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Quality of Immediate Postpartum Care Provided by Midwives at Selected Hospitals in the Gaza Strip, Palestine

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Thesis Approval

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Dedication

To my great father and mother, to whom I owe my life and success,

To my beloved husband, who supported me all the way,

To my children,

To my brothers and sisters

To my friends and colleagues,

I sincerely appreciate that you were always with me, gave me the support I needed to realize this accomplishment and inspired me with love and warm feelings

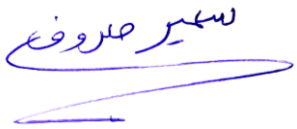
I want to express my heartfelt thanks and appreciation to all those who contributed to the completion of this thesis. Without your support, this work would not have come to an end.

Sohier Nael Abdelrahman Marouf

Declaration

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

Signed:



Sohier Nael Abdelrahman Marouf

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First, praise Allah, the world's Lord, and may Allah's peace and blessings be upon our Prophet Muhammad, all thanks to Allah, who granted me the capability to accomplish this thesis.

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Abstract

The quality of immediate postpartum care **(**QoPPC) provided by midwives is a life-threatening factor influencing maternal and newborn health outcomes. This study evaluated QoPPC at governmental Gaza Strip (GS) hospitals. The study focused on midwives' perceptions regarding maternal and newborn care within the first six hours after birth. The study explored key domains, newborn care, and midwifery practices. Additionally, the satisfaction of mothers with postpartum services was also studied. A cross-sectional study design included 72 midwives (census) and 335 postpartum mothers (random) from Helou International Hospital, Patient Friends Hospital, and Assahaba Medical Complex, Gaza, Palestine. Data was collected using structured questionnaires targeting midwives and mothers. A pilot study was conducted to examine the validity and reliability of the questionnaires, and the alpha coefficient was 0.948 for the midwives' questionnaire and 0.920 for the mothers' questionnaire. Statistical analysis was conducted using the SPSS program (version 25). Ethical approval was obtained from the Helsinki Committee and administrative approval from. Findings indicated high overall perceptions of QoPPC among midwives across all studied domains (88.6%). The highest-rated domain was midwives' maternal care practices (89.0%), followed by newborn care (88.2%). The study found significant differences in care quality across hospitals ($P < 0.05$). Still, no statistically significant differences were observed based on academic qualifications, marital status, years of experience, income, place of residence, or training received ($P > 0.05$). Additionally, a strong positive correlation was observed between total postpartum care and newborn care ($r = 0.881$, $P < 0.001$) and between total care. Mothers' satisfaction with postpartum care services was 81.25%. Statistical analysis revealed no statistically significant differences in satisfaction levels based on socio-demographic characteristics ($P > 0.05$)**.** The study revealed high quality of postpartum care provided by midwives and high satisfaction of mothers with the services they received at maternity hospitals in the GS. The study recommended the need to enhance midwifery training to ensure continuous professional development.

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List of Abbreviations

AEs	Adverse Events
ANC	Antenatal Care
EPNC	Early Postnatal Care
GS	Gaza Strip
HCPs	Health Care Providers
HICs	High-Income Countries
IPP	Immediate Postpartum Period
IPPC	Immediate Postpartum Care
LMICs	Low- and Middle-Income Countries
MMR	Maternal Mortality Rate
MNH	Maternal and Newborn Health
MoH	Ministry of Health
NGOs	Non-Governmental Organizations
NICU	Neonatal Intensive Care Unit
PCBS	Palestinian Central Bureau of Statistics
PP	Postpartum Period
PPC	Postpartum Care
PPH	Postpartum Hemorrhage
QoC	Quality of Care
QoPPC	Quality of Postpartum Care
SBA	Skilled Birth Attendants
SDGs	Sustainable Development Goals
UNDP	United Nations Development Program
UNICEF	United Nations International Children's Emergency Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
WB	West Bank
WHO	World Health Organization

Chapter One

Introduction

1.1 Background

The immediate postpartum period (IPP) is important because accompanying this period are several life-threatening complications (Esan et al., 2020). The fourth stage of labor is a critical time in the birthing process because it can lead to a variety of life-threatening problems. As a result, it is essential to provide midwives with comprehensive information and training to manage the fourth stage of labor effectively. The healthcare team provides the basis for preventing complications by offering physical, emotional, and informational social support, with the latter strengthening guidelines that enable a woman to care for herself and her child. (Engstrom & Cockerham, 2025). Midwives can give relevant information and professional nursing care throughout the early (immediate) postpartum period. Midwives must be alert and open-minded during this critical moment (Kebede et al., 2021).

This ability necessitates midwives believe the first two hours following delivery are critical. As a result, professional care for postpartum women and their families should be provided, considering their values, backgrounds, environment, and dignity. Because childbirth is one of the most sensitive times in a woman's life, the nurse's role during labor, delivery, and the immediate postpartum period is unique. Midwives should focus on serving, protecting, advocating for, and inspiring women during this time. Immediate postnatal care should address the unique needs of both the mother and the baby, encompassing the prevention, early identification, and treatment of potential problems and diseases, as well as support for breastfeeding, birth spacing, immunization, maternal nutrition, and encouragement. Midwives should deliver competent nursing care during the early (immediate) postpartum period (Mokhtar et al., 2023).

This serious time requires midwives to be open-minded and patient. This skill set also requires midwives to recognize that the first two hours after labour are of important concern. Thus, they should provide skilled care to postpartum mothers and their relatives, considering their beliefs, experiences, and environment and respecting their human rights and dignity (World Health Organization, 2020).

Midwives play a vital role in monitoring the mother's status, assisting with procedures to control bleeding, educating the mother about her condition, and supporting the mother and her family (El-khawaga et al., 2019). As with any postpartum issues, ensure you provide

emotional support to the mother and family, explain all events and measures to reduce anxiety and fear, and protect the family by informing them of the condition. Most maternity midwives focus on assisting mothers during labor, remaining by the patient's side to support both the mother and her newborn baby, offering encouragement, coaching, education, and support (Okorie et al., 2025).

1.2 Problem Statement

Immediate postpartum care (IPPC) encompasses the baby's delivery within 24 hours of delivery. It is part of the facility-based continuum of perinatal care for women and newborns (WHO, 2022). It entails monitoring vital signs, assessing the maternal and newborn's wellbeing, and educating the mother and her caregiver on self-care, newborn care, hygiene, contraceptive use, postnatal danger signs, and when to return to the health facility. IPPC is recognized as key in preventing, diagnosing, treating complications, and improving care quality (Kikuchi et al., 2018). This is because most maternal and newborn morbidity and mortality occur within this time frame. However, facility-based care during this period is suboptimal despite its importance for women and newborns (Muwema et al., 2022).

Guidelines for clinical practice have been a focus of the WHO and the MoH over the past two decades to improve the quality of care (QoC). These clinical guidelines for facility-based immediate postpartum care include monitoring the mother and baby, providing health education, conducting assessments at discharge, and offering advice on when to return to the health facility (WHO, 2020).

The benefits of clinical guidelines in improving the quality of patient care and patient outcomes have been documented in several countries. However, having practice guidelines may not always translate into the provision of high-quality PPC or care based on the latest evidence. Instead, they may sometimes overwhelm health workers when faced with impractical guidelines, especially in low-resource settings (Sserwanja et al., 2022).

A recent study on the facility's readiness to provide IPPC showed that disseminating the MoH guidelines and their adoption into facility policies was low. As per the MoH guidelines, over half of the rural facilities assessed had no scores for the routine monitoring of mothers and their newborns (Dey et al., 2021).

In GS, because of the ongoing war against the strip, access to health care has been worsened by repeated displacement, inadequate living conditions, insecurity, poor nutrition, and many health facilities have become out of service. The decimation of the infrastructure of health centers created severe obstacles for pregnant women and women in labour, which affects the quality of maternal care and the safety of the mothers and their offspring (Doctors without Borders, 2024).

Implementation of evidence-based practice is crucial for improvements in IPPC. Nurses and midwives play a vital role in ensuring that patient care is provided by the available evidence and established patient care protocols. The guidelines for IPPC were intended to serve as a guide for postpartum care provision for mothers and their newborns, thereby establishing the minimum standard of care for all clients. To ensure that the guidelines are implemented, an increased level of staff awareness of the guidelines, the availability of trained staff, mentorship, and support from supervisors must be in place. Additionally, hindrances such

as the cost considerations and the motivation of the intended users of the guidelines need to be addressed (Kimiaeimehr et al., 2019).

Midwives are pivotal in providing this care, particularly in contexts with limited healthcare resources and ongoing socio-political challenges. However, there is a lack of comprehensive data on the effectiveness and quality of the care midwives provide during this crucial period. This study aims to evaluate the quality of immediate postpartum care provided by midwives at selected hospitals in the GS, identifying gaps and areas for improvement to enhance maternal and neonatal health outcomes.

1.3 Justification of the study

IPPC for a mother and newborn baby involves ensuring the mother's and fetus's general well-being, assessing vital signs, and examining the newborn using APGAR scoring. Furthermore, assessing uterine contraction, any vaginal tears/discharge, ability to urinate and defecate, assessing sign postnatal depression, and any other assessments are required. The purpose of providing immediate care is to enable early assessments and treatment to be initiated, and to provide health workers with the opportunity to advise and counsel on breastfeeding and newborn care. To ensure that mothers and babies have received this vital care, WHO recommended that, all women need to be monitored as well as cared for in the facility where they gave birth for at least 24 hours following vaginal delivery (WHO, 2022).

All women need to be monitored and cared for in the facility where they gave birth for at least 24 hours following vaginal delivery to ensure that mothers and babies have received this vital care, as recommended (WHO, 2022). A recent survey conducted in 77 countries found that approximately 63% of countries reported disruptions in PPC in general (United Nations, 2020).

The primary objective of the Sustainable Development Goals (SDGS) was to reduce maternal mortality to less than 70 per 100,000 live births by the end of 2030. Implementing IPPC guidelines in the maternity ward and enhancing salary and education opportunities for healthcare providers (HCPS) will significantly improve HCPS' adherence to IPPC guidelines (WHO, 2020).

Improving the quality of immediate postpartum care is crucial for reducing maternal and neonatal morbidity and mortality. This period is crucial for the mother and the newborn, and high-quality care can significantly impact their health outcomes. Midwives are vital in providing postpartum care, especially in regions with limited healthcare resources. Evaluating their practices and identifying areas for improvement can enhance the overall quality of care provided. By identifying gaps and deficiencies in postpartum care, the study can inform policy changes and training programs to enhance healthcare delivery in the Gaza Strip and Understanding the current state of postpartum care can facilitate the more effective allocation of resources, ensuring that hospitals and healthcare providers have the necessary tools and support to deliver optimal care.

