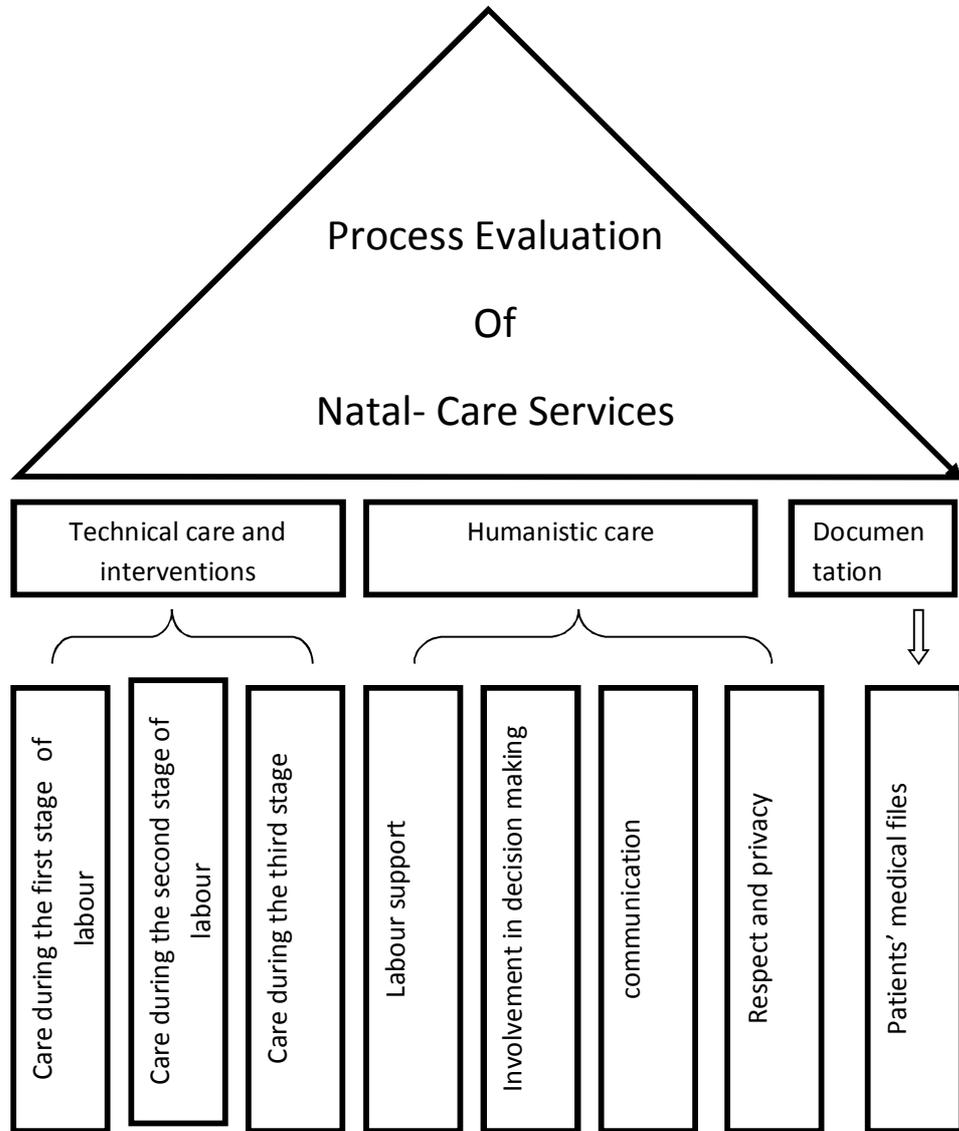


Fig.2.1: The conceptual framework of the study (self developed)

2.2. Literature Review

2.2.1. Evaluation

Many researchers agree that evaluation is the systematic collection and analysis of information about the activities, characteristics, and outcomes of programs or activities, to make judgments about a project, improve, or inform decisions about opportunities (Marynowski, et al. 2006, Shackman, 2010, and Cupitt, 2007).

In health care services, evaluation is carried out to decide how to improve a program or whether it should be sustained. A comprehensive evaluation to take decisions must not only consider the current situation of the program but also must consider fundamental questions. These questions are addressed by looking back at decisions taken during planning, development, implementation and operation phases; this will help to identify problems earlier (Health Services Research Group, 1992), because, programs that work well in some settings fail in others due to the financial, socioeconomic, demographic, interpersonal, and inter-organizational setting in which they are placed (U.S. Department of Health and Human Services, 2005).

The evaluation of health services is usually based on the collection of data about the structure, inputs, process, outputs and outcomes of the service (Donabedian, 1988). The structure of an organization refers to the organizational framework for the activities, to the buildings, equipment, staff, and so on which are required to meet definite standards. The assessment of health care services will be in relation to their numbers, type, and suitability. These can be defined in relation to: the distribution of staff, their level of training, grade and skills. To: availability, and type of buildings, facilities and equipment. To: number and type of services, disposables used and further types of financial resources (Bowling, 2002).

The process refers to how the service is organized, delivered, and used. It includes accessibility, staff and activities interact, and interaction between the staff and patients. While, Outcomes refer to the effectiveness of the activities in relation to the achievement of the planned goal (Bowling, 2002).

Evaluation in health have to lead to the recognition of problems and to redirect the actions and services, as well as to reflect on the adoption of new practices by professionals and to estimate the impact on the health of the people related to the actions implemented by services and programs (Brazilian MOH,2005). It must be practical and feasible and should be done within the available resources, time, and political situation. In addition, evaluation should assist a valuable purpose, be achieved in a decent way, and produce precise results (U.S. Department of Health and Human Services, 2005).

2.2.1.1. Types of evaluation:

There are three types of evaluation:

The first type is planning evaluation; it collects input and builds up guidance before and during the design of the program. It considers program goals, objectives, strategies, and timelines. It establishes basis for future formative and summative evaluation by developing indicators and benchmark (Marynowski, et al. 2006).

The second type is formative evaluation; it keeps a focus on improving the program before and during implementation. It results in information that helps in forming a better program, and provides definite information to produce a well-designed and a well-targeted program from the start. It is done at several points in the developmental life of a program and its activities (Marynowski, et al. 2006). Process evaluations can be used to improve how services are delivered. It collects information about outcomes and related processes, strategies, and activities that have led to them (Hollander, et al.2010).

The third type of evaluation is summative evaluation; it is performed to determine the effects of a program. It provides an evidence of program success. It is called also the final evaluation as it summarizes and describes what happened after the delivery of the program (Marynowski, et al. 2006). Outcome evaluations can be used to find out the value of a program and can be used to make choices about whether a program will be continued, tailored or ended (Hollander, et al. 2010).

2.2.1. 2. Evaluation Data

There are two types of evaluation data that could be collected: Quantitative and Qualitative. Qualitative data focus on collecting data through observation, interviews, discussions and analysis, leading to reports that are narrative and contain quotes and stories to dig deeper insight into a service. Quantitative data focus on collecting data that is measurable and can be reported with numbers or rankings to identify or measure program components (Gelmon, et al.2005).

Qualitative methods are appropriate to understand attitudes, measure and understand behavioral change, recognize outcomes or impact of services, collect narrative descriptive information, identify unintended or unexpected service outcomes, and else (Marynowski, et al. 2006).

Quantitative data uses numbers or rating to calculate service elements, and for comparing categorizing, and evaluating the effects of the program. Qualitative methods such as surveys, content analysis, and observations can be coded, categorized, and statistically analyzed. Quantitative data are most suitable to evaluate large-scale programs, generalize results to large population, measure levels of knowledge and attitudes, determine if changes are statistically significant, and rank features of different groups (Marynowski, et al. 2006).

2.2.1.3. Benefits of evaluation

Evaluation can help researchers in improving the design, implementation, and effectiveness of the services, determine service strengths and weaknesses, measure service performance, outcomes, and impacts, justify the costs of services, reveal service successes to supporters, funders, and stakeholders, and finally share information with colleagues and similar organizations (Marynowski, et al. 2006, Gelmon, et al.2005).

2.2.1.4. Process evaluation in health care

Process evaluation is done to find out if services are being delivered in a way that is consistent with the model of care adopted and with the policies of the program. It can be used to improve how the services are delivered (Hollander, et al.2010). Most assessments focus on outcomes, not on the processes involved in implementing an intervention. Process evaluations search the implementation, delivery, and setting of an intervention and help in the reading of the outcome results (Oakley, et al. 2006).

Health care providers increasingly seek new technological and organizational methods of improving the efficiency and clinical effectiveness of clinical care and health service delivery. The assessment of these methods has become a center of attention of research in health services research. Assessing the conditions in which compound interventions can be introduced in health care is important to patients, clinicians, managers and policy-makers (May, 2006). Without direct assessment of intervention implementation, a very strong assumption is made about the effect of the intervention (Sales, and Saint, 2012). Understanding barriers and facilitators, which are often determinants of success or failure of implementation gives a close seen about what may or may not really work.

Process evaluation assesses the degree to which a program is operating as it was planned. It assesses program activities according to program design, and professional standards or patients' expectations (General Accounting Office.1998). Process evaluation involves documentation and description of specific program activities. Also, it includes monitoring the frequency of participation by the target population and is used to verify the frequency of implementation of chosen programs or program aspects (Linnan, and et al.2002).

2.2.2.Normal Childbirth

Childbirth is considered the meaning of human existence and the purpose of marriage which is to produce a new life (Lee, et al. 2000). Also, Natal care is the care provided to the woman during labour and delivery. The World Health Organization (1996) defines normal birth as:

Spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth mother and infant are in good condition (WHO,1996, p.4)

Birth with minimal intervention or without technical or medical intervention is considered to be normal. Care during normal birth consists of evidence-based interventions in appropriate conditions to smooth the progress of labour and normal vaginal delivery like; augmentation of labour, artificial rupture of membranes, managed third stage of labour, non-pharmacological pain relief and intermittent fetal auscultation (Joint Policy Statement on Normal Childbirth, 2008).

In New Zealand the Ministry of Health (2003) defined normal birth as “*the birth of a baby without obstetric operative intervention; vaginal birth, in order to achieve a healthy mother and child with the least possible level of intervention that is compatible with safety*”.

Childbirth is complex, multidimensional and subjective, connected to the outcome and the process. Although labour is a universal physiological process, other precise related physiological and emotional aspects that women experience are often ignored preferring more clear parts such as quality of care, interventions, and mortality and morbidity measures (Baker, et al. 2005)

Almost all maternal mortality is avoidable, the death of a woman during pregnancy or childbirth is an abuse of her rights to life and health (UNFPA, and et al. 2004), which reflects severe problems related to care in all phases: pregnancy, birth and postpartum. Therefore, the quality of women’s care in this period of life is considered an indicator of human development. Thus, identifying weaknesses and strengths in service delivery, and promoting care reorganization at any time, is a method for reducing maternal mortality and inequity as expressed by the millennium development goals (Parada, and et al.2007). Childbearing women need a range of care to ensure the best possible health outcome for them and their babies, which starts with the woman and her family in her own home. To provide a successful range of care, this requires operating health care system with the

necessary infrastructure in place. It also needs effective, efficient and practical cooperation between all those involved in the provision of care (WHO, 2004).

2.2.2.1. Importance of Normal Childbirth

Pregnancy and birth are important events for every woman, and the woman's memory of the experience will last for the rest of her life. Women's evaluation of their childbirth experience is affected by physical and psychosocial factors, giving the importance to the approach of care in childbirth as a whole (TorkZahrani, 2008).

The aim of healthcare during childbirth is to achieve a healthy mother and child with the least probable level of intervention that is friendly and safe (WHO, 1996). Although the majority of women receive maternity care at health facilities (WHO, 2003), this does not mean that women get high-quality maternity care. Medical management of childbirth decreases the control of the birthing woman on her body, therefore fails to improve the physical and emotional outcomes of the birth (Nusbaum, 2006).

WHO (1994) mentioned that the quality of maternal care in hospitals reduces maternal deaths and disabilities. But medicalized and sometimes harmful interventions may interfere with woman's health, autonomy, and physiological process of birth and infant health (Wick, et al. 2004).

Belief in the normal childbirth practice is essential to the philosophy and performance of healthcare providers, the language they speak and the care they provide to women. This care includes the development of specific skills and clinical practices that ease normal, peaceful labour progress and spontaneous delivery without routine use of drugs and interventions causing lower rates of intervention which lead to very low rates of maternal and neonatal morbidity and mortality (Canadian Association of Midwives, 2010). Promoting normal birth is an important value of maternity care, with intervention only if necessary for the benefit of the mother or child (NCT, 2008).

Furthermore, maternal and neonatal care has been recognized as one of the top 10 patient safety problems in developing countries (WHO, 2008).

2.2.2.2. Technical care and interventions

Giving birth represents a major transition in a woman's life; she is becoming a mother, and she will also be growing and learning throughout the process. The memories and experiences of labour and birth remain with women throughout their lives. So, the support and care they receive during this time is significant (PHAC, 2000).

When labour starts, women start asking for care. Wherever birth takes place the formation of a good relation between woman and caregiver is critical, and the quality of reception and welcome offered to a birthing woman may influence the level of trust that she and her family might give to her caregivers (WHO, 1996). Now hospitalization for birth is the recognized model, and women in labor usually enter an unfamiliar, busy institutional setting to receive care from a range of strangers where many technical care measures are used routinely.

Suggestions to improve practice in order to improve patient safety and quality need to be grounded in knowledge of existing structures and processes in health-care delivery in order to be capable to connect them to actual health outcomes.

2.2.2.2.1. WHO Recommendations for Normal Delivery

The United Nations Millennium Development Goals are eight goals that all UN member states have decided to try to reach by the year 2015. The fifth millennium goal is to improve maternal health by reducing maternal mortality ratio by three quarters, between 1990 and 2015. The risk of maternal death is very high in developing countries, and the increasing numbers of women who are looking for care during childbirth in health facilities gives an importance to the quality of care provided (WHO,2012).

In 1996, WHO published a report that identified the commonest practices used throughout labour and tried to establish some norms of good practice to manage a non-complicated labour and delivery, with the aim of improving outcomes for mothers and babies (WHO,1996).

In 2005, the WHO created the Department of Making Pregnancy Safer , and encouraged national programs to assure skilled care before, during and after pregnancy and to make emergency obstetric care available if complications take place (WHO,2011).This department plans to assist countries to adapt and implement the standards for maternal and neonatal care in order to influence improve health service provision in the direction of the reduction of maternal and neonatal mortality and morbidity, as a result contributing to the achievement of MDG5 (WHO,2007b).

However, globally there is a great number of situations where inadequate, outdated and sometimes dangerous practices continue as a result of tradition and lack of upgrading of knowledge, skills and practice among HCPs, as well as lack of a supportive environment. A good care should always be based on practices that have been justified by scientific research. WHO seeks to reduce maternal mortality by providing and promoting evidence-based clinical guidance. And promotes skilled care at every birth through evidence-based guidelines and assisting countries in implementing such standards within health systems (WHO, 2008b).

WHO (1996) classified practices in normal birth into four categories based on the best available evidence (Annex 1). These are:

- Category A: Practices which are useful and should be encouraged. For example; use of the partograph for monitoring progress of labour, non-supine position in labour and early skin-to-skin contact between mother and child.
- Category B: Practices which are clearly harmful and should be eliminated. Practices such as routine intravenous infusion in labour and routine use of supine position during labour are examples of harmful practices

- Category C: Practices for which insufficient evidence exists to support a clear recommendation and which should be used with caution. Practices like routine early amniotomy in first stage, and fundal pressure.
- Category D: Practices which are frequently used inappropriately. Such as restriction of fluids during labor, electronic fetal monitoring, bladder catheterization, and routine use of episiotomy.