1.4 General objective

The general objective is to evaluate the quality of immediate postpartum care midwives provide and mothers' satisfaction with the health services provided at selected hospitals in the Gaza Strip.

1.5 Specific objectives

1. To investigate the quality of care delivered to newborns within the first six hours after birth.
2. To identify the quality of practicing maternal care within the first six hours after birth.
3. To investigate the relationship between the quality of immediate postpartum care and specific sociodemographic characteristics of midwives.
4. To assess mothers' satisfaction level with the quality of services after childbirth.
5. To identify the differences in mothers' satisfaction with the quality of postpartum care related to sociodemographic factors of mothers.

1.6 Research questions

1. What is the quality of care provided to the newborn in the first six hours after birth?
2. What is the quality of practicing maternal care within the first six hours after birth?
3. Is there a significant association between the quality of immediate postpartum care and sociodemographic factors of midwives?
4. What is the mothers' satisfaction level with the quality of services after childbirth?
5. Are there statistically significant differences in mothers' satisfaction with the quality of postpartum care related to sociodemographic factors of mothers?

1.7 Definition of terms

1.7.1 Theoretical definitions

Quality of care

Care that provides comprehensive coverage, including access to quality essential healthcare services and safe, effective, affordable, and quality essential medicines and vaccines for all (WHO, 2020).

Immediate postpartum care

Defined as the period beginning immediately after the baby's birth to 6 to 24 hours (WHO, 2020). The IPPC includes skin-to-skin contact, APGAR score, drying clamping period, the period in which the fetus is born, complete delivery of the placenta, and follow-up of the newborn and mother for 6 hours.

Midwife

Skilled, knowledgeable, and compassionate care for childbearing women, newborn infants, and their families across the continuum, from pre-pregnancy through birth, postpartum, and the early weeks of life (WHO, 2019).

1.7.2 Operational definitions

Quality of postpartum care

Quality of postpartum care is operationally defined as the delivery of maternal and newborn health services after childbirth that meet established clinical standards, are free from preventable harm, respect women's rights, and result in improved maternal and neonatal

outcomes, as assessed through adherence to care protocols, patient satisfaction, and outcome-based indicators.

In this study, the quality of postpartum care is measured by the total score obtained on the midwives' questionnaire.

Immediate postpartum care

Operationally, immediate postpartum care is defined as clinical assessments and interventions administered to the mother and newborn from birth up to 6 hours postpartum. This includes monitoring maternal vital signs, assessing vaginal bleeding and uterine contraction, promoting skin-to-skin contact, and conducting newborn screening and thermal protection measures.

In this study, immediate postpartum care is measured by the total score obtained on the midwives' questionnaire domain.

Midwife

Any qualified nurse-midwife with a valid midwifery license works full-time in a maternity hospital in the Gaza Strip.

1.8 Context of the study

1.8.1 Demographic characteristics

In 2020, the population of Palestinians in the State of Palestine, according to estimates from the Palestinian Central Bureau of Statistics (PCBS), reached 5,101,152 individuals, comprising approximately 2.59 million males and 2.50 million females. Meanwhile, the population of the West Bank (WB) reached approximately 3.05 million individuals, accounting for 59.9% of the total population of Palestine, including 1.55 million males and 1.49 million females. In the same year, the population of the GS reached approximately 2.04 million individuals, accounting for 40.1% of the total population of Palestine, including approximately 1.03 million males and 1.01 million females (PCBS, 2021).

1.8.1 Socio-economic context

Movement and access restrictions, violent attacks, and the slow pace of post-conflict reconstruction continue to degrade economic conditions in GS, the smaller of the two areas comprising the Palestinian territories. Israeli controls became more restrictive. At the socio-economic level, conditions are terrible. Poverty and food insecurity are growing, as is a reliance on foreign aid. Unemployment continues to increase among youth and adults; according to PCBS (2022), the unemployment rate among participants in the labor force (15 years and older) in 2022 was approximately 24%, compared to 26.4% in 2021. On the other hand, the total underemployment rate reached 31%, according to the revised standards of the International Labor Organization. There is still a significant disparity in the unemployment rate between the WB and the GS, which reached 45% in the GS compared to 13% in the WB. Regarding gender, the unemployment rate for females was 40% compared to 20% for males in Palestine (PCBS, 2021). One of the highest in the world, according to the World Bank, about 410,000 families are living under the poverty line in GS, and almost 80% of

Palestinians in GS depend on humanitarian assistance for survival, with no means to access education, health, clothing, and shelter (UNDP, 2020).

1.8.2 Healthcare system

Al Helou International Hospital

The Helou International Specialist Hospital is a private hospital in northwest Gaza City, managed by Dr. Tharwat Yousef Helou. The clinic was founded in 1995 and opened as a hospital in 2017, spanning an area of 600 square meters and with a clinical capacity in 2022 of six beds. Since early 2023, the hospital has received referrals from the Ministry of Health for patients who require hematology and oncology chemotherapy. The hospital offers several specialized services, the most important of which are oncology treatment and transplants in the infertility and IVF clinic.

In 2013, the hospital announced the "Charity and Procreation for Allah Almighty" campaign and sponsored treatment, fertilization, and embryo transplants for 500 cases. That same year, the hospital implanted embryos for eight wives of prisoners in occupation prisons in response to a campaign by the Hussam Foundation for Prisoners and Liberators and the mothers of prisoners. Similar campaigns that provided free fertility treatments have been held, including the "We, with God's help, care for you" campaign in 2018, and the free fertility campaign in 2022 and 2023 (Institute of Palestine Studies, 2025).

Al-Sahaba medical complex

Al-Sahaba Medical Complex is a non-profit charitable organization founded in Gaza, Palestine, in 1424 AH, 2004 AD. It has obtained a license from the Ministry of Interior with No. [7319] and a license from the Ministry of Health No. (2009).

The complex was established to revive a command from Allah to cover the private aspects of Muslim women, especially during parturition. Al-Sahaba Medical Complex is the first hospital of its kind in Palestine. It holds a special character: "Female patients' treatment with Female staff," where the management provided a distinguished female staff of doctors, nurses, midwives, and workers.

The patients are from the women's category and must enter the women's section. The nature that prevails in the transactions will overtake it with a feminist character, and with the grace of Allah, the idea of the complex met with great response and great success (www.alsahaba.ps, 2025).

Al-Awda Hospital

Al-Awda Hospital is a non-governmental civil hospital, located in Nuseirat refugee camp in al-Wusta governorate. It was established as a primary health care center in 1989 and later developed into a hospital in 2022. The hospital has a medical staff of around 141, including 60 doctors and medical specialists. The hospital is managed by Al-Awda Health and Community Association (formerly the Union of Health Work Committees), which seeks to achieve community health empowerment and promote comprehensive health through primary health care programs, secondary and tertiary health care programs, and protection of women and children. Al-Awda Health and Community Association is a Palestinian non-

governmental organization that aims to improve the health situation in the West Bank and Gaza Strip. Founded on the initiative of volunteers working in the health sector in 1985, the Union of Health Work Committees worked in the context of the First Intifada, and their work continued to be politicized through the provision of relief and emergency services. These committees were established as part of the mass frameworks that strengthened Palestinian steadfastness and resistance to the occupation, before the arrival of the Palestinian Authority in the late 1990s. Since then, Al-Awda Association has moved towards more professional health work without losing its status as a mass organization.

Al-Awda Hospital - Nuseirat was built as part of a collaboration between the Al-Awda Health and Community Association and the Palestinian Welfare Association. The Arab Fund and the Big Heart funded the hospital's solar energy system. In December 2022, the hospital's management decided to allocate an additional budget for constructing an additional five-story building and continues seeking funding within the institutional networking framework (Institute of Palestine Studies, 2025).

Chapter Two

Conceptual framework and literature review

2.1 Conceptual framework

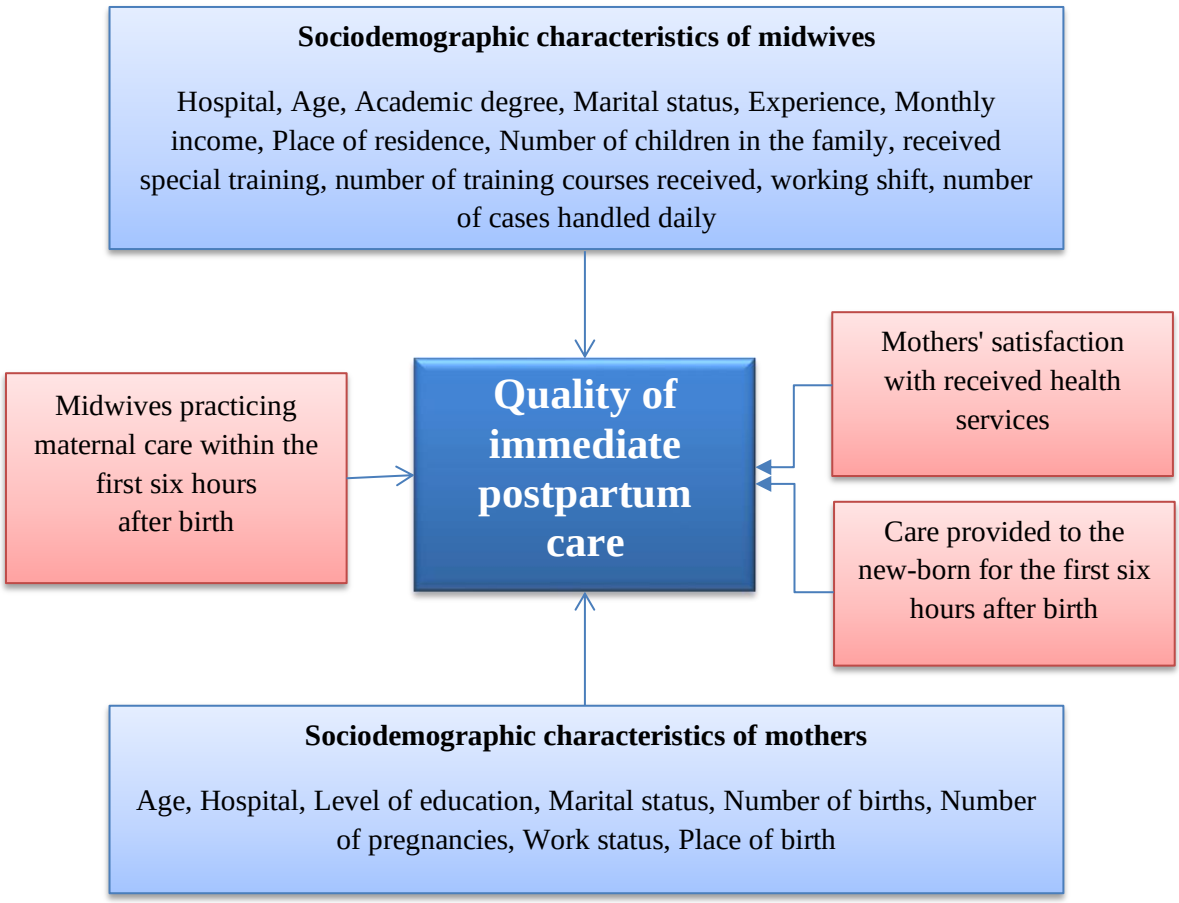

Figure (2.1): Diagram of conceptual framework (self-developed)

The framework emphasizes a holistic and integrated approach to quality of IPPC by addressing multiple dimensions critical to the health and well-being of mothers and newborns during the immediate PP period. This approach addresses immediate newborn and maternal care and maternal satisfaction.