Despite the increased importance on the use of evidence-based medicine, many unhelpful, untimely, inappropriate and unnecessary practices remain frequent, without appropriate consideration of their value to women or their newborns (WHO,1996).

2.2.2.2.2. Evidence-based maternity care

Evidence-based health care is the reliable use of recent best evidence in making decisions about the care of patients. It is an approach to decision-making in which the clinician uses the best evidence available, in consultation with the patient, to make a decision about which best option is appropriate for that patient (The Cochrane Collaboration, 2011).

Evidence-based maternity care gives priority to the way of care and practices that are effective and least invasive, with limited or no injuries. It uses the best available research on the safety and effectiveness of definite practices to help lead maternity care decisions and facilitate best outcomes in mothers and newborns (Sakala, et al.2008).

Evidence -based maternity care includes the relationship between evidence about human physiology and evidence about specific maternity practices. During labour and delivery woman's physical and emotional well-being must be evaluated regularly. This implies measuring vital signs, checking fluids intake and urine output, assessing pain and need for support. This assessment must continue until the end of birthing process (Hulton, et al.2000).

The provision of skilled care is one of the main strategies to avoid maternal death and disability (UNICEF,2004). Clinical skills in normal childbirth are essential since care during childbirth, can prevent some life-threatening complications (JHPIEGO, 2004b).

In maternity hospitals, evidence-based interventions are often underused, whereas ineffective or harmful practices continue to be used. Obstetric intervention rates significantly varied across Canadian territories suggesting variable practice models. Some factors that might affect this variability include the types of health care providers in different states, hospital size, availability of resources, maternal access to care, and maternal demographic variables such as parity, age, and body mass index (Chalmers, et al.2008). The same was in USA; rates of use of exact practices that are disproved or unsuitable for mothers and babies vary broadly across facilities, providers, and geographic areas, generally because of differences in practice style and other unnecessary factors rather than differences in needs of women and newborns (Sakala, et al.2008).

The routine use of these interventions does not make birth safer for women and babies. In fact, unless there is a clear medical reason for the use of technology or other interventions, interfering with the natural process of labor and birth is not likely to be beneficial and may be harmful. It is safer and healthier to allow labor to develop and not to interfere in any way with the natural process, unless there is a clear medical indication. Unnecessary interventions during childbirth sometimes rise from the models of care during normal childbirth. Studies have shown that one unnecessary intervention in the physiological process of childbirth often leads to a lot of interventions, which may at the end indicate a caesarean section (WHO, 1985).

2.2.2.2. 3. Care during the first stage of labour

2.2.2.2.3.1. Assessing the Well-being of the Woman during Labour and delivery

During labour and delivery the woman's physical and emotional well-being should be assessed regularly to determine the general condition. Which means measuring

temperature, pulse and blood pressure, checking fluid intake and urine output, and assessing pain. Taking and recording vital signs can have implications for the last outcome of birth, and could thus influence the management of labour. These routine procedures should not be dismissed, and they are part of ongoing assessment in labour (WHO, 1996).

Enemas and pubic shaving are considered unnecessary and should not be done except at the woman's request. A systematic review found that enemas did not improve puerperal or neonatal infection rates, episiotomy rates or maternal satisfaction. So, their use is unlikely to help women or newborn children, and no scientific base to recommend their routine use during labour (Reveiz, et al.2007). Another systematic review shows that there is no enough evidence to recommend perineal shaving for women on admission in labor (Basevi, et al.2000).

Being mobile during Labour shortens labour and reduces the need for pain relief and assisted deliveries (Better Births Initiative, 2002). There is evidence that walking and upright positions in the first stage of labour do not appear to be related to increased intervention or negative effects on mothers, and babies' wellbeing. Women should be supported to adopt whatever position they find most comfortable in the first stage of labour. Observational studies suggest that maintaining a supine position in labour may have bad physiological effects on the woman and her baby (Lawrence, et al.2008).

Labour requires huge amounts of energy. As the length of labour and delivery cannot be expected, so there must be continuous sources of energy in order to ensure fetal and maternal well-being. Severe restriction of oral intake can lead to dehydration and ketosis. This is usually treated by an intravenous infusion of glucose and fluid which leads to rise in serum glucose levels and its complications to the delivering woman and her baby. These complications can be prevented by offering oral fluids and light meals during labour (WHO, 1996). The evidence shows that there is no justification for the restriction of fluids and food in labour for women at low risk of complications. Women should be free to eat and drink in labour, or not, as they want (Singata, et al.2009).

Routine intravenous infusions interfere with the natural process and limit women's freedom to move. The prophylactic routine insertion of an intravenous cannula is considered unnecessary interventions (WHO, 1996). No studies show that routinely

placing an intravenous cannula in low-risk laboring women prevents poor outcomes (Enkin, et al. 2000). An increased rate of intravenous fluids showed no benefit in labor progression over usual care when women were allowed to drink freely (Coco, et al.2010).

2.2.2.2.3.2. Labour Pain

Almost all women experience pain during labour, but their responses to labour pain are widely different. An important task of the birth attendant is to help women cope with labour pain. This can be achieved by pharmacological pain relief, or by non-pharmacological approach, starting during prenatal care by giving reassuring information to the pregnant woman and family. Empathetic support, before and during labour, from health care providers and companions, can reduce the need for pharmacological pain relief and hence improve the childbirth experience (WHO, 1996). Continuous support during labour has significant advantages for women and infants and no known harm. All women should have support during labour and birth. Women provided with continuous support were more likely to have a spontaneous vaginal birth and less likely to have intrapartum analgesia or to report dissatisfaction. They were less likely to have a caesarean or instrumental vaginal birth or a baby with a low 5-minute Apgar score. (Hodnett, et al.2011).

In a review done by Smith et al. (2011a) it was found that relaxation was associated with a reduction in pain intensity during the latent phase and active phase of labour. There was an evidence of improved outcomes from relaxation instruction with increased satisfaction with pain relief, and lower assisted vaginal delivery. Yoga was associated with reduced pain, increased satisfaction with pain relief, satisfaction with the childbirth experience, and reduced length of labour when compared to usual care and when compared with supine position.

Massage and other manual healing methods are effective and have a role in reducing pain, improving women's emotional experience of labour, and reducing anxiety during the first stage of labour (Smith et al. 2011b).

Parenteral opioids provide some relief from pain in labour but are related with bad effects. Opioids drugs were associated with maternal nausea, vomiting and drowsiness (Ullman, et al. 2010). The most frequently used opioids drug is pethidine, which has many disadvantages as it not only decreases the mother's responsiveness to pain but may delay the birthing process too. It also crosses the placenta and may depress the baby's breathing and suckling, which is a specific problem if the delivery happens within an hour of pethidine being administered intramuscularly. Babies born to mothers given pethidine may also be sleepy for some days after birth, and this may in turn interfere with successful breastfeeding (WHO, 2002).

2.2.2.2.3.3. Fetal Monitoring during Labour and Delivery

A systematic review indicates that intermittent auscultation(IA) is the preferred method of fetal observation in women without complications. IA is associated with fewer caesarean and operative vaginal deliveries when compared to EFM. IA allows women more mobility, which in order increases comfort and progress of labor (ACNM, 2010).

If there is no risk factor, intermittent auscultation using a Pinard's stethoscope or hand-held Doppler is the recommended way for fetal assessment. And all tools should be kept in good working condition (RCOG. et al.2007). On the other hand, Continuous cardiotocography during labour is associated with a reduction in neonatal seizure, but it was associated with an increase in caesarean sections and instrumental vaginal births (Alfirevic, et al.2006).

2.2.2.2.3.4. Vaginal Examination

It is one of the important diagnostic actions in the assessment of the start and the progress of labour. Vaginal examination should only be conducted with clean hands, covered by sterile gloves. The number of vaginal examinations should be controlled to the exactly necessary; during the first stage of labour usually once every 4 hours is enough, or when

there is an indication for the need (WHO, 1996). In hospitals where a vaginal examination by a student sometimes will have to be repeated and checked by the supervisor, the woman has to agree before repeating the examination.

Under no circumstances should women be forced to undergo repeated or frequent vaginal examinations by a number of health care providers or students (WHO, 1996). Using sterile gloves protect the client from contact with micro-organisms on the health worker's hands and the health worker from contact with blood and other body fluids (Basic Support for Institutionalizing Child Survival (BASICS), and et al. 2009).

2.2.2.2.3.5. Use of Partogram

Partograph is a simple method to express the progress of Labour in a graphic sheet. When the partograph is used properly, it gives an early indication of abnormal progress of labour, allowing timely interventions to investigate and deal with the complication and refer women to a correct facility for treatment. It is valuable tool to assist the HCP to detect early onset of problems in labour, WHO encourages the use of the partograph strongly (WHO, 2008a, Maternal and Neonatal Health, 2002).

Findings in a systematic review indicate rare or incorrect use of the partograph. Low rates of use and of correct use of the partograph are most frequently seen in health care settings where labor management practices are generally poor. This review also indicated that the impact of partograph use on labor or on caesarean section rates and that from these studies is limited. Other non-controlled studies provide supporting evidence of a positive impact on maternal and perinatal outcomes (Levin, et al.2011). On the other hand, Dangal (2007) said that the partograph has been found to be effective and practical in many different locations. Using it has shown to be effective in preventing prolonged labour, in reducing operative intervention and in improving the neonatal outcome.

2.2.2.2.3.6. Augmentation of Labour

It is not clear from the available data that liberal use of oxytocin augmentation is of benefit to women and babies. There is no evidence that the prevention of prolonged labour by the liberal use of oxytocin in normal labour is beneficial. Oxytocin augmentation is a major intervention and should only be implemented on a valid indication (WHO, 1996). Which requires regular fetal heart rate and contraction monitoring throughout the administration of oxytocin (National Women's Health, 2008).

The main finding of a review was the increase in spontaneous vaginal deliveries associated with early oxytocin use. Women were more likely to report an unpleasant experience with pain in labor. The risk of hyperstimulation was increased with early oxytocin, which can be associated with negative effects on fetal oxygen status and fetal heart rate patterns (Wei, et al. 2009).

The use of oxytocin for augmentation in the multigravida is discouraged unless it is used for a precise reason. If oxytocin is used, it should only be used with well trained adequate staff, and continuous fetal monitoring (Cluver, & Odendaal, 2010). Inadequate oxytocin use can cause fetal asphyxia uterine hyperstimulation, uterine atony, uterine rupture, and hemorrhage. Complications caused by oxytocin use are almost due to improper doses or inadequate supervision (Kruse, 1986).

2.2.2.2.4. Care during the second stage of labour

2.2.2.2.4.1. Pushing during the Second Stage

Caregivers often decide on the onset of the second stage by encouraging the woman to push, either when full dilatation has been diagnosed, or sometimes even earlier. The physiological approach is to wait until the woman feels the urge to bear down herself. At full dilatation sometimes the urge is not yet present, and by waiting ten or twenty minutes the expulsion phase may start spontaneously (WHO, 1996). The evidence from a systematic review does not support the routine use of Valsalva (direct) pushing in the

second stage of labour. The Valsalva pushing method has a negative effect on urodynamic factors. The duration of the second stage of labour is shorter with Valsalva pushing but the clinical significance of this finding is uncertain (Prins, et al.2010).

In a randomized controlled trial, Jahdi. et al (2011), found that physiological pushing was not associated with demonstrable adverse outcome. It seems that this technique can reduce the duration of the second stage of labor and it can be a safe method during the second stage of labor without any harm for mother and baby.

In several countries fundal pressure during the second stage of labour is frequent. Its purpose is to speed up the delivery, sometimes it is performed shortly before delivery, sometimes from the beginning of the second stage (WHO,1996). It is associated with increased maternal discomfort, there is a doubt that the practice may be harmful for the uterus, the perineum and the fetus, but there is insufficient evidence to conclude on beneficial or harmful effects of manual fundal pressure (Verheijen, et al.2009).

2.2.2.2.4.2. Maternal Position during the Second Stage

The position of the lady during the second stage of labour has an effect on the condition of the Fetus. The lithotomy position with the legs in stirrups was felt as less comfortable and more painful and limited movement. Women can adopt any position they like, and long periods of lying supine should be avoided if possible. They should be encouraged to try out what feels most comfortable and should be supported in their choice (WHO, 1996).

2.2.2.2.4.3. Care of the Perineum

Episiotomies should be an uncommon events (perhaps occurring in less than10% of births) (WHO, 2002).A policy of restricted use of episiotomy for spontaneous vaginal birth has a number of benefits compared to routine episiotomy policies. There is less perineal trauma, less suturing and fewer complications (NHS, 2008).

Routine sweeping or massage of the perineum in any way has not been shown to be beneficial either. These can be replaced instead by a “hands off” approach of watching and waiting unless the mother’s or baby’s condition give reason for intervention (WHO, 2002).

2.2.2.2.5. Care during the third stage of labour

2.2.2.2.5.1. Active Management of the Third Stage

The active management of the third stage of birth includes a set of interventions which prevent postpartum bleeding. These interventions consist of: Prophylactic administration of uterotonic agents at birth or immediately after birth, the clamping and cutting of the umbilical cord, and the controlled traction of the cord for the expulsion of the placenta.

On the other hand, the expectant approach implies a policy of “non-intervention”, in which the signs of spontaneous separation and expulsion of the placenta are waited for, and in which the clamping of the umbilical cord is done later (Healthcare, 2007).

Routine active management is better than expectant management in terms of blood loss, post partum hemorrhage and other serious complications of the third stage of labour. Active management should be the routine management of choice for women expecting to deliver a baby by vaginal delivery in a maternity hospital (Prendiville, et al, 2000).

Oxytocin appears to be beneficial for the prevention of postpartum hemorrhage (McDonald, et al. 2004). According to the evidence and recommendations available, active management should be applied using oxytocin in preference to other uterotonic agents immediately after birth, late clamping of the umbilical cord, controlled traction of the cord to extract the placenta (Healthcare, 2007).

Prophylactic intramuscular or intravenous injections of ergometrine is effective in reducing blood loss and postpartum hemorrhage, but adverse effects include vomiting, elevation of blood pressure and pain after birth requiring analgesia, particularly with the intravenous route of administration (Liabsuetrakul, et al.2007).

2.2.2.2.5.2. Cord Clamping

Clean cord care practices should be the chief focus of any clean delivery. It could lower neonatal sepsis deaths and tetanus deaths (WHO, 2008a). There is a general agreement about the clean technique for cutting the cord using a sterile cutting instrument and clean hands to avoid infection (Zupan, et al.2004).

Early clamping of the umbilical cord is that which is carried out within three minutes of birth, or before it stops pulsing. Late clamping is associated with a lower incidence of anemia in the newborn child between 24-48 hours after birth (Healthcare, 2007).

2.2.2.2.5.3. Immediate Care of the Newborn

Immediate care is done to minimize risk of cold stress for new born infants immediately after birth by providing a warm delivery room, drying the infant, removing any wet blankets and wrapping in a pre warmed blanket. The interventions in this review including skin-to-skin contact to keep infants warmer (McCall, et al.2010).

Skin-to-skin contact may help in breastfeeding outcomes, early mother-infant attachment, infant crying and cardio-respiratory stability, and has no apparent short or long-term negative effects (Moore, et al.2007).

2.2.2.2.5.4. Immediate Care of the Mother after Delivery of the Placenta

The placenta should be examined carefully at the time of delivery to detect abnormalities can give information that may be important in the management of mother and infant (Nagi,2011), but above all to ensure that it is complete, and no part of the placenta is missing (WHO,1996).

A routine exploration of the uterine cavity after every delivery is a very common practice in many countries. There is no evidence that such a practice is useful; on the opposite, it can cause infection or mechanical trauma or even shock (WHO, 1996). Manual uterine

exploration is a painful method for the newly delivered, episiotomised mother, and is of no proven benefit (Hulton, et al. 2000).

The mother should be observed carefully during the first hour postpartum. The most important observations include the amount of blood lost, and uterine fundal height. If the blood loss is abnormal and the uterus is contracting poorly, gentle abdominal massage of the uterus can be helpful. The condition of the mother is also important: blood pressure, pulse and temperature, and general well-being should be assessed (WHO, 1996).

Routine obstetric practice varied between hospitals in Shanghai, and some unnecessary and uncomfortable procedures were common. For example, routine practice included supine delivery, rectal examination, pubic shaving, and episiotomy. Pain relief was not usually given. Episiotomy is being used selectively in one hospital, and the use of enemas has been reduced and social support has been encouraged at all study sites (Qian, et al. 2001).

Injury to the genital tract during vaginal birth, either through tearing or episiotomy, can lead to adverse health outcomes for women, ranging from minor temporary discomforts to severe pain, bleeding, infection, urinary incontinence, and interference with establishment of breastfeeding. Short and long-term health problems resulting from perineal trauma can significantly affect woman's quality of life, and they are less likely to experience these problems when their perineum is intact (Shorten, et al. 2002).

In Cote d'Ivoire (Delvaux, et al. 2007), the researchers found that the technical interventions of care for normal delivery were poor in all the studied hospitals. The study showed that the assessment of women's general condition at admission was poor. Vital signs were measured in less than 50% of women, obstetrical history was incomplete, contractions were rarely monitored, partograph was rarely completed during labour, episiotomy rates were high, post partum care was commonly provided by the midwife, and uterine retraction was checked in less than 30% of cases. A positive and a common practice was active management of the third stage of labour (AMTS).

Births in Greece included the routine use of enema, shaving pubic hair, intravenous line, Oxytocin to speed up labour, episiotomies, electronic fetal monitoring, and the supine

position with arms and legs fixed to the delivery table (Nusbaum, 2006). Also in Brazil, Practices markedly favorable to health and useful in delivery, such as the presence of a companion, non-pharmacological control of pain, skin-to-skin mother/baby contact, and the early start of breastfeeding, are still little practiced in the maternities studied, while other clearly harmful or ineffective practices, such as fasting, and episiotomy, are still frequently used (Parada, and et al. 2007).

In Egypt (El-Nemer, et al. 2005), childbirth care is provided by physicians with the assistance of midwives, fetal heart was monitored irregularly, almost all labouring women were fastened to intravenous line with oxytocin to accelerate labour, intravenous line restricted women from moving around, and the vaginal examination each women had during labour was very high following no pattern or protocol.

Also in Turkey (Turan, et al. 2005), childbirth practices in a governmental hospital did not follow evidence-based guidelines, including early amniotomy and augmentation with oxytocin which were commonly used, episiotomy rates were high and problems due to this procedure were noticed, routine enema, restriction of mobility and of oral fluids, and delivery in supine position. Using oxytocin for AMTSL was only used in 28% of cases before the delivery of the placenta. Monitoring for bleeding in the post partum was always inappropriate.

Several Latin American public hospitals have not updated their clinical performance to show the effects of evidence based interventions such as selective episiotomy and active management of third stage. Limited access to new knowledge, limited time and physical resources, lack of skills in performing new practices, and attitudes resistant to change are reasons limiting the implementation of new practices in such hospitals (Belizan,et al.2007).

In the West Bank, Wick, et al. (2004) observed the same malpractices. The researcher observed that supine position on giving birth and the use of episiotomy were widely adopted. Pethidine also was frequently used causing newborn's respiratory difficulties which delay early breast feeding.

Interventions during birth should not be applied routinely. A lot of standard medical tests, procedures, technologies, and drugs have risks to both mother and baby, and should be prevented in the absence of scientific indications for their use (CIMS, 1996). Access and availability of institutional delivery only is not enough to reduce MMR, it is also the quality of obstetric care that saves lives (Miller, et al. 2003).

2.2.2.3. Non- Technical/ Humanistic Care

2.2.2.3.1. Labour support

Labour support is a phrase used to describe the attendance of a caring person who gives advice, information, comfort measures, and other types of touchable assistance to help a woman deal with the stress of labour and birth (Hodnett, et al. 2002).

Traditionally, women are supported by other women during labour and birth. But in hospitals, continuous support in labour has become the exception instead of being the routine. In modern obstetric care women are commonly exposed to institutional interventions, which may have bad effects on the progress of labour. Supportive care during labour may include emotional support, information and advocacy, which may improve physiologic labour processes as well as women's feelings of control and competence, therefore this may decrease the need for obstetric intervention. Women who received continuous labour support were more likely to give birth spontaneously. They were also less likely to use pain medications, were more likely to be satisfied, and had slightly shorter labours. Their babies were less likely to have low 5-minute Apgar Scores. No adverse effects were identified. And continuous support of the mother in labour reduces the need for analgesia and caesarean section rates (Hodnett, et al. 2011).

In developing countries with limited resources, support during the first stage of labour by a female relative has been considered a first step in improving the quality of maternity services . It lowered caesarean deliveries and the necessity for sedation during labour and elevated patient satisfaction (Khresheh, 2010). Birth is an active, not passive, experience

and women's part as active members are of major importance in childbirth (Whitty-Rogers, 2006).

Despite the clear advantages of support during childbirth in China, researchers found that the main barriers to implementing support at the hospitals they studied were the labour wards. They were too small to have room for them, and the family members had less necessary information about childbirth so the providers prevented them from attending (Qian, et al. 2001).

If the labouring woman is able to recognize what is happening to her and is to recognize at what phase of labour she is, she needs attendants who will keep her completely informed of progress and any difficulties. To keep her attached with reality she must share that reality with all those who attend her, and should be able to use the information and skills she has more effectively if she is being guided and encouraged from health care providers who understand what she is doing, and why (Kitzinger, 1978).

The importance of woman-to-woman help has been rediscovered. A lot of randomised controlled trials show that companionship from another woman reduced the mother's need for pain-relieving drugs, instrumental deliveries and caesarean sections, while the Apgar scores of babies were higher (Kitzinger, 2001). Supportive care during labour is the most important thing to help the woman stand labour pains and ease the progress of labour.

2.2.2.3.2. Involvement in decision making

The relationship between doctor and patient is the core of the health care system, and doctor-patient interaction continues to be a central focus of the study of health systems. The belief that patients are allowed to be informed and contribute in decisions concerning their own medical care is now the dominant view among patients' organizations and the medical profession (Carlsen, et al. 2005).

Some studies of patients' preferences reported that patients generally would like to be informed and involved in the decision-making process (Ogden, et al. 2002, Schattner, et al. 2004).

Women suffer from loss of control during labour and birth process which occurs together with the transfer from home to the medical centre, causing greater levels of intervention and decreasing the woman's role. Women can feel the power of choice about their health when they are involved in the care they receive and participate actively at the moment of birth. This can be encouraged with the adequate, sufficient and timely information concerning the available best practices to achieve best results (HealthCare, 2007). The aim of the participation of women in the decision making process is to give up the classical pattern of the doctor / patient relationship and establish a new pattern of a consensus and shared responsibility which involves other elements in the process of decision-making, such as: Information, Consensus and shared decision making, shared responsibility, and starting a plan of action (HealthCare, 2007). In general, the policy of providing women with information was seen to have a valuable effect as it improved their awareness and guided them to have accurate expectations about their health, and it lowered the level of uncertainty when it came to choosing between different options (HealthCare, 2007).

2.2.2.3.3. Communication

Communication involves active listening, understanding the client's story, and maintaining privacy. Communication is the core of the relationship between provider and client, and good communication is the key to make a correct diagnosis and a successful treatment (Stein, 2006). Communication and information should be given in a form that is accessible to birthing women in an effective sensitive way (NCT, 2008). The patient has a right to get from HCPs complete and current information about the diagnosis, treatment, and outcomes.

As health care providers try to accomplish more in less time, the rapport between patients and providers and among providers obviously suffer. Miscommunications

decreased staff and patient satisfaction, and poor care coordination results. The researchers found that communication problems were time consuming, and staff members were task oriented rather than patient centered (Chapman, 2009).

Good communication skills are the result of more complicated inputs like, good observation skills, good listening skills, ability to detect emotional matter, and problem solving. Patients need healthcare providers who are able to detect feelings, and to express real interest in why they have been consulted (Bundy, 2004). Finally, the heart of childbirth must change to one that highlights and rewards shared information and decision-making between health care providers and clients based on evidence-based practice (Fenwick, et al. 2004).

2.2.2.3.4. Respect and Privacy

All women should be treated with respect and should be involved in what is happening to them. To achieve this, health care providers should establish a relationship with labouring women, asking them what they want. Providers must be aware of their voice tone and behaviour (NICE, 2007). Words can hurt, it is a very old idea, and physician must pay attention to both talk and silence (Lang, et al. 2004). Attitudes and behaviors of care givers can affect the relationship between them and childbearing mother.

The privacy of the labouring woman should be respected, she is in need for her own room where the number of healthcare providers should be limited to the needed minimum (WHO, 1996). The individual's right to privacy is highly valued, widely approved, and usually violated. Privacy involves protection from unnecessary physical interventions, which may occur during a physical examination, and no one who is unnecessary to be present when performing a procedure or examination should be allowed into the exam room without the clear permission of the client. The client must agree to any compromise of her right to privacy (PATH, 2003).

Examples of disrespect include humiliation, not respecting a woman's privacy and dignity, examinations performed without her consent, discrimination based on

characteristics such as race, class, or socio-economic status, neglect or denial of care, and physical and verbal abuse during childbirth (USAID, 2011). Non-dignified care in childbirth is described as on purpose humiliation, blaming, forceful treatment, shouting, and scolding (Bowser, et al. 2010). Dignity is preserved and improved through the respectful behavior of HCPs (Jacobson, 2006).

The approaches to birthing in latest years have shifted strongly in the direction of protecting and respecting women's dignity and privacy at all times. Routine vaginal examinations should be reduced to the minimum required for medical care and should always be done with the woman's involvement, willingness and permission. Women should be given whatever covering they need to feel comfortable at all times and consideration should be given to the provision of appropriate and dignified sanitary requirements (WHO, 2002).

El-Nemer, et al. (2005), observed that women were not offered any personal privacy; they laboured in a common room with seven beds, delivery room's door was always left open, no curtains were between the two delivery beds, and the room was always full with care providers, students, or a cleaning staff. The surrounding environment was always noisy, full of crying, screaming, and shouting from the labouring women. The only touch was just to carry out technical interventions, and communication was only to give orders or to criticise.

Turan, et al. (2005), observed that women were frequently separated from companions at the time of admission, and support from care providers during labour and delivery was limited.

Women in Cote d'Ivoire (Delvaux, et al. 2007), got little supportive care, they were only told how to lie down on the delivery table, little or no information was provided to them about the progress of labour, and in about less than one fourth of women a person provided support to them. This person was commonly a health care provider and rarely a family member. No privacy was provided to women during labour as they were exposed to other women.

In Japan, researchers found that the most important barriers in humanized birth care were the institutional rules that limited the presence of a birth companion. The chief facilitators were women's own beliefs and values in a natural birth, and hospital's strategies to avoid unnecessary medical interventions (Behruzi, et al. 2010).

The study by Miller and her team (2003) in the Dominican Republic clearly described the de-humanizing care including lack of privacy, dignity and communication with the patients, despite, it is a chance for the hospital to show that it cares for clients with every interaction between client and health care provider.

Privacy was difficult to achieve in Malawi rural district hospital. Maternity room beds did not have curtains, and many people had access to the room. Women had to bring towels and blankets for them and for the new baby. Staff at the maternity room talked very little to the women. Some women delivered without any help, or supervision at all (Seljeskog, et al. 2006).

Finally, The continual presence of a labor companion who has an exclusive focus on providing emotional support, comfort, and information has been found to offer important benefits to laboring women, in comparison with usual care. And the patient have the right to receive kind, respectful care with identification of personal dignity and unbiased access to emotional support, at all times and under all circumstances,

2.2.2.2. Medical Records and Documentation

Medical record is a systematic documentation of a patient's personal and social data, history of his or her illness, treatment procedures and final outcome (Sinha, et al. 2009).

It is also a clinical document that should include information to identify the client, the care provider, the date of the admission, the problems being addressed, care provided, and future plans. It is a record of the many events involving a client from admission to discharge (College and Association of Registered Nurses of Alberta, 2006).

The patient record is an account of a patient's health and disease after he or she asked for medical service. Usually the notes in the record are written by the nurse or the physician. The record contains findings, concerns, tests results, treatment information related to disease process and professional advice. The patient record is used first and foremost to support patient care. But now there is also a large need for patient data for purpose other than patient care such as for supporting clinical, and epidemiological research, educating health care providers, and assessing quality of care (Van Bommel, et al, 1997).

An obstetric record is a book documenting information about a woman's characteristics, medical history, pregnancy, childbirth, and postnatal care (Letamo, et al. 2001). Brief medical record documentation is critical to providing patients with quality care as well as to receiving accurate and timely services. It documents the care of the patient and is required to record important facts, findings, and observations about the patient's health history including past and present illnesses, examinations, tests, treatments, and outcomes (Centers for Medicare & Medicaid Service, 2009).

To evaluate provider performance and skills, it is essential to ensure that maternity records are complete and well kept, and the data on the management of obstetric complications is regularly recorded (Family Care International, 2005). Documentation in health records must be clear, relevant and accurate.

Accurate and complete medical records are important, from a medical and a legal perspective, and should be available as a reference to ensure quality of care (DeVon, et al. 2004). The main goal of recording information is to support patient care. If the information recorded is not required routinely for patient care, it is unlikely to be recorded completely, or consistently especially in the long term (General Practitioners Committee, et al. 2005). Additional goal of medical records is to interact with a decision making system to support teaching and continuing medical education, to support medical governance activities, to support specialized assessment, and to facilitate epidemiological monitoring, and clinical research (The Department of Health, 2005).

Medical record documentation also helps physicians and other health care providers in assessing and planning the patient's immediate treatment and monitoring his or her health

care over time. The documentation of each patient should include reason for the admission and relevant history, physical examination findings, and prior diagnostic test results, assessment, clinical impression, or diagnosis . Medical records should also record date and clear identity of the observer (Centers for Medicare & Medicaid Service, 2009). The accuracy of medical records system requires effective training, ongoing education, and great communication among the staff that handle the records, and need adequate time to document all events that occur (Wittkofski, 2012).

The record must be written as soon as possible after an event has occurred, providing current information on the care and condition of the patient. HCPs must document all aspects of the patients' care, including any emotional support or education given to the patient (Sydney South West Area Health Service, 2009).

If the components of a medical record are not present, this refers to two reasons: The required care is not provided, or the required care is provided but not adequately documented (The Health and Human Services Commission, HHSC, 2010).

Chapter 3

Methodology

3.1. Study Design

This study is a cross sectional descriptive one. This design allows some understanding of the event over time when time allowed for the study is limited, and selecting subjects at different stages in the process will give important information about the whole process (Burn, et al. 1993). Cross sectional study enables the researcher to meet the study objectives in a short time and low cost, and it examines the association between cause and effect at a point of time (Coggen, et al. 1993).

This study is a cross-sectional practice review of natal care services provided in governmental hospitals in G.Gs, and record review documenting the completeness and accuracy of patients' medical records.