1. **Immediate maternal care:** This includes physical health activities such as monitoring for postpartum hemorrhage, blood pressure irregularities, infections, or other complications. It also includes emotional support by providing psychological reassurance and support to mitigate postpartum stress or anxiety. Additionally, breastfeeding support from the midwife can help mothers learn proper breastfeeding techniques.
2. **Immediate newborn care:** This includes essential practices such as immediate skin-to-skin contact, delayed cord clamping, initiation of breastfeeding within the first hour, thermal protection, and prophylactic medications. It is also important to be ready for emergencies and provide timely resuscitation or other interventions in case of complications such as asphyxia or low birth weight. Additionally, monitoring and assessing vital signs (e.g., breathing, temperature, and heart rate) are crucial for promptly detecting and addressing complications.
3. **Maternal satisfaction:** Mothers' satisfaction with health services is integral to QoC. Mothers must be respected, ensuring dignity, privacy, and culturally appropriate care and support.

Respect maternal preferences and involve family members in the care process where appropriate. Additionally, provide clear and compassionate explanations about the mother's and baby's conditions and care plans. Counsel on signs of danger (e.g., excessive bleeding, newborn feeding difficulties) and when to seek help. Encouraging bonding through uninterrupted time for skin-to-skin contact and exclusive breastfeeding.

2.2 Literature review

2.2.1 Introduction

PPC plays a crucial role in childbirth, and midwives ensure high-quality care for both the mother and baby from birth through six weeks postpartum (Pindani et al., 2020). After delivery, the mother may experience generalized physical fatigue immediately after delivery, the pulse rate may be elevated a few hours after childbirth due to excitement or pain and usually normalizes on the second day. The blood pressure could be elevated due to pain or excitement, but is generally in the normal range; a significant decrease (> 20% below baseline) in blood pressure could be a sign of postpartum hemorrhage or septic shock (Chauhan & Tadi, 2020). Therefore, midwives should pay special attention to the care provided during this period to prevent or reduce the risk of adverse outcomes.

The postpartum period (PP) remains a critical concern, as approximately 800 women die every day from preventable pregnancy- and childbirth-related complications, with 95% of these deaths occurring in developing countries. More than 60% of maternal deaths take place during this period, with around 45% occurring within the first 24 hours after delivery (WHO, 2022).

Since the year 2000, global maternal and neonatal mortality rates (MMR) have declined significantly, currently standing at 211 maternal deaths per 100,000 live births and 18 neonatal deaths per 1,000 live births (Hug et al., 2019). Although this progress is encouraging, it remains insufficient to meet the SDGs, which aim to reduce maternal mortality to 70 per 100,000 live births and neonatal mortality to 12 per 1,000 live births by 2030 (United Nations, 2020). Over the past decade, efforts to improve maternal healthcare have focused on strengthening the continuum of care during pregnancy and childbirth by

increasing access to skilled antenatal care and facility-based deliveries. The maternity continuum of care (MCC) is an integral component of universal health coverage and a crucial strategy for reducing maternal and neonatal mortality. Despite its importance, MCC coverage remains low in low- and middle-income countries (LMICs) with the highest maternal and neonatal mortality (Mihret et al., 2025). Despite significant progress achieved through the Millennium Development Goals and notable reductions in maternal and child mortality rates, neonatal mortality remains a persistent challenge. Maternal and neonatal morbidity and mortality levels are still unacceptably high, and opportunities to enhance maternal well-being and improve newborn care have yet to be fully leveraged (WHO, 2022).

2.2.2 The postpartum period

The PP, also known as the fourth stage of labor, is a crucial phase in the childbirth process, as it poses risks for various life-threatening complications. This period is important for both short-term and long-term health and well-being for a woman and her newborn. Therefore, the interprofessional health team should provide comprehensive postpartum care for the mother (Lopez-Gonzalez & Kopparapu, 2022).

One of the key objectives of the WHO within the SDGs is to reduce the MMR to fewer than 70 deaths per 100,000 live births by 2030. To support this goal, the WHO recently updated its global guidelines on postpartum care (PPC) for mothers and newborns, emphasizing the importance of timely care—particularly within the first 24 hours after birth for all mothers and babies, regardless of the place of delivery—as well as follow-up assessments before hospital discharge. These guidelines focus on low-resource settings in low- and middle-income countries (LMICs) (WHO, 2016).

The PP period is critical for both the mother and newborn, as it significantly impacts their long-term health and well-being. During this time, women undergo numerous physical, psychological, and social adjustments, including recovery from childbirth, hormonal changes, and learning how to care for and feed their newborn. The first 24 hours following delivery present a heightened risk of maternal complications, such as postpartum hemorrhage (PPH) and sepsis, which can lead to severe morbidity and mortality if not properly managed (Clarke-Deelder et al., 2023).

While some postpartum complications may be unavoidable, early detection and timely intervention can significantly lower the risk of severe health outcomes (Borovac-Pinheiro et al., 2021). Despite the critical role of immediate postpartum care (IPPC) in preventing maternal and neonatal morbidity and mortality, it often receives far less attention than quality care during labor and delivery. Providing high-quality PPC is essential, ensuring that mothers and newborns are closely monitored for signs of complications from birth until discharge (Clarke-Deelder et al., 2023).

2.2.3 Immediate postpartum care

IPPC extends from delivery to six hours after birth and is vital to the perinatal care continuum for mothers and newborns. This care includes monitoring vital signs, evaluating the health and well-being of the mother and newborn, and offering health education to the mother and her caregiver. Key topics addressed include self-care, newborn care, hygiene, identifying postnatal danger signs, and understanding when to seek further medical assistance. IPPC is recognized as a critical factor in preventing, diagnosing, and managing complications and

enhancing the Qoc. This is especially significant because a large proportion of maternal and neonatal morbidity and mortality occurs during this time frame (Namutebi et al., 2021).

The first few hours after childbirth are considered a high-risk period for both the mother and the newborn, with many deaths occurring during or shortly after delivery. The immediate postpartum phase is a crucial window for maternal and infant health, as the majority of maternal and infant deaths take place during this period (WHO, 2022). Therefore, I think that delivering high-quality care to both the mother and newborn after birth is essential for preventing postpartum complications and reducing neonatal and maternal morbidity and mortality.

Maternity midwives are crucial in monitoring the mother's condition, assisting with procedures to manage bleeding, educating the mother about her health status, and providing ongoing care to her and her family. Beyond addressing postpartum concerns, midwives are tasked with offering emotional support to the mother and her family, explaining all procedures and events, and taking measures to reduce anxiety and fear. They also inform the family about the mother's condition (Ali & Ghafel, 2022).

High-quality PPC prevents adverse maternal and neonatal outcomes and helps first-time mothers adjust to motherhood. Adverse events (AEs) refer to medical treatment outcomes that do not meet established standards of care, resulting in temporary or permanent patient harm. Unplanned AES during labour and delivery can have significant repercussions in the early postpartum period, affecting physical recovery and emotional well-being. Most maternal and neonatal AEs occur during this critical time (Wickramasinghe et al., 2019). Therefore, delivering evidence-based, high-quality PPC is essential to promoting a smooth and complication-free recovery for both mother and newborn.

2.2.4 Quality of postpartum care

QoC is a central focus in health systems to improve patient health outcomes sustainably. WHO defines quality maternal and newborn health (MNH) care as “the extent to which maternal and newborn health services increase the likelihood of timely and appropriate care to achieve desired outcomes, consistent with current professional knowledge, while considering the preferences and aspirations of individual women and their families” (WHO, 2018). This highlights the intricate relationship between expected health outcomes and the quality of healthcare provided. Evidence strongly suggests that maintaining high QoC and expanding access to healthcare facilities are essential for reducing maternal and neonatal mortality and morbidity (Biswas et al., 2019).

Postpartum care services are a critical component of the continuum of care for maternal, neonatal, and child health, playing a pivotal role in achieving the SDGs related to reproductive, maternal, and child health. These goals include reducing maternal mortality rates (MMR) and eliminating preventable neonatal deaths (WHO, 2022). Despite the vital importance of the postpartum period for the survival of both mothers and newborns, PPC remains one of the most neglected interventions in the maternal and child health continuum (Sacks & Langlois, 2016). Inadequate access to quality PPC leads to poor health outcomes for mothers and newborns (WHO, 2022). Early intervention during the postpartum period has the potential to save lives and promote the adoption of healthy behaviors. Previous studies estimate that achieving 90% coverage of quality PPC in sub-Saharan Africa could prevent approximately 10–27% of all neonatal deaths in the region (Zhao et al., 2023).

The most recent reports indicate that the median coverage of PPC for mothers in low- and middle-income countries (LMICs) is 45%. Additionally, Zhao et al. (2023) found that 41.42% of mothers received quality maternal PPC, while 42.34% received quality neonatal PPC. To reduce mortality and improve the health and survival of mothers and newborns during the postnatal period, efforts to enhance PPC must go beyond simply increasing coverage and focus on improving the QoC.

High-quality PPC is essential for preventing and early detecting many potential causes of obstetric complications and neonatal deaths, such as neonatal hypothermia and maternal anemia. Previous studies have highlighted disparities in the quality of postpartum care (QoPPC) during the immediate postpartum period. For instance, Ali & Ghafel (2022) found that 94% of nurse-midwives demonstrated fair practice in IPPC. Similarly, Ronnie et al. (2023) reported that the availability of family planning, immunisation, and nutritional counselling services was associated with a positive perception of the QoPNC.

In LICs with limited resources, the QoPPC is often poor. Pindani et al. (2020) found that midwives frequently did not adhere to reproductive health standards during client examinations. Specifically, 52.2% of midwives inspected perineal wounds, 66.7% checked neonatal vital signs, 62.2% checked maternal vital signs, and only 30.4% examined lochia drainage. Additionally, most midwives (91.3%) did not assess the mother's emotional state. In Bangladesh, a study on the quality and coverage of maternal PPC found that both were low. Key factors influencing the utilization of Qoppc included socio-demographic factors, pregnancy complications, type of birth attendant, delivery method, and financial readiness (Priyanka et al., 2024).

Postpartum care is a critical component of the childbearing process, and midwives are responsible for providing high-quality care to both the mother and baby from birth through six weeks postpartum. However, in low-resource settings, the quality of care for mothers and newborns is often substandard. Pindani et al. (2020) found that midwives' adherence to client monitoring practices fell below the 80% threshold. Specifically, less than 52.2% of midwives inspected perineal wounds, 66.7% checked neonatal vital signs, 62.2% checked maternal vital signs, and only 30.4% examined lochia drainage. Additionally, most midwives (91.3%) did not assess the mother's emotional state. While midwives covered various topics during health education and counselling, some critical areas, such as immunizations, were often neglected.

A systematic review by Zhao et al. (2023) identified essential components of effective PPC, including breastfeeding support, immediate examination of mothers and newborns, skin-to-skin care for neonates at birth, counselling on danger signs for mothers and babies, immunizations, and other services. To ensure comprehensive care during the postpartum period, the WHO recommends regular assessments of vaginal bleeding, fundal height, uterine tone, temperature, blood pressure, and heart rate within the first 24 hours. Screening for postpartum mental health issues, advising on physical exercise, counselling on family planning, breastfeeding support, and hygiene education are key elements of postnatal care (WHO, 2022).

Tappis et al. (2023) assessed maternity care quality in private hospitals in Iraq. Their findings revealed that all the hospitals included in the study had skilled healthcare personnel available on-site or on-call 24/7. Additionally, these hospitals were well-equipped with the necessary personnel, medical equipment, medications, and supplies to provide high-quality antenatal,

intrapartum, and essential newborn care. Many facilities also had specialized units and resources to care for small and sick newborns. However, despite having the necessary resources for basic and advanced care, gaps were identified in the knowledge and implementation of high-impact yet straightforward interventions, such as skin-to-skin thermal care and early breastfeeding support, which require minimal or no additional resources.

Early PPC refers to maternal and child healthcare services from delivery to the first week postpartum. It includes promoting health and offering advice on contraception, immunization, breastfeeding, and nutrition (Sserwanja et al., 2021).

Several factors influence the utilization of PPC. Dona et al. (2022) investigated the factors influencing early PPC service utilization among postpartum women in Ethiopia and found that the prevalence of early PPC utilisation was 45.5%. The most utilized services were physical examinations (37%) and family planning (31%). Factors significantly associated with early PPC utilization included having formal education, receiving antenatal care, delivering in a healthcare facility, and receiving advice from healthcare providers.

A pooled analysis by Zhao et al. (2023) identified the factors most strongly associated with the QoPPC. These included delivery by skilled birth attendants (SBA), attending four or more antenatal care (ANC) visits, and institutional delivery. Similar associations were found for quality newborn care, except for institutional delivery. Additionally, Tsegaye et al. (2021) investigated the prevalence and factors associated with IPPC utilization in Ethiopia. The study found that only 6.3% of women utilized IPPC services. Factors positively associated with IPPC utilization included living in urban areas, higher education levels, regular radio listening, better economic status, having fewer than six children, and being informed about pregnancy complications.

The PP period is often the most neglected phase for providing quality PPC services. Globally, the IPP accounts for over 45% of maternal deaths and more than 40% of neonatal deaths, with the majority occurring in LMICs (Sharrow et al., 2020). Therefore, proper implementation of PPC guidelines is crucial to reducing preventable maternal and neonatal morbidity and mortality. Bune et al. (2023) assessed the implementation of IPPC guidelines among healthcare providers in public health facilities in Ethiopia. The study found that only 44.4% of HCPs implemented IPPC guidelines well. Factors significantly associated with better implementation included receiving basic emergency obstetric and newborn care training, working in tertiary-level hospitals, and accessing maternal and newborn care guidelines in their facilities.

Several factors have been identified as contributing to the late initiation of IPPC among postnatal women, with variations observed between rural and urban areas (Ndugga et al., 2020). Studies emphasize that timing PPC initiation is crucial for ensuring a continuum of care and improving health outcomes for both mothers and children. In developing countries, factors influencing IPPC attendance include the availability, accessibility, and quality of health services and demographic characteristics such as socioeconomic status, knowledge of the importance of IPPC, previous pregnancy experiences, and cultural beliefs (Konje et al., 2021). For instance, a study conducted in Dodoma, Tanzania, found that only 41.7% of postnatal mothers initiated care within the first seven days (Lwelamira et al., 2015).

Additionally, Hussen et al. (2023) reported an increase in the percentage of women receiving immediate postnatal checks, rising from 6.4% in 2011 to 16.3% in 2016 and further to 33.4% in 2019. Factors positively associated with IPPC utilization included attending four or more antenatal care (ANC) visits and undergoing cesarean delivery. Similarly, Panga et al. (2024) found that a lack of awareness about the appropriate timing for IPPC visits and the recommended number of postnatal visits contributed to delays in care. Many postnatal women perceived the PP period as a normal condition that did not require medical attention, leading to the belief that IPPC visits were unnecessary unless they were unwell. Other barriers included long waiting times, transportation costs, and negative attitudes of healthcare providers, all of which were reported as significant reasons for late PPC attendance.

In GS, a quasi-experimental (pre-test, intervention, post-test) study was carried out by Abu Kwaik (2025). The study examined the effectiveness of a training program on improving midwives' knowledge and practice of IPPC. The study involved 76 midwives from Al Emaraty Maternity Hospital in Rafah. The results showed a statistically significant increase in midwives' knowledge about IPPC after the education program (m= 0.98) compared to before the educational program (m= 0.93). Also, there was a statistically significant increase in participants' knowledge about care provided to the mothers and babies after one hour post-delivery, after the education program (m= 0.98) compared to knowledge before the educational program (m= 0.90). Moreover, there was a statistically significant increase in participants' knowledge about health education and discharge planning after the education program (m= 0.99) compared to before (m= 0.88). In addition, there was a statistically significant improvement in participants' practice about immediate postnatal care after the education program (m= 1.95) compared to practice before the educational program (m= 1.74). Also, there was a statistically significant improvement in participants' practice about care provided to the mothers and babies after one hour post-delivery, after the education program (m= 1.97) compared to practice before the educational program (m= 1.68). There was a statistically significant improvement in participants' practice about health education and discharge planning after the education program (m= 1.96) compared to practice before the educational program (m= 1.69). There were statistically no significant differences in knowledge and practice score before and after the education program related to age, level of education, marital status, years of experience, income, and previous training. The study concluded that the education program successfully enhanced midwives' knowledge and practice in various aspects of postnatal care, contributing to improved maternal and newborn health outcomes.

Another cross-sectional study was conducted in GS. The study involved 200 pregnant women were selected by a convenience sampling method from 4 governmental hospitals in the GS is providing postnatal care. The study participants rated the postnatal services they received as high-quality care. High mean scores were achieved for all study domains. The "quality of postnatal care provided by midwives" received the highest Mean±SD score of 4.16±0.60, followed by the domain "quality of postnatal baby care" with a Mean±SD score of 3.89±0.85. The other two domains of "quality of provided health education" and "quality of provided communication and psychological support" received the lowest mean scores of 3.81 with standard deviations of 0.90 and 0.80, respectively. Patient-perceived postnatal care quality was not affected by many variables, such as age, parity, and gravidity. It was only affected by the subjects' level of education (P=0.001) and the place of delivery (Alkasseh et al., 2020).

2.2.5 Maternal satisfaction with postpartum care

Healthcare services are responsible for providing adequate care for women during the PP period. Designing effective interventions based on practical, community-accepted activities tailored to the PP period is crucial to maximizing engagement and improving outcomes (Bawazir, 2023). Women's satisfaction has gained significant attention in medical literature and is a key indicator of the QoC.

In this context, Al-Hussainy et al. (2022) assessed women's satisfaction with PPC and found that 68% perceived the care provided as high quality. High scores were reported for assurance (mean = 4.39), tangible aspects (mean = 4.22), and reliability (mean = 3.93), while responsiveness and empathy were rated as moderate. Overall, satisfaction with postnatal care was above average. Women were highly satisfied with the value and preference dimension (mean = 4.76) and comfort and care (mean = 3.77). However, they were moderately satisfied with communication skills (mean = 3.34), orientation (mean = 3.07), and information provision (mean = 3.02), and less satisfied with the dimension of postpartum care (mean = 2.73). The gap between the expected and perceived quality of maternity care was reported at -1.27, with a significant positive relationship between care quality and women's satisfaction.

Maternal satisfaction with medical and healthcare services is a key indicator of the QoC and is crucial in monitoring healthcare service delivery. Assessing mothers' satisfaction with healthcare services is fundamental to health policy development and contributes significantly to improving service quality. Additionally, satisfaction provides valuable insights for enhancing care, as psychological and mental well-being indirectly influence healthcare effectiveness.

Research conducted by Sandall et al. (2024) found that women who received midwifery continuity of care were less likely to undergo cesarean sections and instrumental births and had a lower likelihood of episiotomy. They were more likely to have spontaneous vaginal births and report positive birth experiences. However, the certainty of some findings varied due to potential biases, inconsistencies, and imprecision in specific estimates.

Additionally, mothers' perceptions of the QoC significantly influenced their level of satisfaction. It is believed that dissatisfied mothers may choose not to return to the same facility for future care. In this context, Wickramasinghe et al. (2019) assessed the Qoppc and found that scores ranged from 48 to 115, with a median of 108, representing 93.9% of the total possible score (IQR: 96–114). Over 90% of mothers rated interpersonal care, technical care, and information provision as good or very good. However, lower ratings were observed for facilities and cleanliness, with only 81.1% rating the cleanliness of toilets as good or very good. Satisfaction levels for space and available facilities were slightly higher, at 88.0% and 88.8%, respectively. IPPC satisfaction is considered a critical outcome of healthcare systems and influences the likelihood of mothers utilizing future healthcare services. A study by Bekele et al. (2022) assessed IPPC satisfaction and associated factors among Ethiopian women who had recently given birth. The findings indicated an overall satisfaction rate of 60.9%. Factors positively associated with higher satisfaction included multiparity, attending four or more ANC visits, satisfaction with delivery care, receiving friendly care, and having a companion present during childbirth.