3.2. Study Population

The study population consisted of all eligible women who gave birth in the labour wards at the four governmental hospitals; Shifa Hospital, Shohadaa Al-Aqsa Hospital, Nasser Hospital, and Al- Helal Al-Emiratee Maternity. Hospital Observations of their labour and birth were done during the period of the study. In addition, all medical records for the observed women are considered to be the second study population.

3.3. Sample size

Field observations for 40 deliveries were done to document actual practices and better understanding for natal-care management and the interpersonal relations. These observations were obtained from the four hospitals equally. The researcher has spent

about a week in each hospital all over the days of the week within the period of the study to observe labour and delivery.

The medical record for each was reviewed to collect data on the completeness and the accuracy of actual practices documentation.

3.4. Study Setting

The study were conducted at Shifa Hospital, Shohadaa Al-Aqsa Hospital, Nasser Hospital, and Al- Helal Al-Emiratee Maternity Hospital. These governmental hospitals provide natal care services for the majority of G.Gs population.

3.5. Period of the Study

The study started in June 2010. Data collection begun in November 2011, after obtaining approval from sectors of MOH. The pilot study was conducted in December 2011. Data continued till the beginning of February 2012. Data entry and data cleaning were conducted in February and March 2012 . And finally, data analysis and writing the results lasted till June, 2012.

3.6. Selection Criteria

3.6.1. Inclusion Criteria

All women in labour at gestational age between 37- 40 weeks, who are expected to have normal delivery, at low obstetric risk, including uncomplicated pregnancies, singleton pregnancy, and cephalic presentation.

3.6.2. Exclusion Criteria

Any delivery for a woman who is not expected to have normal childbirth, with high-risk pregnancy, with mal- presentation or twins pregnancy, or at gestational age less than completed 37 weeks.

3.7. Ethical Considerations

The researcher is committed to all ethical and administrative considerations required to conduct the research. An approval was obtained from the School of Public Health at Al-Quds University (Annex 2). And an ethical approval was obtained from Helsinki Committee in G.Gs Governorates to carry out the research (Annex 3). Additionally, An approval was obtained from MOH to conduct the study at its four maternity hospitals (Annex 4).

Every observed woman was provided with an explanatory letter , and the right to participate or not, which was attached to each observation checklist (Annex 5).

Honesty was kept during collection, and analysis of data with regard to confidentiality and results.

3.8. Study Instruments

The researcher used two instruments to collect data. The first was an observational checklist for normal labour and delivery. The main items for the checklist are: Condition of the delivery, care during first stage, care during second stage, care during third stage, and labour support. It contains 103 items that include medical practices during the stages of labour and delivery. This checklist was adopted from The Galaa Study: an observation checklist for facility-based normal labor and delivery practices (Sholkamy, et al.2003), and from the Assessment Tool for the Quality of Hospital Care for Mothers and Newborn

Babies (WHO, 2009c) with some modification to be suitable for the Palestinian society (Annex 6).

The second tool is a checklist for medical records (Annex 7). The main items for the checklist were:

- Demographic information (including patient's name and family name, , date of birth, address and phone number.
- Diagnostic procedures (including physical examination, and, laboratory tests).
- Management procedures (including medical orders, partograms filling, and post partum observation).
- Discharge information.

3.9. Data Collection

The data were collected by the researcher herself and one assistant by non-participant observation of activities . The assistant was a midwife and trained to observe the delivering women. An observation was done by the researcher and the assistant for the same woman. The result of the observation showed an agreement in 90% of items. The assistant observed eight cases out of the forty. The observation collects information about what HCPs actually do during labour and delivery.

Also data was collected from the medical records for the same observed women by the researcher herself, to guide for understanding the current situation of documentation of medical interventions.

3.10. Scientific Rigor

3.10.1. Validity

Validity is defined as the extent to which the instrument measures what it is designed to measure (Bashir, et al. 2008). The research tools were pre-tested by eleven experts with

different backgrounds to ascertain the tools' face and content validity. Specific information were given to them including the title of the research, objectives of the study and research questions. Their comments and advices were considered when applying the tools, and minor adjustments were then made to some questions. A list of experts names are provided in annex (8). Moreover, the pilot study which was conducted before the actual data collection increased the validity of the tools.

3.10.2. Reliability

Reliability refers to the stability or consistency of scores over time or across raters (Bashir, et al. 2008). In this research, the following steps were made to guarantee instruments reliability:

- Standardizing the implementation of data collection by the researcher her- self.
- Training of a data collector assistant in how to observe natal – care practices.
- Data entry by the researcher in the same day of data collection.
- Re-entry of 5% of the data after finishing data entry assures correct entry procedure and decrease entry errors
- Reliability statistics for medical records checklist was high and Cronbach's Alpha was 0.806.

3.11. Data Management and Analysis

After collecting data, the researcher coded the checklists using Statistical Package of Social Science (SPSS) Version 17.0 program then the coded checklists were entered by the researcher and by the help of the supervisor. Data cleaning was done through checking out 5% of the checklists and through exploring descriptive statistic frequencies for all variables .

3.12. Pilot Study

A pilot study was conducted with three observations and their medical records. The pilot study gave the researcher a chance to test the appropriateness of the research tools, to standardize the proper way for data collection and entry, and to enhance the validity and reliability of the research. No misunderstanding or ambiguities were apparent. No questions were added or removed. And because of the small number of cases, the academic supervisor recommended that the pilot study can be added to the study.

3.13. Limitations of the Study

- The possibility of a Hawthorne effect.
- The study cannot be generalized due to the small number of cases.
- Exclusion of non-governmental hospitals that provide natal care services.
- Limited scientific resources about the study like books and journals.

Chapter 4

Results and Discussion

This chapter illustrates the findings revealed by the analysis of the collected data. The chapter starts by descriptive statistics from the observational checklist in accordance with evidence based practices and WHO recommendations for best practices in normal delivery. Then a descriptive statistics from medical records checklist to assess the completeness and the accuracy of documenting medical interventions.

In this chapter, the researcher highlights the findings of her study compared with other global and regional studies and tries to explain the results of the study.

4.1. Observation checklist analysis

Forty women were observed during labour and delivery after taking the consent of each one of them to attend labour and delivery. The mean age of mothers at the time of the observation was 25.2 years. Mothers ages were between 18 and 43 years. 12.5% of them were primiparous. The babies' mean birth weight was 3410 g their weight varied from 2500 g to 4200 g, 52.5% of them were male. The majority of women (39- 97.5%) had a spontaneous vaginal delivery, only one case has emergency CS because of obstructed labour and the fetus died.

Obstetricians and gynecologists were the most frequently reported first healthcare provider to examine the lady (52.5%) and 7.5% were midwives (figure 4.1).

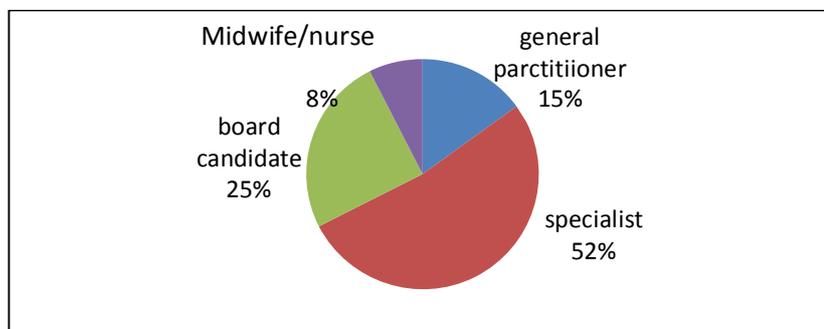


Figure 4.1: First HCP to examine the lady

4.1.1. Care during the first stage of labour

4.1.1.1. Assessing the Well-being of the Woman during labour and delivery

Unfortunately, vital signs weren't checked frequently on admission; BP in 37.5% , pulse and temperature checked in 22.5% of cases (figure 4.2). Checking heart, chest by stethoscope and legs for edema and varicose veins were not done at all. During labour and delivery, vital signs checked in 8.3% of cases .This indicates that the well-being of the mother is poorly assisted.

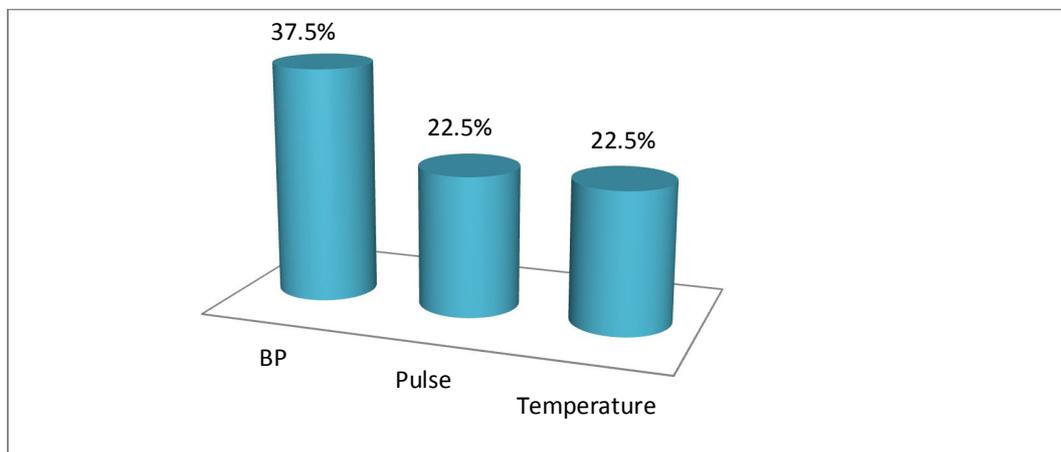


Figure 4.2: Vital signs assessment on admission

Shaving of the perineal area and enema were not used at all, because the culture of the Palestinian women encourages them to be prepared for the delivery by shaving perineal area. The ladies were encouraged to walk and move around in 22.5% of cases, encouraged to eat in 5% ,and encouraged to void in 55%. Catheterization of urinary bladder was used in 10% of cases. All women who were admitted to maternity hospitals had a cannula fixed in their arms, and about 60% of them were started on IV fluids.

This is in agreement with a study conducted in the West Bank (Hassan-Bitar, and Wick, 2007) which revealed that IV fluids were used for 79% of cases, women were not allowed to walk in 69%, and not allowed to eat or drink in 96% of cases.

The same findings were in Egypt and in Lebanon. In Egypt Blood pressure was not assessed at all for 19% of women observed , routine intravenous cannula insertion was 96%, and 99% of the observed women were started on IV fluids (Khalil, et al. 2005).

In Lebanon (Khayat, and cambpell, 2000), women were not allowed to move during labour in 82% . IV fluids given to women in 79%. Perineal shaving used in 92% and enema in 77%. They were not allowed to drink water in 18% of cases, and doctors allowed for sips of water or witting of lips in 59%. Similarly in Jordan, Shaban,et al.(2011) revealed that, women during labour kept fasting with intravenous fluids in 96%and were not allowed to move around in 94%of cases.In Cote d'Ivoire (Delvaux, et al. 2007) The study showed that the assessment of women's general condition at admission was poor. Vital signs were measured in less than 50% of women . But in Canada,19% of women reported having perennial shaving ,and 4.5% having enema (Chalmers, et al. 2009).In Turkey, routine enema, contraction of fluids and mobility were high(Turan, et al. 2005).

So we can say that the labouring women were not encouraged to walk ,eat, and drink as they wished. Their vital signs were inadequately assessed and about two- thirds of them were started on IV fluids like other countries in the region

4.1.1.2. Labour Pain

The ladies who asked for pain reliefwere only 17.5% of , HCP responded to 14.9% of them by giving medication (85.7%), and verbally in a negative way (14.3%). On the other hand, Pethidin was used in 40% of cases, Scobutyl in 32.5% , and Antihistamine in 22.5% . the non-pharmacological methods of pain relief were not used.

Khayat, and cambpell (2000), observed that IM analgesia was used in 31%. In Jordan Shaban, et al. (2011), observed that scobutyl and Pethidin were used for 43% of cases for both of them, and for 44% in Egypt (Khalil, et al.2005).In the West Bank, Pethidin was frequently used causing newborn's respiratory difficulties (Wick, et al. 2004).

In G.Gs, response rate to patients' pain was little, and negative response was observed. Pethidin was used in the same percent like other Arabic countries.

4.1.1.3. Fetal Monitoring during labour and delivery

Fetal heart rate was checked routinely on admission, 40% by CTG only, and 60% by ultrasound. During labour, in 83.3% of cases FHS were checked, 47.1% of them checked once and 20.6% checked twice. During the 2nd stage, FHS were checked in 37.5%, 66.7% of them by continuous CTG and about 33% by intermittent CTG once or twice. Revealing that continuous CTG was used more frequently in maternity hospitals in G.Gs, while intermittent CTG was used less with inappropriate intervals.

This study revealed findings regarding fetal heart monitoring like what was seen in Lebanon, Egypt, Jordan, and Canada. In Lebanon, (Khayat, and Campbell, 2000), intermittent fetal heart monitoring IFM was applied in 28%, and 26% by continuous monitoring CFM. In Egypt, fetal heart was monitored irregularly (El-Nemer, et al. 2005), and in other study it was 21% during labour, and 2% during delivery (Khalil, et al. 2005). In Jordan, CFM 77% and IFM 22% (Shaban, et al. 2011). In Canada, IFM was experienced in 21.1%, and CFM in 62.9% (Chalmers, et al. 2009).

Continuous CTG was used more frequently in maternity hospitals in G.Gs, while intermittent CTG was used less with inappropriate intervals without following any standards.

4.1.1.4. Vaginal Examination

The mean of number of HCPs who examined the ladies was 4.13. About 60% of cases were examined by 3-4 HCPs, and about 25% by 5-6 HCPs. The mean of vaginal examination was 6.3. In 42.5% of the cases the ladies were examined vaginally from 5 to 6 times, and about 12% of them from 10 to 13 times. In 42% of cases the HCP didn't take the permission to examine the lady, on admission 70% of the ladies were not

informed about what would be done to here, and 52.5% were not told about the findings after vaginal examination (figure 4.3).

In the West Bank, Frequent vaginal examinations were carried out ,56% were examined 1 - 4 times and, 44% were examined more than 5 times (Hassan- Bitar, and Wick, 2007).

Among the women observed in Egypt, 16 % were examined vaginally 10 times or more with no use of partograms. Although 12 % were examined by 1 practitioner, 32 % were examined by 4 or more practitioners (Khalil, et al. 2005).But vaginal examination during labour was very high following no protocol or pattern in another Egyptian study (El-Nemer, et al. 2005).

This study revealed frequent rate of vaginal examinations in about half of the observed women, as they were examined more than 5 times like in most countries of the region. About 70% of the ladies were not informed about what will be done to them and half of them did not receive any information about the findings after vaginal examination.