Maternal and newborn health outcomes remain a significant global concern, particularly in LMICs, where MMR and preventable newborn deaths are high. Despite the critical role of PPC in improving these outcomes, the quality of care is often substandard, leading to low mothers' satisfaction with the provided care (Öjenda et al., 2023). Factors contributing to low PPC attendance in underserved areas include low maternal education, young maternal age, rural residence, home births, unemployment, limited media exposure, and lack of ANC visits (Tessema et al., 2020; Dickson et al., 2023).

Respectful care, including woman-centred care, informed choice, and kindness from HCPS, has been emphasised as a key factor influencing PPC utilisation in LMICS. A study in Malawi found that negative experiences with HCPs during ANC can reduce postnatal care attendance (Nyondo-Mipando et al., 2023). Additionally, Öjenda et al. (2023) identified three broad categories of factors affecting the provision of high-quality PPC services:

- **Difficulty achieving high attendance**, which includes long waiting times, low awareness among women, and out-of-pocket payments.
- **Lack of basic resources**, encompassing shortages of HCPs, inadequate facilities, and insufficient medical equipment.
- **Inadequate care routines,** characterised by the absence of standardised guidelines and ineffective information-sharing practices.

Several reasons contribute to late PPC attendance. Panga and Mosha (2024) found that a major barrier was a lack of awareness about the appropriate timing for early PPC visits and the recommended number of visits. Many postnatal women perceived the postpartum period as a normal condition that did not require medical attention, leading to the belief that early postnatal care was unnecessary unless they were unwell. Other barriers included long waiting times, transportation costs, and negative attitudes of healthcare providers.

The WHO (2022) recommends that postnatal mothers be observed for at least 24 hours after childbirth and receive care in a health facility. Mothers should have a health facility checkup for home births within 24 hours. Nuwabaine et al. (2024) investigated the prevalence and determinants of PPC quality in Kenya. They found that only 39% of mothers received all essential PPC components within the first two days after childbirth. Factors positively associated with QoPPC included being 35–49 years, making joint decisions about healthcare, receiving high-quality antenatal care, having a first childbirth between ages 30–34, delivering via cesarean section, giving birth in public health facilities, and experiencing quality intrapartum care. Conversely, mothers who gave birth to female children and those who reported not being consistently respected during their hospital stay were less likely to receive QoPPC.

2.2.6 Summary

Midwives play a crucial role in optimizing the provision of IPPC to mothers and newborns. Midwives can optimize the quality of IPPC by implementing several activities, such as immediate skin-to-skin contact immediately after birth, which helps improve bonding, regulate the newborn's temperature, and stabilize the newborn's heart rate. Also, encourage early breastfeeding after birth. In addition, close monitoring of the mother and her baby, including vital signs, hemorrhage and signs of shock, is necessary. Moreover, midwives can play a role in promoting maternal comfort and pain relief. Privacy is another important aspect

of QoC. Therefore, the midwife should always maintain the mother's privacy during their hospital stay.

Additionally, effective communication, respect, and accurate documentation of care provided to both mother and newborn are crucial for enhancing the exchange of information between midwives and mothers and among midwives themselves.

Finally, planning for discharge is another aspect of QoPPC. The midwife can assess the mother and her newborn to evaluate their readiness for discharge. Ensure that both the mother and her baby are ready for discharge and provide information on accessing PPC and when to seek help if abnormalities arise after discharge.

By emphasizing these activities, midwives can provide comprehensive, individualized, and effective care to both mothers and newborns in the immediate PP, promoting positive health outcomes for both.

Chapter Three

Materials and Methods

This chapter outlines the materials and methods employed to address the research questions. It begins with an overview of the study design, study setting, study population, study period, sample, sampling method, and eligibility criteria used for subject selection. It also provides questionnaire development, measuring its validity and reliability, data collection, piloting, and analysis, concluding with ethical and administrative considerations.

3.1 Study design

The design of this study is descriptive and cross-sectional. It is suitable to examine the QoPPC provided by midwives. A cross-sectional study looks at data simultaneously (Polit & Beck, 2020).

3.2 Study setting

This study was conducted in the Gaza Strip hospitals affected by the war: Helou International Hospital, Patient Friends Hospital, and Assahaba Medical Complex.

3.3 Population of the study

The population consisted of all midwives working in the studied hospitals and all the women who delivered during normal vaginal delivery in the hospital.

3.4 Sample size and sampling process

The study sample consisted of two groups: the first group comprised 72 full-time midwives working in the selected hospitals (census sample). The second group consisted of 335 mothers who delivered to the hospitals under study. They were selected randomly from the mothers who delivered during the data collection period and agreed to participate in the study.

3.5 Period of the study

The study was carried out from November 2024 to March 2025.

3.6 Eligibility criteria

3.6.1 Inclusion criteria

- Midwives working full-time for at least 6 months in the selected maternity hospitals.
- Women who delivered normally in assigned hospitals during the data collection period.
- Read and write

3.6.2 Exclusion criteria

- Midwives who are working part-time or are volunteer midwives.
- Women who delivered by cesarean section or delivered in other hospitals.

3.7 Instruments of the study

The researcher prepared two self-administered questionnaires:

- The first one is designed for midwives and assesses the quality of care midwives provide in the immediate postpartum period, covering the study objectives.
- The second questionnaire is designed for mothers, assessing women's satisfaction with the care provided to them and their babies after birth.

The questionnaires were translated into Arabic to facilitate the study participants' understanding. A consent form was attached to each questionnaire to obtain an agreement to participate in the study (Annex 1).

3.7.1 Description of the study instruments

3.7.1.1 The questionnaire for midwives

The questionnaire consisted of the following domains: (Annex 2).

First domain: Sociodemographic characteristics and work-related information.

Second domain: Care provided to the newborn for the first six hours after birth (33 items).

Third domain: Midwives practicing maternal care within the first six hours after birth (23 items).

Response to items of the questionnaire was according to a 5-point Likert scale as follows:

Strongly agree	Agree	Neutral	Disagree	Strongly disagree
5	4	3	2	1

3.7.1.2 The questionnaire for mothers

First domain: Sociodemographic factors. (Annexe 3)

Second domain: Mothers' satisfaction with the quality of provided services (21 items).

Response to items of the questionnaire was according to a 5-point Likert scale as follows:

Always	Often	Sometimes	Rarely	Never
4	3	2	1	0

3.8 Pilot study

Before commencing the actual data collection, a pilot study was conducted with 10% of the total sample of mothers (30 participants), while for midwives, the pilot study was conducted with 10 participants only. The pilot's study served multiple purposes within the research. Firstly, it assessed the effectiveness and suitability of the study instrument to ensure its adequacy for the main study. Second, it provided an opportunity to evaluate the participants' comprehension of the questionnaire's questions, ensuring clarity and understanding. Lastly, the pilot study aimed to identify and address any potential issues or challenges that could arise during the data collection phase, thereby enhancing the quality and smoothness of the research process. The pilot study questionnaires were included in the overall sample, as no changes had been made to the questionnaire.

3.8.1 Face validity

The questionnaire was distributed to a panel of experts to assess its appropriateness and clarity (Annex 4). Their comments were considered when modifying the questionnaire.

3.8.2 Reliability of the instrument

The reliability of an instrument is the degree of consistency with which it measures the attribute it is intended to measure. The researcher used two methods: Cronbach's alpha and the split-half method.

1. Cronbach alpha method

Table (3.1): Reliability of the questionnaire items

No.	Domains	No. of item	Cronbach's Alpha
Midwives' questionnaire			
D1	Care is provided to the newborn for the first six hours after birth	33	0.966
D2	Midwives practicing maternal care within the first 6 hours after birth	23	0.963
Total		56	0.965
Mothers' questionnaire			
D1	Mothers' satisfaction level with the quality of services provided to them in hospitals after childbirth	21	0.920

Table 3.1 displays the values of Cronbach's Alpha for each domain of the questionnaire administered to the participants. The table illustrates the reliability of the domains, with a Cronbach's Alpha value of 0.965 for the midwives' questionnaire and 0.920 for the mothers' questionnaire in the pilot sample, indicating good reliability for the entire questionnaire.

3.8.2 Internal Consistency

To assess internal consistency, the researcher computed the correlation between each item and its corresponding domain. Table 3.4 displays the correlation of each item with the total score of its corresponding domain for the midwives' and mothers' questionnaires. In all the

items, the p-values were less than 0.05, indicating that the correlation was statistically significant. This proved that all the items are consistent and valid in measuring the intended attribute.

Table (3.2): Correlation of each item with the total score of its corresponding domain

Items	Statistical test		Items	Statistical test		Items	Statistical test	
	r	P-value		r	P-value		r	P-value
Midwives' questionnaire						**Mothers' questionnaire**		
D2: Care is provided to the newborn for the first six hours after birth			**D3: Midwives practicing maternal care within the first 6 hours after birth**			**D1: Mothers' satisfaction level with the quality of services provided to them in hospitals after childbirth**		
Q1.1	0.780	0.000*	Q2.1	0.725	0.000*	Q1.2	0.737	0.000*
Q1.2	0.792	0.000*	Q2.2	0.782	0.000*	Q1.3	0.780	0.000*
Q1.3	0.794	0.000*	Q2.3	0.769	0.000*	Q1.4	0.631	0.000*
Q1.4	0.709	0.000*	Q2.4	0.868	0.000*	Q1.5	0.759	0.000*
Q1.5	0.733	0.000*	Q2.5	0.855	0.000*	Q1.6	0.749	0.000*
Q1.6	0.903	0.000*	Q2.6	0.902	0.000*	Q1.7	0.763	0.000*
Q1.7	0.796	0.000*	Q2.7	0.941	0.000*	Q1.8	0.761	0.000*
Q1.8	0.792	0.000*	Q2.8	0.937	0.000*	Q1.9	0.772	0.000*
Q1.9	0.746	0.000*	Q2.9	0.941	0.000*	Q1.10	0.658	0.000*
Q1.10	0.907	0.000*	Q2.10	0.929	0.000*	Q1.11	0.744	0.000*
Q1.11	0.855	0.000*	Q2.11	0.875	0.000*	Q1.12	0.896	0.000*
Q1.12	0.848	0.000*	Q2.12	0.847	0.000*	Q1.13	0.744	0.000*
Q1.13	0.906	0.000*	Q2.13	0.877	0.000*	Q1.14	0.764	0.000*
Q1.14	0.775	0.000*	Q2.14	0.972	0.000*	Q1.15	0.902	0.000*
Q1.15	0.818	0.000*	Q2.15	0.966	0.000*	Q1.16	0.951	0.000*
Q1.16	0.843	0.000*	Q2.16	0.948	0.000*	Q1.17	0.898	0.000*
Q1.17	0.893	0.000*	Q2.17	0.907	0.000*	Q1.18	0.887	0.000*
Q1.18	0.843	0.000*	Q2.18	0.817	0.000*	Q1.19	0.963	0.000*
Q1.19	0.834	0.000*	Q2.19	0.876	0.000*	Q1.20	0.919	0.000*
Q1.20	0.821	0.000*	Q2.20	0.888	0.000*	Q1.21	0.930	0.000*
Q1.21	0.839	0.000*	Q2.21	0.828	0.000*			
Q1.22	0.797	0.000*	Q2.22	0.768	0.000*			
Q1.23	0.865	0.000*	Q2.23	0.793	0.000*			
Q1.24	0.878	0.000*						
Q1.25	0.843	0.000*	**Total**					
Q1.26	0.828	0.000*	**D1**	**0.881**	**0.000***			
Q1.27	0.841	0.000*	**D2**	**0.813**	**0.000***			
Q1.28	0.760	0.000*						
Q1.29	0.808	0.000*						
Q1.30	0.730	0.000*						
Q1.31	0.869	0.000*						
Q1.32	0.854	0.000*						
Q1.33	0.818	0.000*						

3.9 Data collection procedure

The researcher collected data at three hospitals, with trained assistants assisting in data collection at each hospital under the researcher's supervision. The estimated time to fill out each questionnaire was 10 to 15 minutes.

All questionnaire forms were prepared, organized, and assigned serial numbers to ensure the required information was available. This systematic approach helped maintain the integrity and completeness of the data.

The researcher gave all the participants sufficient time to respond to the questions and encouraged them to be honest in their answers. The purpose of the questionnaire was to explain the topic to the participants before obtaining their consent. The researcher clarified any unclear information to ensure accurate and comprehensive responses.

3.10 Data entry and statistical analysis

The data from the questionnaires was entered into the computer using the SPSS program (version 25) for statistical analysis. The results were expressed as descriptive statistics, including frequencies, means, and percentages, which were used to illustrate sample characteristics. Inferential statistics, including independent sample t-tests and One-way ANOVA, were used to identify differences in the level of quality related to sociodemographic factors. The Pearson correlation test was also employed to determine the relationship between the study variables.

3.11 Ethical and administrative considerations

The researcher ensured that all ethical considerations were adhered to in this study to ensure proper research conduct. Before conducting this study, administrative approval was obtained from Al-Quds University. An official letter from the MoH was obtained to conduct the study. (Annex 5). All women participating in the study received a thorough explanation of the study and its purpose before data collection began. Furthermore, participation in the study was voluntary. Each participant was assured that the information provided would be confidential and used solely for research.

3.12 Limitations of the study

The exclusion of some hospitals from the study due to the war circumstances may limit the generalizability of the results to the broader population.

Chapter Four

Results

This chapter presents the study's results and analyses its objectives statistically. The findings highlighted the socio-demographic characteristics of the participants and various domains of postpartum care. Statistical analyses included descriptive and inferential statistics, independent t-tests, one-way ANOVA, and the Pearson correlation test.

4.1 Midwives' perception about the quality of immediate postpartum care provided to mothers and newborns

4.1.1 Socio-demographic characteristics of midwives

Table (4.1): Socio-demographic data of midwives

Socio-demographic data	Categories	N	%	Mean±SD
Hospital	Helou International Hospital	19	26.4%	
	Patient Friends Hospital	17	23.6%	
	Assahaba Medical Complex-Gaza, Palestine	21	29.2%	
	Al-Awda Hospital	15	20.8%	
Age groups (years)	30 or less	25	34.7%	34.04±8.40
	30-35	27	37.5%	
	More than 35	20	27.8%	
Academic degree	Diploma	10	13.9%	
	Bachelor’s degree	55	76.4%	
	Postgraduate studies	7	9.7%	
Marital status	Single	23	31.9%	
	Married	46	63.9%	
	Divorced/widow	3	4.2%	
Number of years of experience in maternity departments/hospitals	5 or less	32	44.4%	8.24±7.17
	6-10	22	30.6%	
	More than 10	18	25.0%	
Monthly income	Less than 1000 NIS*	15	20.8%	1231.46±692.91
	1000 – 1500 NIS	46	63.9%	
	More than 1500 NIS	11	15.3%	
Place of residence: Gaza	Central Gaza	65	90.3%	
	Mid Zone	7	9.7%	
	South Gaza	0	0.0%	
Number of children in the family	0 (No children)	26	36.1%	2.17±2.1
	1-3	26	36.1%	
	More than 30	20	27.8%	

*NIS= New Israeli Shekel

Table 4.1 showed that the most participants were from Assahaba Medical Complex-Gaza, Palestine, 21 (29.2%). Concerning age group, 27 (37.5%) of participants were 30-35 years. Most participants, 55 (76.4%), have a bachelors. Most participants, 46 (63.9%), were married, and 32 (44%) had experience of 5 years or less. The majority, 46 (63.9%), earned a monthly income of 1000 - 1500. Most participants, 65 (90.3%), resided in Central. The largest group had either no children or 1-3 children (36.1%).

4.1.2 Work status of midwives

Table (4.2): Work-related information of midwives

Work status	Categories	N	%	Mean±SD
Have you received special training in maternal and newborn care after childbirth?	Yes	61	84.7%	
	No	11	15.3%	
Working shifts	Straight morning	21	29.2%	
	Mixed shifts (morning, evening, night)	51	70.8%	
Place of residence	Central Gaza	65	90.3%	
	Mid Zone	7	9.7%	
	South Gaza	0	0.0%	
Number of training courses related to maternity and childcare	2 or less	34	47.2%	
	More than 2	38	52.8%	
Number of cases handled daily	20 or less	38	52.8%	26.58±18.53
	More than 20	34	47.2%	

Table 4.2 indicated that the majority of participants 61 (84.7%) received special training in maternal and newborn care after childbirth, 51 (70.8%) worked mixed shifts (morning, evening, night), 65 (90.3%) live in central Gaza, 38 (52.8%) attended more than two training courses, and 34 (47.2%) handled more than 20 cases daily.

4.1.3 Level of care provided to the newborn in the first six hours after birth

Table (4.3-A): Level of care provided to the newborn in the first six hours after birth

Care is provided to the newborn for the first six hours after birth.		Strongly Disagree	Disagree	Neutral	Agree	Strongly agree	Mean	SD	% Mean	Rank
Q1 The newborn is placed on the mother's belly, and I make sure she is in good condition	N	0	0	2	32	38	4.5	0.55	90	8
	%	0.0%	0.0%	2.8%	44.4%	52.8%				
Q2 The mother is sure to hold the newborn correctly	N	0	0	2	30	40	4.52	0.55	90.4	5
	%	0.0%	0.0%	2.8%	41.7%	55.5%				
Q3 The EENC policy is applied, and its importance for the mother and newborn is explained	N	0	1	6	34	31	4.31	0.68	86.2	24
	%	0.0%	1.4%	8.3%	47.2%	43.1%				
Q4 The newborn is placed close to the mother's belly or chest for 90 minutes unless there is any impediment to that	N	0	3	8	29	32	4.25	0.81	85	27
	%	0.0%	4.2%	11.1%	40.3%	44.4%				
Q5 The mother and newborn are kept in the delivery room for 90 minutes after birth for observation	N	0	3	11	28	30	4.18	0.84	83.6	29
	%	0.0%	4.2%	15.3%	38.9%	41.6%				
Q6 The correct procedures are followed to resuscitate the newborn if he does not breathe or scream after 30 seconds of birth	N	0	0	3	30	39	4.5	0.58	90	8
	%	0.0%	0.0%	4.2%	41.7%	54.1%				
Q7 The nursery doctor is called for the newborn if I notice any abnormalities	N	0	0	2	26	44	4.58	0.55	91.6	1
	%	0.0%	0.0%	2.8%	36.1%	61.1%				
Q8 My hands are washed before and after any procedure I do with the mother	N	0	0	6	32	34	4.38	0.64	87.6	23
	%	0.0%	0.0%	8.3%	44.4%	47.3%				
Q9 The place is kept as clean as possible	N	0	0	4	31	37	4.45	0.6	89	15
	%	0.0%	0.0%	5.6%	43.1%	51.3%				

Table (4.3-B): Level of care provided to the newborn in the first six hours after birth

Care is provided to the newborn for the first six hours after birth.		Strongly Disagree	Disagree	Neutral	Agree	Strongly agree	Mean	SD	% Mean	Rank
Q10 The patient's privacy is maintained as much as possible	N	0	1	3	31	37	4.44	0.64	88.8	16
	%	0.0%	1.4%	4.2%	43.1%	51.3%				
Q11 Preventive methods are followed in dealing with cases if they are infected with infectious diseases	N	1	0	4	29	38	4.43	0.72	88.6	18
	%	1.4%	0.0%	5.6%	40.3%	52.7%				
Q12 The newborn's warmth and airway safety are maintained, and the color is monitored. Breathing and movements	N	0	0	2	27	43	4.56	0.55	91.2	2
	%	0.0%	0.0%	2.8%	37.5%	59.7%				
Q13 The newborn's identification bracelet is checked every shift and before leaving (Color according to gender, placed on the wrist, details)	N	1	0	5	29	37	4.4	0.74	88	21
	%	1.4%	0.0%	6.9%	40.3%	51.4%				
Q14 The newborn's urine is monitored	N	1	4	14	24	29	4.05	0.97	81	33
	%	1.4%	5.6%	19.4%	33.3%	40.3%				
Q15 The midwife confirms the newborn's gender	N	0	0	3	28	41	4.52	0.58	90.4	5
	%	0.0%	0.0%	4.2%	38.9%	56.9%				
Q16 The newborn's spine is checked for safety	N	0	1	4	31	36	4.41	0.66	88.2	19
	%	0.0%	1.4%	5.6%	43.0%	50.0%				
Q17 The benefits of breastfeeding are explained to the mother, and its importance is stated	N	0	0	2	30	40	4.52	0.55	90.4	5
	%	0.0%	0.0%	2.8%	41.6%	55.6%				
Q18 Mothers are helped and encouraged to breastfeed within a third of an hour after birth	N	0	0	4	28	40	4.5	0.6	90	8
	%	0.0%	0.0%	5.6%	38.8%	55.6%				
Q19 The mother is directed to wear her clothes after birth	N	0	0	4	34	34	4.41	0.59	88.2	19
	%	0.0%	0.0%	5.6%	47.2%	47.2%				
Q20 The hygiene protocol and maintaining the stitches after birth are explained	N	0	0	6	31	35	4.4	0.64	88	21
	%	0.0%	0.0%	8.3%	43.1%	48.6%				
Q21 The mother is given sufficient information about the danger signs for her and the newborn	N	0	0	3	34	35	4.44	0.57	88.8	16
	%	0.0%	0.0%	4.2%	47.2%	48.6%				
Q22 The mother is encouraged to carry the newborn and pay attention to her	N	0	0	3	32	37	4.47	0.58	89.4	14
	%	0.0%	0.0%	4.2%	44.4%	51.4%				