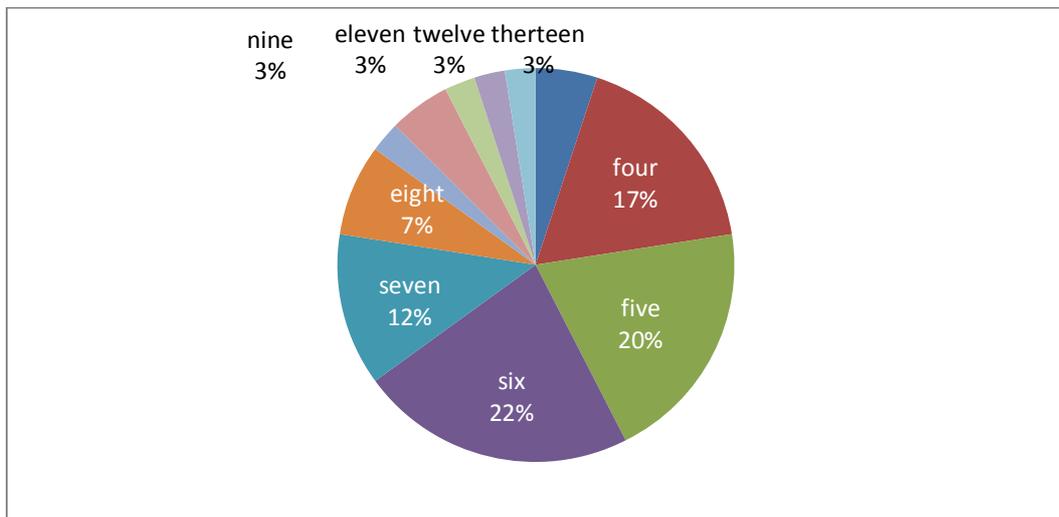


Figure 4.3: Frequency of vaginal examination

4.1.1.5. Use of Partogram

On admission, partograph was filled in 35% of cases, about 9% in the first stage, and about 15% in the second stage. In all cases from the researchers observation, the partograph wasn't filled accurately with little attention to its importance.

Partograph was used in 8% only in Lebanon (Khayat, and cambpell, 2000). But in 95% in Jordan (Shaban, et al. 2011). And not used at all in an Egyptian obstetrics teaching hospital (Khalil, et al. 2005), and in the West Bank too (Hassan- Bitar, and Wick, 2007).

In GGs, partograms were poorly used and in some hospitals it was not used at all. The same as in Egypt and the West Bank.

4.1.1.6. Augmentation of Labour

Augmentation of labour with oxytocin was used in 62% of the observed women and by artificial rupture of the membranes in 77.5%. In West bank, 80% of the observed women had an artificial rupture of membranes, and medication added to the infusion in 34% (Hassan- Bitar, and Wick, 2007). In Jordan, labour was augmented using oxytocin in 42% of cases (Shaban, et al. 2011), and for 91% in Egypt while routine early artificial rupture of the membranes in the first stage was done for 70% of the observed women (Khalil, et al. 2005). In Canada, 37.3% of the questioned women reported speeding up their labour. The same were seen in Greece (Nusbaum, 2006) and Turkey (Turan, et al. 2005).

Oxytocin augmentation ,and artificial rupture of the membranes were found to be common in GGs. This result may suggest that work load and inadequate number of HCPs during the shifts play a role in this situation. HCPs have to speed-up labour to free up beds for the next women, the same like in other countries.

4.1.2. Care during the second stage of labour

4.1.2.1. Pushing during the Second Stage

The majority of ladies were encouraged to push during delivery between contractions (90%). Fundal pressure was applied in 17.5% of cases. About that ;17% was experienced in Canada (Chalmers, et al. 2009) but it was higher in Egypt; 36% (Khalil, et al. 2005).

4.1.2.2. Maternal Position during the Second Stage

All the ladies were not encouraged to adopt positions that they felt it comfortable. They were obliged to deliver in a lithotomy position (65%) or in semi-sitting position (35%). In 25% of cases the legs of the ladies were hanged up but no lady had her hands or legs tied . In Lebanon (Khayat, and cambpell, 2000) 59% of woman had been tied during delivery, and all of them adopted the lithotomy position, as well as in Jordan with stirrups for all cases (Shaban, et al. 2011). In Canada 47.9% of women were delivered in supine position and 45.8% in lithotomy position . 57% of Canadian women had their legs tied (Chalmers, et al. 2009). Using of supine position during labor was commonly practiced in Egypt (Khalil, et al. 2005).

4.1.2.3. Care of the Perineum

The perineum was washed before starting the delivery only in 17.5% of the observed ladies, and perineal massage was applied in 82.5% of cases. 20% of cases had an episiotomy as a routine policy. In 63% of the observed women local anesthesia was used to repair episiotomy/ tear, and only in 10% of cases the perineum was cleaned with antiseptic before conducting the repair.

The lady wasn't informed about the repair in 55.6%,and after finishing it, vaginal examination was done in 40% ,rectal examination in 20% of all cases.

In G.Gs, episiotomy was used for all primiparous (12.5% of the observed women were primiparous) as a routine policy. The same was observed in Lebanon reaching 80% in some hospitals (Khayat, and Campbell, 2000), the West Bank 89% (Hassan-Bitar, and Wick, 2007) , and Egypt 93 % (Khalil, et al.2005). But in Canada it was 27.1% (Chalmers, et al. 2009), and 37% in Jordan (Shaban, et al. 2011).

4.1.3. Care during the third stage of Labour

4.1.3.1. Active Management of the Third Stage

Oxytocin was given in 94.9% of case, as intravenous infusion in 91.9% of cases during birth, at the anterior shoulder in 13.5% and after the delivery of the baby in 86.5%.

The cord was clamped and cut early in almost all cases. But controlled cord traction was applied only in 46.2% of cases. Uterine massage was done in 59%, 60.9% of them immediately after delivery of placenta and the rest after finishing the delivery of the baby. The active management of the third stage unfortunately ,was not applied in almost all cases. Oxytocin as mentioned above , was given in general after finishing the care of the baby, and the signs of spontaneous separation and expulsion of the placenta are waited without controlled traction of the cord to extract the placenta. Neglecting this management exposes birthing women to post partum hemorrhage and other serious complications of the third stage of labour.

Methrgin was administrated in 74.4% of the cases, intravenous in 69% without checking BP before administration in all cases.

In Egypt, only 15% of the cases had third-stage prophylactic oxytocin and 14% of them had Methrgin (Khalil, et al. 2005). In Turkey, oxytocin was used only in 28% of cases before the delivery of the placenta and the monitoring for vaginal bleeding in the post partum period was always inappropriate (Turan, et al. 2005). Contrary, In Cote d'Ivoire, A positive practice was that active management of the third stage of labour (AMTS) was a common practice (Delvaux, et al. 2007).

In summary, prophylactic third-stage oxytocin was given appropriately in only 13.5% of the observed deliveries, and active management of the third stage was not applied, losing its protection against postpartum hemorrhage. But Methergin was administered more frequently than oxytocin in spite of its side effects like nausea, vomiting, headache, and raised blood pressure.

4.1.3.2. Cord Clamping

The cord was clamped early in 97.4% of cases, in 94% with sterile scissors, but 97.4% didn't wash their hands before dressing the cord and 57.9% didn't use clean gloves for this purpose. They used the same gloves that were used to deliver the lady. The same was observed in an Egyptian teaching hospital as the cord was clamped early in 94% of cases (Khalil, et al. 2005).

4.1.3.3. Immediate Care of the Newborn

Almost in all cases the care of the newborn was done; weighing, giving Vitamin K, and putting identification bracelets. 46% of babies were put in direct skin to skin with their mothers but only for a short time until the cord was clamped and cut. 97% were placed on a radiant warmer and were dried with towels. One baby died and another was taken to neonatal care unit because the father works there. The baby's mouth and nose were suctioned in about 13% as a routine.

The findings are inconsistent with other studies. Suction was widely used in maternity hospitals in Jordan, it reached 91% of babies (Shaban, et al. 2011). In Egypt only in 34% of newborns were placed on a radiant warmer and none of them was put in skin-to-skin contact with his/her mother (Khalil, et al. 2005).

4.1.3.4. Immediate Care of the Mother after Delivery of the Placenta

The placenta was examined after delivery only in 10.3% of cases. Uterine exploration done in 41% of cases as a routine in 93.8%. In one case only, exploration done because of membranes loss . In half of the cases of uterine exploration ,sterile gauzes were used without any anesthesia.Uterine contractility was confirmed after deliveryonly in 69.2% of cases. Unfortunately ,in all cases vital signs were not checked after delivery.

HCP congratulated the lady in 66.7% of cases .In 64% the lady had her perineum cleaned after delivery. In 84.6% she was covered well. And only in 10.5% she was given the baby to hold in delivery room and they were transferred quickly to post natal ward.

Routine examination of the placenta was done for 63% of the observed women in Egypt , manual exploration of uterus after delivery was done in11% of them (Khalil, et al. 2005) different from what was found in this study.

The results of this research support findings from other studies, recording the difference between evidence- based practices and the real care in Palestine, Arab countries, and other regions of the world. Evaluations of natal-care services reveal alarming results and stresses the prevalence of practices that are not evidence- based.

4.1.4. Practices in the light of WHO recommendation for normal delivery

4.1.4.1. Category A: Practices which are useful and should be encouraged.

Observation revealed low rates of beneficial practices as shown in Table 4.1. Although infection control like single use of disposable materials, and sterility in cutting of umbilical cord, as well as prevention of hypothermia of the baby by using radiant warmer ; were generally used, monitoring women's physical well-being was weakly assisted during labour and delivery. Blood pressure was assessed in one- third of the observed

women during labour and for 8.3% in delivery. This is a huge error, since hypertensive diseases of pregnancy constitute to be one of the leading causes of maternal deaths among the world (WHO, 2005).

Table 4.1: Practices which are useful and should be encouraged

A	Useful practices and should be encouraged	Frequency of observed practices	
		Labour	Delivery
1	Monitoring the woman's physical and emotional well-being throughout labor and delivery - Blood pressure - Pulse - Temperature - Woman's request for pain relief addressed	37.5% 22.5% 22.5% 17.5%	8.3% 8.3% 8.3% 0.0%
2	Offering oral fluids during labor and delivery	5%	0.0%
3	Respecting the right of privacy in the delivery place (covered during examination)	90%	7.5%
4	Giving women as much information as they desire (Sharing vaginal exam findings)	47.5%	10.3%
5	Fetal monitoring with intermittent auscultation	83.3%	33%
6	Single use of disposable materials (gloves)	100%	100%
7	Use of gloves in vaginal examination	100%	100%
8	Freedom in position and movement in labor	22.5%	0.0%
9	Encouragement of nonsupine position in labor (semi-sitting position)	NA*	35%
10	Partogram use	35%	15%
11	Sterility in cutting of umbilical cord	NA*	100%
12	Prophylactic oxytocin in third stage	NA*	94.9%
13	Prevention of hypothermia of the baby (Radiant warmer)	NA*	100%
14	Early skin-to-skin contact	NA*	46%
15	Routine examination of placenta	NA*	10.3%

NA* = Not Applicable.

The same concern is that prophylactic third-stage oxytocin which was given appropriately in only 13.5% of the observed deliveries (at the delivery of the anterior shoulder) decreasing its protection against postpartum hemorrhage . Infrequent information sharing (47.5% and 10.3% in labor and delivery, respectively) was observed. Skin- to skin contact is a useful practice but it was used only in 46% of observed cases.

Offering oral fluids during labor and delivery only was in 5% . Routine examination of the placenta was done only in about 10% of the observed women.

This reveals that practices clearly favorable to health, useful in natural delivery and advised by the WHO are not widely used. These practices must be encouraged and supported. The practices of HCPs during labor and birth may either contribute to or help prevent infections in both the mother and the baby (USAID and et al. 2010).

4.1.4.2. Category B: Practices which are clearly harmful and should be eliminated.

Table 4.2 shows the observed frequencies of 13 of 15 practices defined by WHO, as clearly harmful or ineffective, the prevalence of which should be nil.

Only 4 practices were never done (use of enema, pubic shaving, directed bearing down efforts during the second stage, and oral ergometrine in third stage). Still, routine IV cannula insertion, IV infusion, and supine and lithotomy position were widely used. Oxytocin augmentation was found to be common reaching 62.5% without using dropper machines or closed monitoring for the mother and her fetus by HCPs. Inadequate use of oxytocin can cause uterine hyper-stimulation, fetal asphyxia, uterine atony, uterine rupture, and hemorrhage (Cluver, & Odendaal, 2010).

Use of parenteral ergometrine , associated with nausea, vomiting, headache, and raised blood pressure (Liabsuetrakul, et al. 2007) was administered in the third stage in 74.4% of observed women.

Uterine exploration was observed. However, it is associated with complications of varying severity, which can cause infection and shock (Hulton, et al. 2000). It was performed routinely in 41% of observed deliveries.

Labour and birth practices include interventions that should be neglected, such as speed-up of birth with routine augmentation of labour, and routine episiotomy, or practices that

should simply be controlled, such as lithotomy position, fundal pressure, uterine exploration and Methergin administration in the third stage.

Table 4.2: Practices which are clearly harmful and should be eliminated.

B	Clearly harmful or ineffective practices	Frequency of observed practices	
		Labour	Delivery
1	Routine use of enema	0.0%	0.0%
2	Routine use of pubic shaving	0.0%	0.0%
3	Routine intravenous infusion in labor	60%	NA*
4	Routine prophylactic insertion of intravenous cannula	100%	NA*
5	Routine use of supine position during labor	NA*	100%
6	Rectal examination	NA*	0.0%
7	Administration of oxytocics at any time before delivery in such a way that their effect cannot be controlled	62.5%	NA*
8	Routine use of lithotomy position with or without stirrups during labor	NA*	65%
9	Use of oral tablets of ergometrine in the third stage to prevent or control hemorrhage	NA*	0.0%
10	Routine parenteral ergometrine in the third stage	NA*	74.4%
11	Routine revision (manual exploration) of uterus after delivery	NA*	41%
12	Sustained, directed bearing down efforts during the second stage	NA*	0.0%
13	Massaging and stretching the perineum during second stage	NA*	82.5%

NA* = Not Applicable.

4.1.4.3. Category C: Practices for which insufficient evidence exists to support a clear recommendation and which should be used with caution

Fundal pressure was performed in 17.5% of observed deliveries (Table 4.3). This practice may harm the uterus, perineum, and fetus (Verheijen, et al. 2009). The early cord clamping observed (97.4%) is satisfactory. Early amniotomy was frequently observed (77.5%). Non-pharmacological methods of pain relief during labour were not used.

Table 4.3: Practices for which insufficient evidence exists to support a clear recommendation and which should be used with caution

C	Practices for which insufficient evidence exists	Frequency of observed practices	
		Labour	Delivery
1	Non-pharmacological methods of pain relief during labor(Positive verbal responseto pain)	0.0%	0.0%
2	Routine early amniotomy in first stage	77.5%	NA*
3	Fundal pressure during labor	NA*	17.5%
4	Early clamping of umbilical cord	NA*	97.4%

NA* = Not Applicable.

4.1.4.4. Category D: Practices which are frequently used inappropriately.

Vaginal examinations by providers were estimated to be too frequent in nearly one-half of examinations as shown in Table 4.4. Among the women observed, 12 % were examined vaginally 10 times or more. Although 10 % were examined by 2 HCPs, 47.5 % were examined by 4 or more HCPs . Whereas 20% episiotomy rate has been suggested as a current practice , which has been shown to be harmful and unnecessary and findings from randomized trials do not support routine episiotomy (Carroli ,&Belizan, 2007), it was performed for all primiparas.

Manual exploration of the uterus was frequently used (41%), and EFM during delivery was not applied commonly (33%). The response rate to ladies’ request for pain relief was poor (15%).

Table 4.4: Practices which are frequently used inappropriately.

D	Practices which are frequently used inappropriately.	Frequency of observed practices	
		Labour	Delivery
1	Restriction of fluids during labor	95%	NA*
2	Pain control by systemic agents	15%	NA*
3	Pain control by epidural analgesia	0.0%	NA*
4	Electronic fetal monitoring	83.3%	33%
5	Wearing masks and sterile gowns during labor	0.0%	0.0%
6	Repeated or frequent vaginal examinations especially by more than one caregiver Women examined vaginally more than 5 times Women examined by: - 2 practitioners - 4 practitioners - 6 practitioners - 10 practitioners	54.5% 10% 35% 10% 2.5%	
7	Oxytocin augmentation	62.5%	NA*
8	Routinely moving laboring woman to a different room at onset of second stage	100%	NA*
9	Bladder catheterization	10%	NA*
10	Operative delivery	NA*	0.0%
11	Liberal or routine use of episiotomy: Episiotomy performed Episiotomy performed for primiparas	NA*	20% 100%
12	Manual exploration of uterus after delivery	NA*	41%

NA* = Not Applicable

In summary, medical interventions during labour and delivery are of high levels, giving indication of their inappropriate or routine use, contrasting to the best available evidence. Avoiding harmful practices would make the quality of care better. Overloading, and understaffing are reasons for spread in use of these interventions (Wick, et al.2005). Also high levels of poverty increased the demand on governmental hospitals which increased the stress on HCPs who have to overcome this situation by accelerating labour(Hassan-Bitar, and Wick,2007).

Childbirth practices in this study were mostly away from the well-known best practice recommended by WHO for normal birth, which may play a part in the incidence of obstetric complications.

4.1.5. Non- Technical/ Humanistic Care

4.1.5.1. Labour support

A family member was allowed to stay with the lady during labour only in 22.5% of the observed women. But no companion was allowed during delivery which is a policy in the ministry of health. The lady asked for pain relief in 17.5% of cases. HCP responded by giving medications in 85.5%, and in a verbally negative way in 14.3%.

During labour, 76.9% of cases the delivering HCP was one of those who met the lady in the pre-labour ward. But 10.3% of them explain what would be done to her during delivery, and 55.6% not informed about the procedure to repair an episiotomy/tear. 57.2% of the HCPs take women's permission before conducting vaginal examination. 20.5% of HCP were aggressive during delivery. And doctors were more aggressive than midwives. 66.5% of HCP congratulated the lady and 84.6% of the observed ladies were covered after delivery.

The findings of this research are not in agreement with the study conducted in Lebanon (Khayat, and Campbell, 2000), a family companion was always allowed in 77% during labour, and 33% during delivery. In contrast with what was seen in Jordan. Women were not allowed to have a companion or support person during labour and birth almost in all cases (99%) (Shaban, et al. 2011). In Turkey women were frequently separated from companions at the time of admission (Turan, et al. 2005), and in Cote d'Ivoire too (Delvaux, et al. 2007).

In Egypt, Sharing vaginal exam findings was 17% during labour and 31% during delivery. Woman's request for pain relief was addressed in 32% of cases during labour, and in 92% during delivery. Most of the observed women were laboring without a birth companion which is not offered in the free section of an Egyptian teaching hospital (Khalil, et al. 2005).

The Palestinian women in G.Gs were rarely supported during labour and birth by a family member, and not given information as they desired. Half of them were not asked for permission for examination.

4.1.5.2. Involvement in decision making and Communication

Infrequent information sharing was clear and frequent. Only 47.5% of cases were told the findings of examination on admission ,and 16.1% in pre labour ward . HCP explained what would be done in delivery ward to 10.3% of observed women. The women were receiving medication, and maneuvers done to them without any explanation.

In Jordan, 70% of women were not given information as they wished (Shaban, et al. 2011). In Egypt, infrequent information sharing was observed in labour (17%) and in delivery (31%) (Khalil, et al. 2005). In Turkey (Turan, et al. 2005), communication was only to give orders or to criticism.

Women in G.Gs are not involved in what is happening to them leading to increased levels of intervention. They are not invited to make decisions about the actions to be done during birth. Lack of communication between HCPs and patients is too frequent leading to dissatisfaction. Satisfaction in natal-care was found to be directly related to the quality of the relationship between the HCPs and birthing women (Simmonds, 2010).

4.1.2.3. Respect and Privacy

During delivery, 57.5% of cases HCP took the permission to examine the lady. 30% of ladies received an explanation about what have been done to them during examination. 90% of the ladies were covered during examination and 100% of curtains /partitions were closed. 92.5% of the health care providers didn't introduce themselves to the ladies. 55% of them didn't call the ladies by their names.

70% of cases were examined by 2-4 HCP, and 25% by 5-6 HCP. 37.5% were vaginally examined 4-5 times during labour and delivery , 35% were examined 6-7 times, while 23% were examined from 8 to 13 times (figure.4.4).

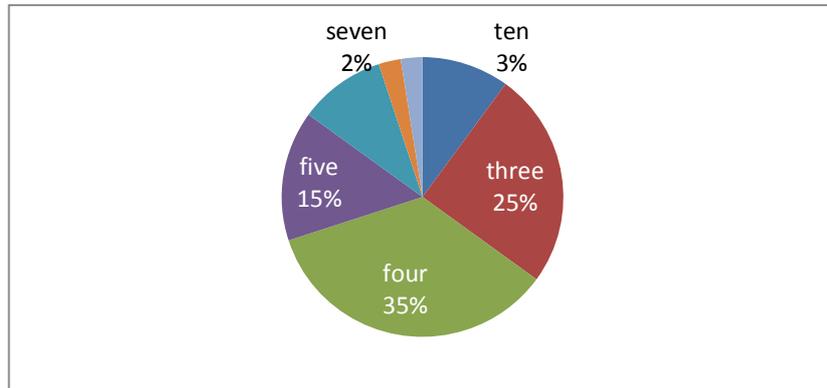


Figure 4.4: No. of HCPs who examined the lady

During delivery partitions/curtains were closed in 62.5% of cases and the lady was covered except for perineal area only in 7.5% of cases.

This study revealed the same results as in other Arab countries. Women did not have privacy during their labour and birth in 67% in Jordan (Shaban, et al. 2011). In Egypt, 89% of women were covered during examination and 16% of women were examined vaginally more than 10 times, 12% by one practitioner, 32% by 4 practitioners (Khalil, et al. 2005). In Cote d'Ivoire (Delvaux, et al. 2007) the researchers noticed that privacy was not provided to the birthing women because they were exposed to other women.

In summary, in this research, women didn't have privacy during birth and were frequently exposed to others. HCPs didn't respect women by not introducing themselves and by not calling the birthing women by their names. Communications between HCPs and birthing women were relatively limited. And changing this situation may require organizational and behavioral changes. Continuous labour support is proven to be an effective method to improve birth outcomes (Hodnett, et al. 2011) but it was not commonly applied in governmental hospitals in G.Gs.

4.2. Medical Records Checklist analysis

A birth record consists of many papers which are not the same in the four hospitals. There was no standard medical record. In one hospital partogram paper was not attached to the medical record at all. The sheet of post-partum care differs in two hospitals from the other two. The sheet of neonatal care was available only in one hospital leading to a non-standard medical record, and difficulty in collecting data from them.

4.2.1. Completeness of medical records.

Medical records for the forty observed women were reviewed and data were filled in the checklist. Items were re-coded to compute total scores for HCPs recording. Answers “no” having the value of 0, whereas answers “yes” were assigned the value of 1, so that the total score for each domain could be calculated by summing all eligible variables. The following scale was used to determine the level of completeness: < 40% - very poor, 41-60 – poor, 61-80 good, and > 81 – excellent (Bakalyan, et al.2004).The overall completeness of records was found to be poor (Table 4.5). A very poor level of completing medical records may partially explain the often low levels of performance of recommended care items. The observed values are quite lower than the standard value of 100%.The completeness of demographic information (67.5%) was good in general, diagnosis on admission (90%), present history (82.5 %), menstrual history (85 %) was very good, but, Obstetric history (27.5%) was very poor.

The completeness level of some items was very poor such as general examination and vital signs (12.5%), abdominal examination (10%), vaginal examination (2.5%),and Investigations (5%).

Partograms completion was unsatisfactory and very poor (20%) and the recorded orders too. Medical staff only wrote the findings after vaginal examination and gave orders for drugs. Nothing was written about how to manage labour and delivery. Completeness level of post partum observation was very poor (40%), and discharge information too

(17.5%) .The same was observed in the West Bank, the medical records were incomplete and did not allow the researchers to track them (Hassan- Bitar, and et al. 2007).

Table 4.5: percentage of medical records filling.

No	Item	Filling score	Complete level
A	Demographic information	67.5%	Good
	patient's name	100%	Excellent
	patient's age	95%	Excellent
	Address	92.5%	Excellent
	phone number	0.0%	Very poor
	Insurance number	72.5%	Good
	Identity number	82.5%	Excellent
B	Diagnostic procedures		
	diagnosis on admission	90 %	Excellent
	present history	82.5 %	Excellent
	Menstrual history	85 %	Excellent
	Obstetric history	27.5%	Very poor
	past history	22.5 %	Very poor
	General examination and vital signs	12.5 %	Very poor
	Abdominal examination	10 %	Very poor
	Vaginal examination	2.5%	Very poor
	Investigations	5 %	Very poor
C	Management procedures		
	partograms filling	20%	Very poor
	Recorded orders	2.5%	Very poor
	Post partum observation	40%	Very poor
D	Discharge information	17.5%	Very poor
	Total	46.4%	Poor

Poor level of completeness of medical records indicates poor care. Incomplete recording of obstetric ,medical and past histories, suggests lack of knowledge of patient rights about having a complete medical record. Allowing for these lacks, the patient records do not touch the standards of medical records, reflecting a poor quality of information and documentation.

4.2.2. Accuracy of medical records

A comparison was made between the observed and the documented practices which revealed that documentation unfortunately, was far away from observation (Table 4.6).

Blood pressure was assessed in the observation only in 37.5% of cases but documented in 72.5% . The same was for pulse, temperature, heart examination and chest examination.

Frequent vaginal examinations were carried out, but not always documented in the records. According to the records, 70% of the ladies were examined vaginally once. While the observations confirm that no one of them were examined vaginally once. On the other hand 57.5% of the ladies were examined vaginally more than five times, but nothing was documented. There was a discrepancy between observation, and documented numbers of vaginal exams.

Augmentation of labour was used widely to speed up labour by oxytocin and artificial rupture of the membranes (62.5 % and 77.5% respectively), but they were less documented in medical records (52.5% and 42.5%). Many harmful and inappropriate practices were observed ,but they were not documented at all.

The demographic information in this study was incomplete which is in agreement with findings of other study (Prins, et al. 2002). and in agreement with a study by WHO (2009d).

Table 4.6: comparison between observation and medical records data to detect the accuracy of data filling.

No	Item	Observation %	Medical record %
1	Blood pressure	37.5	72.5
2	Pulse	22.5	72.5
3	Temperature	22.5	72.5
4	Heart exam	0.0	55
5	Chest exam	0.0	50
6	Intermittent fetal monitoring	83.3	75
7	Prophylactic oxytocin in third stage	94.9	77.5
8	Routine examination of placenta	10.3	45
9	Oxytocin augmentation	62.5	52.5
10	Artificial rupture of membranes	77.5	42.5
11	Routine parenteral ergometrine in the third stage	74.4	80
12	Routine early amniotomy in first stage	77.5	42.5
13	Pain control by systemic agents	15	40
14	vaginal examinations		
	Once	0.0	70.0
	3 times	5.0	10.0
	4 times	17.5	2.5
	5 times	20.0	2.5
	More than 5 times	57.5	0.0
15	Bladder catheterization	10	0.0
16	Liberal or routine use of episiotomy	20	20
17	Manual exploration of uterus after delivery	41	0.0
18	Fundal pressure during labor	17.5	0.0
19	Massaging and stretching the perineum during second stage	82.5	0.0

Pringle et al. (1995) conducted a study to assess the completeness and accuracy of the computer medical records in four high-recording general practices. They found that completeness in computer recording of diabetes mellitus and glaucoma showed high levels of accurate recording, 97% and 92% respectively.

In the UK, codes for cancer in medical records have a poor level of completeness (29.4%) and accuracy (65.6%) when compared with the Cancer Registry, lacking the

required documentation to confirm the cancer type, date of diagnosis or other aspects of the malignant condition (Pascoe, et al. 2008).

Donabedian (1988) announced that the” *medical record is frequently incomplete in what it documents, often ignoring significant aspects of technical care and including nothing about the interpersonal process. Also, some of the information recorded is inaccurate because of mistakes in diagnostic testing, in clinical observation, in clinical assessment, and in recording*”.

Good quality records can provide support for the HCP, for the benefit of patient care . Improving the healthcare services is closely related to a well-developed medical records system in the hospitals. This highlights the need for increased attention by HCPs to ensure the complete and accurate documentation of information in medical records.

Chapter 5

Conclusion and Recommendations

5.1. Conclusion

This study is limited in its generalizability by the small sample, and short assessment period. But still sheds light on the current practices of natal-care services in Gaza. Governmental hospitals in G.Gs play a critical role in natal-care service provision, given the large number of women and newborns who depend on the maternity care.

All the items in this study were measured by direct observation which is believed to give a good reliability. Large gaps were recognized by comparing current natal-care practices in governmental hospitals to lessons from the best available research, which indicates that non-evidence-based practices are commonly used to support, monitor and manage birth in GGs. In many cases, it is indicated that these practices are unnecessary due to the differences in medical schools. High levels of obstetric interventions were observed giving evidence of their inappropriate or routine use, contrasting to the best available evidence. Natal-care practices for women in labour in our study were largely deviated from the well-known best practice recommended by WHO for normal birth. This deviation from best practice could possibly be playing a part in the incidence of obstetric complications which is the reflect of the very assorted way of training among HCPs.

The low frequency of beneficial normal labor practices like monitoring the woman's physical and emotional well-being, non supine position in labor, early skin-to-skin contact and sharing vaginal exam findings, suggests that many evidence-based obstetrical interventions are underutilized. Together with a high frequency of harmful interventions such as routine IV cannula insertion, IV infusion, supine and lithotomy position and Oxytocin augmentation, has serious association related to maternal mortality and morbidity. Averting this condition will be essential to deliver humanized and quality care to women, with increased appreciation of the importance of standardized and evidence-based normal delivery. So, there is obviously a need to monitor the use of obstetrical interventions in our hospitals.

Practices that are useful and should be encouraged were frequently documented, except for physical assessments, such as pulse and temperature and emotional sides. Vaginal examinations were done more often than recommended and fetal heart rates were infrequently monitored intermittently. Practices classified as harmful, practices with insufficient evidence and practices frequently used inappropriately, were used frequently. Interventions were carried out without a clear reason. The WHO recommendations were partially followed.

There was a failure in telling women about practices and in involving them in decision-making regarding their own care. Infrequent information sharing was clearly demonstrated. Women should always be told about vaginal examination, progress of labour, and the condition of the fetus.

Birthing women were not always treated with respect with frequent lack of communication with HCPs. Women didn't have privacy during birth and were frequently exposed to others. HCPs didn't respect women's dignity by not introducing themselves and by not calling the birthing women by their names which indicates training HCPs on communication skills.

Support and help during labour and delivery decrease women's anxiety. It was noticed that there was lack of support from HCPs and family member. A family member was allowed to stay with the lady during labour only in 22.5% of the observed women. But no companion was allowed during delivery which is a policy in the Ministry of Health.

This highlights the importance of provider-patient interpersonal relations. These findings prove that HCPs pay no attention to the emotional processes that women experience during labour and delivery by completely medicalising all the elements of natal-care. HCPs should improve methods to work with birthing women to help in promoting comfort and relaxation during labour and delivery. When a birthing woman is comfortable and trustful, everything goes easily. But HCPs confuse this biological process by using many interventions because of high birth rates and fertility rates in G.Gs, combined with the shortage in HCPs numbers which increased the load on

governmental hospitals and HCPs. Shortage in medical supplies and equipments due to siege on G.Gs increased the load and worsen the situation in these hospitals.

If the data from medical records are to be of value to the practices, they must be complete and accurate. Accuracy and completeness of medical records is crucial to determine the provided care.