Table (4.3-C): Level of care provided to the newborn in the first six hours after birth

Care is provided to the newborn for the first six hours after birth.		Strongly Disagree	Disagree	Neutral	Agree	Strongly agree	Mean	SD	% Mean	Rank
Q23 The midwives in the postpartum department are informed and asked about their readiness to receive the mother and her child, and to transfer them	N	1	0	5	35	31	4.31	0.72	86.2	24
	%	1.4%	0.0%	6.9%	48.6%	43.1%				
Q24 The midwife gives the newborn a vitamin K injection after birth	N	0	0	4	25	43	4.54	0.6	90.8	4
	%	0.0%	0.0%	5.6%	34.7%	59.7%				
Q25 The ABGAR Score is checked for the first minute and then after 5 minutes	N	0	0	2	33	37	4.48	0.55	89.6	13
	%	0.0%	0.0%	2.8%	45.8%	51.4%				
Q26 The midwife takes the child to the nursery to give the vaccination if the mother is infected with Hepatitis B	N	0	1	4	25	42	4.5	0.67	90	8
	%	0.0%	1.4%	5.6%	34.7%	58.3%				
Q27 The midwife measures the weight of the newborn after birth and records it in the file	N	0	0	2	27	43	4.56	0.55	91.2	2
	%	0.0%	0.0%	2.8%	37.5%	59.7%				
Q28 The midwife measures the length of the newborn and records it in the file	N	1	3	9	26	33	4.2	0.91	84	28
	%	1.4%	4.2%	12.5%	36.1%	45.8%				
Q29 The midwife measures the circumference of the newborn’s head and records it in the file	N	1	3	9	28	31	4.18	0.9	83.6	29
	%	1.4%	4.2%	12.5%	38.8%	43.1%				
Q30 The midwife measures the circumference of the newborn’s chest and records it in the file	N	1	3	14	23	31	4.11	0.95	82.2	32
	%	1.4%	4.2%	19.4%	31.9%	43.1%				
Q31 Everything you did is recorded in the memo	N	0	0	2	32	38	4.5	0.55	90	8
	%	0.0%	0.0%	2.8%	44.4%	52.8%				
Q32 Sufficient time is provided to listen to the mother’s concerns or inquiries	N	0	0	9	35	28	4.26	0.67	85.2	26
	%	0.0%	0.0%	12.5%	48.6%	38.9%				
Q33 The newborn's vital signs (temperature, heart rate, respiratory rate, and oxygen saturation) are assessed and documented accurately after birth.	N	1	3	9	28	31	4.18	0.9	83.6	29
	%	1.4%	4.2%	12.5%	38.8%	43.1%				
Total							**4.41**	**0.48**	**88.2**	

Table 4.3 A,B,C shows that, the highest ranked item was number (7), "The nursery doctor is called for the newborn if I notice any abnormalities," with a percentage mean of 91.6%, followed by item number (12), "The newborn's warmth and airway safety are maintained and the color is monitored, breathing and movements," and item number (27), "The midwife measures the weight of the newborn after birth and records it in the file," both with a percentage mean of 91.2%. While the lowest item was number (14), "The newborn's urine is monitored," with a percentage mean of 81.0%, followed by item number (30), "The midwife measures the circumference of the newborn’s chest and records it in the file," with a percentage mean of 82.2%. The overall mean score was 4.41, with a mean percentage of 88.2%, indicating a high level of care provided to the newborns.

4.1.4 Level of midwives practicing maternal care within the first 6 hours after birth

Table (4.4-A): Level of midwives practicing maternal care within the first 6 hours after birth

Midwives practicing maternal care within the first 6 hours after birth		Strongly Disagree	Disagree	Neutral	Agree	Strongly agree	Mean	SD	% Mean	Rank
Q1 The midwife measures the safe transfer policy for the mother and her newborn from the delivery room to the postpartum department after 90 minutes of birth using a wheelchair	N	1	1	7	32	31	4.26	0.8	85.2	23
	%	1.4%	1.4%	9.7%	44.4%	43.1%				
Q2 The midwife applies the policy of handing over and receiving cases using the ISBAR form	N	0	2	7	32	31	4.27	0.75	85.4	22
	%	0.0%	2.8%	9.7%	44.4%	43.1%				
Q3 The midwife informs the mother of the transfer of the newborn to the nursery if necessary	N	0	1	2	33	36	4.44	0.62	88.8	15
	%	0.0%	1.4%	2.8%	45.8%	50.0%				
Q4 The midwife informs the mother of the department to which the baby is to be transferred	N	0	1	4	31	36	4.41	0.66	88.2	17
	%	0.0%	1.4%	5.6%	43.0%	50.0%				
Q5 The midwife takes vital signs every hour during the four hours after the first hour after birth	N	0	0	2	31	39	4.51	0.55	90.2	7
	%	0.0%	0.0%	2.8%	43.0%	54.2%				
Q6 The midwife informs the doctor of any abnormal signs in the vital signs	N	0	0	2	34	36	4.47	0.55	89.4	11
	%	0.0%	0.0%	2.8%	47.2%	50.0%				
Q7 The midwife massages the uterus and assesses its contraction or relaxation	N	0	0	2	28	42	4.55	0.55	91	1
	%	0.0%	0.0%	2.8%	38.9%	58.3%				
Q8 The midwife assesses the amount of blood coming out of the vagina after birth every hour for 4 hours after birth	N	0	0	2	30	40	4.52	0.55	90.4	3
	%	0.0%	0.0%	2.8%	41.6%	55.6%				
Q9 The mother is provided with sufficient information about the danger signs to look out for herself and the newborn.	N	0	0	3	35	34	4.43	0.57	88.6	16
	%	0.0%	0.0%	4.2%	48.6%	47.2%				
Q10 The midwife monitors bleeding every hour during the first 6 hours after birth.	N	0	0	3	28	41	4.52	0.58	90.4	3
	%	0.0%	0.0%	4.2%	38.9%	56.9%				
Q11 The midwife encourages going to the bathroom and emptying the bladder every hour during the first 6 hours after birth.	N	0	0	3	32	37	4.47	0.58	89.4	9
	%	0.0%	0.0%	4.2%	44.4%	51.4%				
Q12 The midwife encourages mothers to empty their bladders for the first time in the postpartum department with a reminder.	N	0	2	6	28	36	4.36	0.75	87.2	21
	%	0.0%	2.8%	8.3%	38.9%	50.0%				

Table (4.4-B): Level of midwives practicing maternal care within the first 6 hours after birth

Midwives practicing maternal care within the first 6 hours after birth		Strongly Disagree	Disagree	Neutral	Agree	Strongly agree	Mean	SD	% Mean	Rank
Q13 The midwife checks for vaginal stitches, if any.	N	0	0	6	30	36	4.41	0.64	88.2	18
	%	0.0%	0.0%	8.3%	41.7%	50.0%				
Q14 The midwife ensures safe breastfeeding.	N	0	0	3	33	36	4.45	0.57	89	13
	%	0.0%	0.0%	4.2%	45.8%	50.0%				
Q15 The midwife ensures that the uterus is in its natural place after birth by massaging it.	N	0	0	2	30	40	4.52	0.55	90.4	3
	%	0.0%	0.0%	2.8%	41.6%	55.6%				
Q16 The midwife monitors signs of bleeding every quarter of an hour during the first hour after birth.	N	0	0	3	29	40	4.51	0.58	90.2	6
	%	0.0%	0.0%	4.2%	40.2%	55.6%				
Q17 The midwife encourages mothers to use the bathroom and empty their bladders every quarter of an hour during the first hour after birth.	N	0	0	3	32	37	4.47	0.58	89.4	11
	%	0.0%	0.0%	4.2%	44.4%	51.4%				
Q18 The midwife discusses self-care and hygiene with the mother, especially around the perineum, including care of any stitches, mobility, and the importance of drinking fluids and maintaining a healthy diet.	N	0	1	3	36	32	4.37	0.63	87.4	20
	%	0.0%	1.4%	4.2%	50.0%	44.4%				
Q19 The midwife encourages the mother to hold the newborn and pay attention to her.	N	0	0	1	33	38	4.51	0.53	90.2	7
	%	0.0%	0.0%	1.4%	45.8%	52.8%				
Q20 The midwife informs the midwives in the postpartum department and inquiries about their readiness to receive the mother and her baby for transfer.	N	0	0	1	38	33	4.44	0.52	88.8	14
	%	0.0%	0.0%	1.4%	52.8%	45.8%				
Q21 The midwife records everything she has done in the memo.	N	0	0	2	29	41	4.54	0.55	90.8	2
	%	0.0%	0.0%	2.8%	40.3%	56.9%				
Q22 The midwife provides psychological support to the mother after birth.	N	0	0	4	37	31	4.37	0.59	87.4	19
	%	0.0%	0.0%	5.6%	51.3%	43.1%				
Q23 The midwife documents every procedure or any new developments in the mother’s condition after birth in the mother's file.	N	0	0	3	32	37	4.47	0.58	89.4	9
	%	0.0%	0.0%	4.2%	44.4%	51.4%				
Q11 The midwife encourages going to the bathroom and emptying the bladder every hour during the first 6 hours after birth.	N	0	0	3	32	37	4.47	0.58	89.4	9
	%	0.0%	0.0%	4.2%	44.4%	51.4%				

Table (4.4-C): Level of midwives practicing maternal care within the first 6 hours after birth