Due to poor completeness, and accuracy of the medical records in this study, it is believed that HCPs at these hospitals were not concerned about the importance of the medical record as an essential document for treatment and follow-up of their patients.

A poor level of completeness and accuracy of medical records indicates poor care. Given that sufficient recording of obstetric information is important for appropriate response to emergencies. It is essential to find methods to ensure that the documentation of information will be in a standardized and uniformed design in all the governmental hospitals. Maternity medical records must be standardized that each hospital collects the same information. Quality improvement is required for the missed important data, and continuous supervision and training to healthcare providers to increase awareness of the importance of recording data in the medical records. Data is considered to be of high quality if it is accurate, complete, valid, and available when needed.

Poor quality services in this study revealed the need for training HCPs on standardized guidelines and protocols, and supervising them while providing the service. Providing governmental hospitals with the needed supplies and equipments is essential which necessitate removing the siege on G.Gs that exhausted the people and the government. The continuous situation of emergency that G.Gs lives every day because of the Israeli occupation attacks increased the load on governmental hospitals.

The Palestinian woman is living under siege and facing death every day, she is suffering from poverty, but she is still struggling to live in dignity and raise her children peacefully. She is in a weak position in this situation, so she must be treated with respect and love while she is bringing a new life to the world. Palestinian woman worth better natal-care services and to be treated nicely.

5.2. Recommendations

5.2. 1. Recommendations for Governmental Hospitals

- 1- Improve the quality of natal-care services by the support of evidence-based practices and encouragement of normal deliveries to avoid medical complications by:
 - Strengthening management , supervision systems and problem solving visits to implement evidence-based practices.
 - Strengthening the capacity of HCP, and their pre-service and in-service training.
 - Training HCPs on communication skills and attitudes.
 - Promoting the presence of family members to help in providing care and to support both mother and newborn by teaching them good practices.
- 2- Expand the scope of practice and use of midwives , supported by appropriate policies and capacity building methods.
- 3- Promote standardization of medical records among governmental hospitals and strengthen hospital records to improve accuracy of reporting and accountability .
- 4- Structural changes to improve the logistic systems and the condition of governmental hospitals like distribution of sufficient beds and reducing patients' loads .
- 5- Initiate an audit system within the hospitals, and quality assessment and improvement tools to identify poor aspects of care and upgrade practices.
- 6- Create a culture of responsibility and accountability and promote good clinical governance on the basis of research, audit, and continued education.

5.2. 2. Recommendation for Health Policy Makers

- 1- Communicate findings to decision-makers to promote evidence based practices.
- 2- Regulation of practice related to natal-care by developing plan of action to review practices and implement change to be applied by governmental hospitals.

- 3- Development of national policy for promoting normality of natal-care, and suitable use of technology.

5.2. 3. Recommendation for further studies

- 1- Further studies are recommended to explore the perception of HCPs about evidence- based childbirth practices.
- 2- It is recommended to apply this study at other health sectors (NGOs, Private) to evaluate natal-care services.
- 3- Further studies are recommended to explore the role of midwives in providing natal-care services.
- 4- Further studies are recommended to explore the causes behind the poor quality of documenting medical records.

Chapter Six

References and Annexes

6.1. References

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6.2. Annexes

Annex (1)

WHO Classification of Practices in Normal Birth

CATEGORY A: Practices which are Demonstrably Useful and Should be Encouraged

- 1- Monitoring the woman's physical and emotional well-being throughout labour and delivery, and at the conclusion of the birth process
- 2- Offering oral fluids during labour and delivery
- 3- Respecting the right of women to privacy in the birthing place
- 4- Use of gloves in vaginal examination
- 5- Freedom in position and movement in labor
- 6- Encouragement of nonsupine position in labor
- 7- Partogram use
- 8- Prophylactic oxytocin in third stage
- 9- Sterility in cutting of umbilical cord
- 10- Prevention of hypothermia of the baby
- 11- Early skin-to-skin contact
- 12- Routine examination of placenta

CATEGORY B: Practices which are Clearly Harmful or Ineffective and Should be Eliminated

- 1- Routine use of enema
- 2- Routine use of pubic shaving
- 3- Routine intravenous infusion in labor
- 4- Routine prophylactic insertion of intravenous cannula
- 5- Routine use of supine position during labor
- 6- Rectal examination
- 7- Administration of oxytocics at any time before delivery in such a way that their effect cannot be controlled

- 8- Routine use of lithotomy position with or without stirrups during labor
- 9- Routine parenteral ergometrine in the third stage
- 10- Routine lavage of uterus after delivery
- 11- Routine revision (manual exploration) of uterus after delivery
- 12- Sustained, directed bearing down efforts during the second stage
- 13- Massaging and stretching the perineum during second stage

CATEGORY C: Practices for which Insufficient Evidence Exists to Support a Clear Recommendation and which Should be Used with Caution while Further Research Clarifies the Issue

- 1- Non-pharmacological methods of pain relief during labor
- 2- Routine early amniotomy in first stage
- 3- Fundal pressure during labor
- 4- Early clamping of umbilical cord

CATEGORY D: Practices which are Frequently Used Inappropriately

- 1- Restriction of fluids during labor
- 2- Pain control by systemic agents
- 3- Pain control by epidural analgesia
- 4- Electronic fetal monitoring
- 5- Wearing masks and sterile gowns during labor
- 6- Repeated or frequent vaginal examinations especially by more than one caregiver
- 7- Oxytocin augmentation
- 8- Routinely moving laboring woman to a different room at onset of second stage
- 9- Bladder catheterization
- 10- Operative delivery
- 11- Liberal or routine use of episiotomy
- 12- Manual exploration of uterus after delivery

Annex (2)

An official letter from School of Public Health at Al- Quds University

Al-Quds University
Jerusalem
School of Public Health



جامعة القدس
القدس
كلية الصحة العامة

2010/8/25

الأخ/د. ناصر أبو شعبان المحترم
مدير عام تنمية القوى البشرية-وزارة الصحة
تحية طيبة وبعد،،،

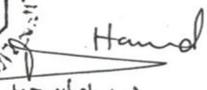
الموضوع: مساعدة الطالبة سحر شلبي

تقوم الطالبة المذكورة أعلاه بإجراء بحث بعنوان:

“Evaluation of Natal-care services provided by Governmental Hospitals in Gaza Governorates .

كمتطلب للحصول على درجة الماجستير في الصحة العامة-مسار ادارة صحية و عليه نرجو التكرم للإيعاز لمن تروته مناسب
لتسهيل مهمة الطالبة في جمع البيانات من المرضى ومقدمي الخدمة وتقييم خدمات الولادة وذلك من أقسام الولادة التابعة
لمستشفيات وزارة الصحة .
علماً بأن المعلومات ستكون متوفرة لدى الباحث و الجامعة فقط.

و اقبلوا فائق التحية و الاحترام،،،



د. بسام أبو حمد
منسق عام برامج الصحة العامة

نسخة:
- الملف

Jerusalem Branch/Telefax 02-24799234
Gaza Branch/telefax 08-2884422-2884411

Sphealth@admin.alquds.edu

02-2799234 فرع القدس/تلفاكس
08-2884422-2884411 فرع غزة/تلفاكس

Annex (3)

An ethical approval was obtained from Helsinki Committee in G.Gs.

Palestinian National Authority
Ministry of Health
Helsinki Committee



السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

التاريخ: 4/6/2012

Name: Sahar Shalabi

الاسم: سحر شلبي

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

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

“Evaluation of Natal Care services provided by Governmental Hospitals”.

In its meeting on **June 2012** and decided the Following:-
To approve the above mention research study.

و ذلك في جلستها المنعقدة لشهر 6 2012
و قد قررت ما يلي:-
الموافقة على البحث المذكور عالياً.

Signature
توقيع

Member

عضو
[Signature]

Member

[Signature]



Chairperson

[Signature]

Conditions:-

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

Annex (4)

An approval from MOH to conduct the study at its four maternity hospitals.

The Palestinian National Authority
Ministry of Health
Directorate General of Human Resources Development

السلطة الوطنية الفلسطينية
وزارة الصحة
الإدارة العامة لتنمية القوى البشرية

الرقم: ١١ / ٢٢٢٩
التاريخ: 2011/12/10

الأخ / د. مدحت محيسن
مدير عام المستشفيات
تحية طبية وبعد...

الموضوع/ بخصوص الباحثة د. سحر شلبي.

تهديكم الإدارة العامة لتنمية القوى البشرية أطيب تحياتها،
بالإشارة إلى الموضوع أعلاه، وإحافاً لكتابنا رقم: 2172 بتاريخ: 2011/12/03 الخاص بطلب الباحثة
المذكورة تنفيذ بحث علمي بعنوان: "تقييم الخدمات المقدمة أثناء الولادة في المستشفيات الحكومية" لنيل
درجة الماجستير من كلية الصحة العامة، وحيث أن الباحثة بحاجة لمتابعة عدد من حالات الولادة
الطبيعية منذ دخولها استقبال الولادة وأثناء عملية الولادة وبعد الولادة وتعبئة استبانة من هذه الحالات
حول الرضى عن الخدمة المقدمة، وكذلك الإطلاع على الملف الطبي لعدد من الحالات وتقييمه وتعبئة
استبانة من العاملين في إدارة مستشفيات الولادة الحكومية، مع العلم الباحثة قد وقّعت على التعهدات
الخاصة بتنفيذ الأبحاث في مرافق الوزارة، وستقوم بأخذ الموافقة المستنيرة من المشاركات في البحث
حسب الأصول.

وحيث أن الطبيبة تعمل في الخدمات الطبية العسكرية في تخصص النساء والتوليد،
أرجو بعد موافقتكم تسهيل إجراء البحث، حتى يمكن الاستفادة من النتائج في تطوير الخدمة المقدمة.

وتفضلوا بقبول التحية والتقدير،،،

د. ناصر رأفت أبو شعبان
مدير عام تنمية القوى البشرية

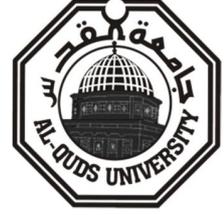
مرفق:
- أدوات الدراسة.
- صورة عن التعهد.
- صورة عن نموذج الموافقة المستنيرة.
صورة لـ:
- معالي الوزير.
- الملف.

الإدارة العامة للمستشفيات
صادر
رقم: 24056
تاريخ: 17/12
11/ 22 29
11/12/11

الإدارة العامة للمستشفيات
صادر
رقم: 26578
11/12

الأخ / د. مدحت محيسن
مدير عام المستشفيات
11/12

Gaza Tel/ 08-2827288 Fax/ 08-2868109 Email/ hrd@moh.gov.ps



Annex (5)

Consent form

بسم الله الرحمن الرحيم

السيدة المحترمة :

تقوم الباحثة بعمل دراسة كجزء من المتطلبات للحصول على درجة الماجستير في الصحة العامة من جامعة القدس كلية الصحة العامة وهو بعنوان

Evaluation of Natal- Care Services Provided by Governmental Hospitals in G.Gs Governorates

البحث يهدف إلى تقييم الخدمات المقدمة أثناء الولادة في المستشفيات الحكومية في محافظات غزة.

أنا طبيبة ولكن لا اعمل في هذا المستشفى و تتطلب عملية جمع البيانات حضور عدد من الولادات منذ دخول المستشفى حتى الولادة . وارغب بالبقاء معك خلال هذه الفترة. مع العلم أن النتائج ستستخدم لأغراض البحث العلمي.

هل تسمحين لي بالبقاء معك و حضور الولادة؟

لا

نعم

الباحثة / سحر عبد الوهاب شلبي

Annex (6)

Observational checklist for natal- care services provided by governmental hospitals in G.Gs.

Serial number:

Code number:

Health facility: Shifa Al-Aqsa Nasser Tal-Sultan.

Date of observation:.....

Time of

observation:.....

G ---- P ---- A ----

Age: -----

A- Observation of first stage

1- Admission room

1	Time of 1 st examination by a health care provider(HCP):			
2	Who was the first HCP to examine the lady?			
	a. a general practitioner		Yes	No
	b. a specialist		yes	No
	c. a student		Yes	No
	d. a board candidate		Yes	No
3	e. a midwife/ nurse			
	Did the HCP introduce him/herself before the examination?			
			Yes	No
	If yes:			
	a- by name		Yes	No
4	b- by rank			
			Yes	No
5	Did the HCP call the lady by her name?			
			Yes	No
	Did a HCP take the history?			
			Yes	No
	If yes:			
6	a- present history			
			Yes	No
	b- menstrual history			
			Yes	No
7	c- obstetric history			
			Yes	No
	d- past history			
8	Yes			
	No			
	Yes			
9	No			
	Yes			
	No			
10	Yes			
	No			
	Yes			
11	No			
	Yes			
	No			
12	Yes			
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	Yes			
13	No			
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14	Yes			
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15	No			
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16	Yes			
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17	No			
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18	Yes			
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19	No			
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20	Yes			
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93	No			
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94	Yes			
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95	No			
	Yes			
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96	Yes			
	No			
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97	No			
	Yes			
	No			
98	Yes			
	No			
	Yes			
99	No			
	Yes			
	No			
100	Yes			
	No			
	Yes			

	a. did the staff check:			
	1. BP		Yes	No
	2. pulse		Yes	No
	3. temperature		Yes	No
	b. examine the chest by a stethoscope?		Yes	No
	c. examine the heart by a stethoscope ?		Yes	No
	d. check the legs for edema or varicose veins?		Yes	No
	e. examine the abdomen?		Yes	No
9	Did the HCP check the fetal heart sounds ?		Yes	No
	If yes, with:			
	a. Pinard		Yes	No
	b. Sonic aid		Yes	No
	c. CTG		Yes	No
	d. Ultrasound		Yes	No
10	After completing the vaginal examination, did a HCP:			
	a. throw the contaminated items in a trash basket?		Yes	No
	b. if not, where?		Yes	No
	c. tell the findings to the lady?		Yes	No
	d. record findings on partograph?		Yes	No
11	Was a cannula fixed to the lady's arm?		Yes	No

2- Pre-labor ward

12	Time of arrival of lady to the pre-labor ward			
13	who met the lady?			
14	Who helped the lady to settle in:			
	a- no one		Yes	No
	b- midwife		Yes	No
	c- doctor		Yes	No
	d- worker		Yes	No
15	Did a HCP review the admission data before doing the first examination?		Yes	No
16	Time of reviewing the admission data:			
17	Time of examination by a HCP:			
18	Did the HCP introduce him/herself before the examination?		Yes	No
	a- by name		Yes	No
	b- by rank		Yes	No
19	Did the HCP call the lady by her name?		Yes	No
20	Before starting the examination, did the HCP take the permission to examine her?			
	If yes,			
	d. what did s/he say?			
	e. explain what would be done to her?		Yes	No

	g. Type of medication?			
35	How many different HCPs examined the lady vaginally in the 1 st stage?			
36	How many times was the lady examined vaginally in the 1 st stage?			
37	Do HCP assessed the lady's vital signs every 30 mints?		Yes	No
38	Do HCP assessed labor progress at least every 4 hours?		Yes	No

B- Observation of second stage

39	What time did the lady arrive in the delivery room?			
40	Was the lady covered while she was being moved from the pre-labor ward to the delivery room?		Yes	No
41	Was the lady's medical record accompany her during moving to the delivery room?		Yes	No
42	Did the delivering HCP check the name of the lady with that of the file?		Yes	No
43	Did the delivering HCP check the findings in the file?		Yes	No
44	Was the delivering HCP one of those who had seen the lady in the pre-labor ward?		Yes	No
	If no, did s/he introduce him/herself?		Yes	No
	If yes, by what?			
	a. name		Yes	No
	b. rank		Yes	No
	c. other:			
45	Did the HCP who was there to deliver the lady explain what would be done to her?		Yes	No
46	Were the partograph reviewed and filled timely if used?		Yes	No
47	What position did the lady deliver in:			
	a. lithotomy		Yes	No
	b. semi-sitting or half squat		Yes	No
	c. side-lying		Yes	No
	d. squatting		Yes	No
48	Were the mother's legs tied?		Yes	No
49	Were the mother's arms tied?		Yes	No
50	Was the lady covered except for perineal area during the delivery?		Yes	No
51	Were partitions/curtains closed?		Yes	No
52	Before conducting the delivery, did a HCP		Yes	No

	wash his or her hands?			
53	While delivering the lady, did a HCP wear gloves?		Yes	No
	If yes,			
	a. sterile		Yes	No
	b. disposable		Yes	No
54	Was the woman's perineum washed?		Yes	No
55	Was a catheter used to empty the woman's bladder?		Yes	No
56	Was the mother encouraged to push when the presenting part is visible ?		Yes	No
	a- between contractions		Yes	No
	b- with contractions		Yes	No
57	Was fundal pressure applied?		Yes	No
58	Was perineal massage done?		Yes	No
59	Were any of the following instruments used:			
	a. vacuum (ventouse)		Yes	No
	b. forceps		Yes	No
	If yes,			
	a. time of its use			
	b. reason for its use:			
	1. suspected fetal distress		Yes	No
	2. prolonged 2 nd stage		Yes	No
	3. routine		Yes	No
	4. other:			
60	Was an episiotomy done?		Yes	No
	If yes,			
	Why was an episiotomy performed? (research observation)			
61	Was an anesthetic agent used?		Yes	No
	If yes,			
	a. Local?		Yes	No
	b. Cervical block?		Yes	No
	c. Pudendal block?		Yes	No
	d. Epidural?		Yes	No
	e. General?		Yes	No
62	Was perineal support and controlled delivery of the head done?		Yes	No
63	Was any of the HCPs aggressive in any way?		Yes	No
	If yes,			
	a. verbally? How ?			
	b. physically? How?			
	c. who was it?			
64	Did the delivering HCP check the fetal heart during the 2 nd stage?		Yes	No

	If yes, how many times?			
65	Did the lady ask for pain relief during the 2 nd stage?		Yes	No
	If yes, was it dealt:			
	a. medically		Yes	No
	b. verbally		Yes	No
66	Was oxytocin administered during the 2 nd stage of labor?		Yes	No
	If yes,			
	A- was it given:			
	a- at the anterior shoulder		Yes	No
	b- after the delivery of the anterior shoulder		Yes	No
	c- after the delivery of the baby		Yes	No
	B- the dose:			
	C- the route:			
67	Did HCPs ensure that the lady never left alone?		Yes	No

C- Observation of third stage

68	Was the cord clamped early?		Yes	No
69	What was the cord cut with?			
	a- Sterile scalpel		Yes	No
	b- Sterile scissors		Yes	No
	c- Other:			
70	Was controlled cord traction after cord clamping applied?		Yes	No
71	Was uterine massage done?		Yes	No
	If yes,			
	a- immediately after the delivery of placenta?		Yes	No
	b- After finishing the delivery?		Yes	No
72	Was Methergin administered during the 3 rd Stage of labor?		Yes	No
	If yes, 1- How was it given?			
	a. Intramuscular (IM)		Yes	No
	b. Intravenous (IV)		Yes	No
	2- Was the lady's blood pressure checked before giving Methergin?		Yes	No
73	Was the baby in direct skin to skin contact with the mother?		Yes	No
74	Was skin to skin contact maintained until breastfeeding was initiated?		Yes	No
75	Was the baby placed on:			
	a. a radiant warmer		Yes	No

	b. Table		Yes	No
	c. taken to neonatal ward immediately		Yes	No
76	Was the baby dried ?		Yes	No
77	Was the baby placed on his back with his head slightly extended ?		Yes	No
78	Was the baby mouth suctioned?		Yes	No
79	Was the baby nose suctioned?		Yes	No
80	Was the baby weighed?		Yes	No
81	Was an identification bracelet placed on baby's wrist?		Yes	No
82	Was vitamin K given to the baby?		Yes	No
83	Was the following done to the baby:			
	a. holding the leg and slapping the back		Yes	No
	b. rubbing with alcohol		Yes	No
	c. squeezing the chest		Yes	No
	d. flexing lower limbs towards abdomen		Yes	No
	e. gentle rubbing of the back		Yes	No
	f. flickering or slapping the sole		Yes	No
84	Were the HCP's hands washed immediately before dressing the cord?		Yes	No
85	Were clean gloves used?		Yes	No
86	Was the placenta examined after delivery ?		Yes	No
87	After delivery of the placenta, did the delivering HCP confirm uterine contractility?		Yes	No
88	If there was an episiotomy/tear to repair:			
	a. was the lady informed about the procedure?		Yes	No
	b. was adequate light provided?		Yes	No
89	Did the HCP clean the perineum with antiseptic before performing the repair?		Yes	No
90	Did a HCP perform a vaginal examination after finishing the episiotomy/ tear repair?		Yes	No
91	Did a HCP perform a per rectum exam after finishing the episiotomy/ tear repair?		Yes	No
92	Was uterine exploration done?		Yes	No
	If yes,			
	a. as routine?		Yes	No
	b. because of missing placental parts?		Yes	No
	c. using sterile gauze?		Yes	No
	d. was anesthesia used for this purpose?		Yes	No
	e. if yes, What type of anesthesia was used?			
93	Did the delivering HCP congratulate the lady after the delivery?		Yes	No

94	Did a HCP clean the lady?		Yes	No
95	Was the lady well covered?		Yes	No
96	What time is it now (as soon as the delivering HCP finished intervening)?			
97	Was the baby given to the lady to hold in the delivery room?		Yes	No
98	How many different HCPs examined the lady vaginally in the 2 nd stage?			
99	How many times was the lady examined vaginally in the 2 nd stage?			
100	Using Anti-histamines		Yes	No
101	Using Scobutyl		Yes	No
102	Using Diazepam		Yes	No
103	Rupture of membranes: a. spontaneous b. artificial		Yes Yes	No No

The researcher will tick accordingly as she observer.

Time	Vital signs			Fetal heart sound heard	Membranes			Cervical dilatation (in cm)	Type of medication or fluids + dose & rate ORDERED	How Verball y/writte n	Time medicatio n started
	BP	P	T		Intact	S	AR M				

End of observation: Time:.....

Date:.....

Annex (7)

Medical records checklist

A Personal information		Yes	No	Notes
	a- Name			
	b- Age			
	c- Identity no.			
	d- Insurance No.			
	e- Time of admission			
	f- Date of admission			
	g- Address			
	h- Admission employee			
	i- Accountant name			
	j- Telephone number			
B Medical information				
1	Diagnosis on admission			
2	Present history			
3	Menstrual history :			
	a- LMP			
	b- EDD			
	c- GA			
	d- Rhythm			
	e- Duration			
4	Obstetric history :			
	a. Gravida			
	b. Para			
	c. Abortion			
	d. Method of deliveries			
5	Past history :			
	a. Hypertension			
	b. Heart			
	c. Drug allergy			
	d. Blood transfusion			
	e. Diabetes			
	f. Ante natal care			
6	General examination :			
	a. Blood pressure			
	b. Pulse			
	c. Temperature			
	d. Chest			
	e. Heart			
	f. Lower limbs			
7	Abdominal examination :			
	a. Fundus level (FL)			

	b. Fundal grip (FG)			
	c. Pelvic grip (PG)			
	d. Fetal heart sound (FHS)			
	e. Scar			
8	Vaginal examination :			
	a. Vulva			
	b. Vagina			
	c. Cervix			
	d. Effacement			
	e. Position			
	f. Consistency			
	g. Dilatation			
	h. Membranes			
	i. Discharge			
	j. Presentation			
9	Investigations :			
	a. Urine			
	b. Hb			
	c. Bl. Group			
	d. Rhesus			
	e. Ultrasound			
C Management				
10	Total duration of labour (min)			
11	Estimated blood loss (ml)			
12	Birth weight (g)			
13	Presence of meconium at rupture of membrane			
14	Fetal heart recorded in notes			
15	Analgesia: Pethidin			
16	Normal spontaneous delivery			
17	Instrumental vaginal delivery:			
	a- Forceps			
	b- Vacuum extraction			
18	Cesareans delivery			
19	Intact perineum			
20	Episiotomy			
21	1 mint Apgar score of baby			
22	5 mint Apgar score of the baby			
23	Partograph			
	a- Cervical dilatation			
	b- Station			
	c- Artificial rupture of membrane			
	d- Liquor (color/condition)			
	e- Caput			
	f- Moulding			

	g- Oxytocin			
	h- Analgesia			
	i- Fetal heart rate (FHR)			
	j- Blood pressure checked regularly			
	k- Temperature			
	l- Pulse monitored every 30 mint			
	m- Contraction regularly checked every 30 mint			
	n- Time			
24	Recorded drugs:			The route
	a- oxytocin for augmentation of labor			The route
	b-oxytocin after baby out			The route
	c-Methrgin			The route
	d-antibiotics Intrapartum indication:.....			The route
	e-antihypertensive :.....			
25	Recorded orders			
	a- Patient may walk or move about			
	b- Patient may eat			
	c- NPO			
	d- Allow position of choice			
	e- Bed rest			
	f- Drying the newborn			
	g- Skin-to-skin contact			
	h- immediate cord clamp			
	i- Start breast feeding within 2 hours			
	j- Exclusive breast feeding			
26	Complications:			
	a- Eclampsia			
	b- Hemorrhage			
	c- Obstructed/prolonged labor			
	d- Sepsis			
27	Vaginal exam details every 4 hours			
D Discharge information				
28	Date of discharge			
29	Time of discharge			
30	Diagnosis on discharge			
31	Woman's condition on discharge;			
	a- Stable			
	b- Transferred to word			
	c- Died			
32	Newborn's condition on discharge:			
	a- Live birth			
	b- Still birth			

	c- Birth injury			
	d- Infection			

33	Post delivery woman check					
		Immediate post delivery	1 hour	2 hour	3 hour	Before discharge
	a- Time of check					
	b- Fundus					
	c- Lochia					
	d- BP					
	e- Pulse					
	f- Temperature					
	g- Voided					
	h- breastfeeding initiated					
	i- counseling on danger signs					
	j- Baby examined					
	k- Signature					

Researchers notes: -----

Annex (8)

List of Experts Names who reviewed research tools.

1. *Dr. Adnan Radi* *MOH-G. Gs*
2. *Dr. Amena Al-Shorbasi* *UNRWA*
3. *Dr. Bassam Abu Hamad* *Al-Quds University*
4. *Dr. JameelFanona* *Al –Awda Hospital*
5. *Dr. SawsanHammad* *MOH-G. Gs*
6. *Dr. Yehya Abed* *Al-Quds University*
7. *Mrs. Etemad Abo Ward* *WHO*
8. *Mrs. Fayza Al-Shareef* *UNRWA*
9. *Mrs. Lubna Al-Shareef* *WHO*
10. *Mrs. Sahar Hassan-Bitar* *Birzeit University*
11. *Mrs. SabreenNashabat* *MOH-G. Gs*

تقييم الخدمات المقدمة أثناء الولادة في المستشفيات الحكومية في محافظات غزة

إعداد : سحر عبد الوهاب شلبي

إشراف: د. سناء أبو دقة

ملخص:

تعتبر الولادة حدثًا يغير الحياة . وهي حدث طبيعي ، يجب أن يكون هناك سبب واضح للتدخل طبيًا فيها ، وذلك من أجل تجنب المرأة الكثير من التدخلات الطبية وغير الطبية وعدم تعريضها لأشخاص غرباء وقلة الخصوصية ، مما يقلل خصوصيتها ويعرضها للإزعاج والألم .

إن الهدف من هذه الدراسة هو تقييم الخدمات المقدمة أثناء الولادة في المستشفيات الحكومية في محافظات غزة. وقد اتبعت الباحثة الأسلوب الكمي، الوصفي، التحليلي وتم تطبيقها على هذه المستشفيات. لقد تم جمع البيانات من خلال ملاحظة أربعين سيدة خلال فترة المخاض و الولادة من ذوات الحمل قليل الخطورة باستخدام استمارة ملاحظات محكمة، والتي تم إعدادها لتقييم الممارسات المتبعة أثناء الولادة الطبيعية و مدى صلتها بالأسس المدعومة بالأدلة العلمية، و ذلك للحصول على تقدير تقريبي لمدى تكرار بعض الممارسات. كما تم استخدام استمارة أخرى محكمة لتقييم جودة التوثيق من حيث الكمال والدقة في الملفات الطبية لنفس السيدات اللاتي تمت مراقبتهن. تم تحليل البيانات باستخدام الرزمة الإحصائية للعلوم الاجتماعية النسخة 17.0.

لقد أظهرت النتائج أن الممارسات المتبعة أثناء الولادة لمساندة و مراقبة وإدارة الولادة في المستشفيات الحكومية بشكل عام تفتقر لبعض الممارسات المدعومة بالأدلة العلمية. وتمت ملاحظة مستويات عالية من التدخلات الطبية أثناء الولادة معطية الدليل على عدم ملاءمتها أو على ارتفاع وتيرة استخدامها والتي ابتعدت بشكل واسع عن أفضل الممارسات المعروفة والموصى بها من قبل منظمة الصحة العالمية من أجل ولادة طبيعية. وقد انطبق ذلك على استخدام السوائل الوريدية التي كانت بنسبة 60 % من الحالات، نبضات قلب الجنين تم فحصها في المرحلة الثانية من المخاض بنسبة 37 % ، منها 66.7 % عن طريق التخطيط الكهربائي المستمر. البار توغرام تمت تعبئته

بنسبة 35% من الحالات. وتم تسريع المخاض باستخدام الاوكسيتوسين بنسبة 62.5 % وباستخدام ثقب جيب المياه بنسبة 77.5 %. وفي بعض الحالات لم تتم معاملة السيدات باحترام كما لم يتم احترام خصوصيتهن في أغلب الأوقات، مع نقص متكرر في تبادل المعلومات مع مقدمي الخدمة، وقلة الدعم المقدم منهم ومن أفراد الأسرة.

وكان هناك اختلاف واضح بين ما تمت ملاحظته وما تم توثيقه في الملفات الطبية، حيث إن تسريع المخاض باستخدام الاوكسيتوسين كان شائعاً (62.5 %) ولكن تم توثيق ذلك بشكل اقل (52.5 %). ضغط الدم تمت ملاحظة قياسه في 37.5% من الحالات بينما تم تسجيله في الملفات بنسبة 72.5 %. إجمالي التوثيق في الملفات الطبية وجد انه قليل (46.4 %). توثيق المعلومات الشخصية كان جيداً (67.5 %) ولكنه كان قليلاً جداً بالنسبة لبعض البنود مثل الفحص العام والعلامات الحيوية (12.5 %)، فحص البطن 10% ، الفحص المهبل 2.5 %، وتعبئة البارثوغرام 20%. إن التوثيق في الملفات الطبية الخاصة بالولادة لم يكن دائماً كاملاً ويفتقر للدقة، في إشارة إلى قلة جودة الخدمة المقدمة أثناء الولادة مؤكداً على الحاجة إلى زيادة الاهتمام بالتوثيق في الملفات الطبية هذه الدراسة تقدم مجموعة من التوصيات لدعم استخدام الممارسات الطبية المستندة إلى الأدلة العلمية وتشجيع الولادة الطبيعية، مع التوحيد القياسي للملفات الطبية في المستشفيات الحكومية.