Midwives practicing maternal care within the first 6 hours after birth		Strongly Disagree	Disagree	Neutral	Agree	Strongly agree	Mean	SD	% Mean	Rank
Q12 The midwife encourages mothers to empty their bladders for the first time in the postpartum department with a reminder.	N	0	2	6	28	36	4.36	0.75	87.2	21
	%	0.0%	2.8%	8.3%	38.9%	50.0%				
Q13 The midwife checks for vaginal stitches, if any.	N	0	0	6	30	36	4.41	0.64	88.2	18
	%	0.0%	0.0%	8.3%	41.7%	50.0%				
Q14 The midwife ensures safe breastfeeding.	N	0	0	3	33	36	4.45	0.57	89	13
	%	0.0%	0.0%	4.2%	45.8%	50.0%				
Q15 The midwife ensures that the uterus is in its natural place after birth by massaging it.	N	0	0	2	30	40	4.52	0.55	90.4	3
	%	0.0%	0.0%	2.8%	41.6%	55.6%				
Q16 The midwife monitors signs of bleeding every quarter of an hour during the first hour after birth.	N	0	0	3	29	40	4.51	0.58	90.2	6
	%	0.0%	0.0%	4.2%	40.2%	55.6%				
Q17 The midwife encourages mothers to use the bathroom and empty their bladders every quarter of an hour during the first hour after birth.	N	0	0	3	32	37	4.47	0.58	89.4	11
	%	0.0%	0.0%	4.2%	44.4%	51.4%				
Q18 The midwife discusses self-care and hygiene with the mother, especially around the perineum, including care of any stitches, mobility, and the importance of drinking fluids and maintaining a healthy diet.	N	0	1	3	36	32	4.37	0.63	87.4	20
	%	0.0%	1.4%	4.2%	50.0%	44.4%				
Q19 The midwife encourages the mother to hold the newborn and pay attention to her.	N	0	0	1	33	38	4.51	0.53	90.2	7
	%	0.0%	0.0%	1.4%	45.8%	52.8%				
Q20 The midwife informs the midwives in the postpartum department and inquiries about their readiness to receive the mother and her baby for transfer.	N	0	0	1	38	33	4.44	0.52	88.8	14
	%	0.0%	0.0%	1.4%	52.8%	45.8%				
Q21 The midwife records everything she has done in the memo.	N	0	0	2	29	41	4.54	0.55	90.8	2
	%	0.0%	0.0%	2.8%	40.3%	56.9%				
Q22 The midwife provides psychological support to the mother after birth.	N	0	0	4	37	31	4.37	0.59	87.4	19
	%	0.0%	0.0%	5.6%	51.3%	43.1%				
Q23 The midwife documents every procedure or any new developments in the mother’s condition after birth in the mother's file.	N	0	0	3	32	37	4.47	0.58	89.4	9
	%	0.0%	0.0%	4.2%	44.4%	51.4%				
Total							**4.45**	**0.45**	**89.0**	

Table 4.4 A,B,C shows that, the highest ranked item was number (7), "The midwife massages the uterus and assesses its contraction or relaxation," with a percentage mean of 91.0%, followed by item number (21), "The midwife records everything she has done in the memo," with a percentage mean of 90.8%. While the lowest item was number (1), "The midwife measures the safe transfer policy for the mother and her newborn from the delivery room to the postpartum department after 90 minutes of birth using a wheelchair," with a percentage mean of 85.2%, followed by item number (2), "The midwife applies the policy of handing over and receiving cases using the ISBAR form," with a percentage mean of 85.4%. The overall mean score was 4.45 (89%), indicating a high level of maternal care practice within the first 6 hours after birth.

4.1.5 Distribution of domains studied among the study participants

Table (4.5): Distribution of domains studied among the study participants

Domain	Mean	SD	Mean %	t-test	P-vale	Rank
D1 Care is provided for the newborn for the first six hours after birth	4.41	0.48	88.20	24.976	0.000*	2
D2 Midwives practicing maternal care within the first 6 hours after birth	4.45	0.45	89.00	27.147	0.000*	1
Total	4.43	0.47	88.60	26.062	**0.000***	

*Significant at P≤0.05; P>0 05 One sample t-test.

Table 4.5 summarizes the distribution of the studied domains among the study participants. According to the results, the highest-ranked domain was D3, "Midwives practicing maternal care within the first six hours after birth," with a percentage mean of 89.0%, followed by D2, "Care provided to the newborn for the first six hours after birth," with a percentage mean of 88.2%. The total mean score was 4.43 (88.6%), which revealed a high quality of IPPC.

4.1.6 Mean differences of studied domains related to sociodemographic factors

Table (4.6-A): Mean difference of studied domains related to hospitals

Domains	Hospitals	N	Mean	SD	F	P-value	Post Hoc
D1 Care is provided to the newborn for the first six hours after birth.	Helou International Hospital	19	4.07	0.43	5.915	0.001*	Helou International Hospital < others*
	Patient Friends Hospital	17	4.55	0.44			
	Assahaba Medical Complex- Gaza, Palestine	21	4.44	0.46			
	Al-Awda Hospital	15	4.64	0.41			
	Total	72	4.41	0.48			

Table (4.6-B): Mean difference of studied domains related to hospitals

Domains	Hospitals	N	Mean	SD	F	P-value	Post Hoc
D2 Midwives practicing maternal care within the first 6 hours after birth	Helou International Hospital	19	4.16	0.41	4.158	0.009*	Helou International Hospital < others*
	Patient Friends Hospital	17	4.59	0.42			
	Assahaba Medical Complex- Gaza, Palestine	21	4.49	0.46			
	Al-Awda Hospital	15	4.60	0.42			
	Total	72	4.45	0.45			
Total	Helou International Hospital	19	4.09	0.28	7.676	0.000*	Helou International Hospital < others*
	Patient Friends Hospital	17	4.54	0.42			
	Assahaba Medical Complex- Gaza, Palestine	21	4.52	0.39			
	Al-Awda Hospital	15	4.58	0.33			
	Total	72	4.43	0.47			

Significant at P≤0.05; One-way ANOVA.

Table 4.6 A,B presents the mean differences in the study domains between hospitals. The ANOVA test reveals significant differences between hospitals in the average of all domains studied ($P < 0.05$). The post hoc test showed that the average of Helou International Hospital was statistically lower compared to other hospitals regarding care provided to the newborn for the first six hours after birth domain, midwives practicing maternal care within the first six hours after birth domain, and the domain as a total ($P<0.05$). In contrast, the statistical test revealed no statistically significant differences among other hospitals in the study domains ($P > 0.05$).

Table (4.7): Mean difference of studied domains related to age groups

Domain	Age	N	Mean	SD	F	P-value
D1 Care is provided to the newborn for the first six hours after birth.	30 or less	25	4.40	0.53	0.484	0.619
	30-35	27	4.36	0.47		
	More than 35	20	4.50	0.43		
	Total	72	4.41	0.48		
D2 Midwives practicing maternal care within the first 6 hours after birth.	30 or less	25	4.52	0.49	1.312	0.276
	30-35	27	4.34	0.44		
	More than 35	20	4.52	0.42		
	Total	72	4.45	0.45		
Total	30 or less	25	4.43	0.45	0.276	0.759
	30-35	27	4.38	0.37		
	More than 35	20	4.47	0.40		
	Total	72	4.43	0.47		

Table 4.7 presents the mean differences in the study domains between age groups. The ANOVA test shows no statistically significant differences between age groups in the average of the study domains, as care provided to the newborn for the first six hours after birth, midwives practicing maternal care within the first six hours after birth, and the domain as a whole (P>0.05).

Table (4.8): Mean difference of studied domains related to academic degree

Domain	Academic degree	N	Mean	SD	F	P-value
D1 Care is provided for the newborn for the first six hours after birth.	Diploma	10	4.50	0.41	0.209	0.812
	Bachelor's degree	55	4.40	0.50		
	Postgraduate studies	7	4.37	0.41		
	Total	72	4.41	0.48		
D2 Midwives practicing maternal care within the first six hours after birth	Diploma	10	4.41	0.41	0.151	0.860
	Bachelor's degree	55	4.45	0.47		
	Postgraduate studies	7	4.53	0.45		
	Total	72	4.45	0.45		
Total	Diploma	10	4.38	0.41	0.213	0.809
	Bachelor's degree	55	4.44	0.41		
	Postgraduate studies	7	4.35	0.38		
	Total	72	4.43	0.47		

Table 4.8 presents the mean differences in the study domains between academic degrees. The ANOVA test shows no statistically significant differences between academic degree groups in the average of the studied domains, such as care provided to the newborn for the first six hours after birth, midwives practicing maternal care within the first six hours after birth, and the domain as a total.

Table (4.9): Mean difference of studied domains related to marital status

Domain	Marital status	N	Mean	SD	F	P-value
D1 Care is provided for the newborn for the first six hours after birth.	Single	23	4.51	0.52	0.978	0.381
	Married	46	4.38	0.47		
	Divorced/widow	3	4.18	0.24		
	Total	72	4.41	0.48		
D2 Midwives practicing maternal care within the first six hours after birth	Single	23	4.58	0.43	1.481	0.234
	Married	46	4.39	0.46		
	Divorced/widow	3	4.42	0.46		
	Total	72	4.45	0.45		
Total	Single	23	4.54	0.39	1.493	0.232
	Married	46	4.38	0.41		
	Divorced/widow	3	4.27	0.28		
	Total	72	4.43	0.47		

Table 4.9 shows the mean differences between marital status groups in the domains studied. The ANOVA test showed no statistically significant differences between marital status groups in the average domains studied domains, such as care provided to the newborn for

the first six hours after birth, midwives practicing maternal care within the first six hours after birth, and the domain (P>0.05).

Table (4.10): Mean difference of studied domains related to the number of years of experience in maternity departments/hospitals

Domain	Number of years of experience in maternity departments/hospitals	N	Mean	SD	F	P-value
D1 Care is provided for the newborn for the first six hours after birth.	5 or less	32	4.46	0.52	0.502	0.607
	6-10	22	4.33	0.43		
	More than 10	18	4.42	0.47		
	Total	72	4.41	0.48		
D2 Midwives practicing maternal care within the first six hours after birth	5 or less	32	4.53	0.43	0.870	0.424
	6-10	22	4.36	0.48		
	More than 10	18	4.43	0.45		
	Total	72	4.45	0.45		
Total	5 or less	32	4.51	0.40	1.469	0.237
	6-10	22	4.34	0.38		
	More than 10	18	4.37	0.42		
	Total	72	4.43	0.47		

Table 4.10 presents the mean differences between years of experience in maternity departments and hospitals in the study domains. The ANOVA test shows no statistically significant differences between years of experience groups in the average of the studied domains as care provided to the newborn for the first six hours after birth, midwives practicing maternal care within the first six hours after birth, and the domain (P>0.05).

Table (4.11): Mean difference of studied domains related to income (NIS)

Domain	Income (NIS)	N	Mean	SD	F	P-value
D1 Care is provided for the newborn for the first six hours after birth.	Less than 1000	15	4.33	.42	1.027	0.363
	1000-1500	46	4.39	0.52		
	More than 1500	11	4.59	0.37		
	Total	72	4.41	0.48		
D2 Midwives practicing maternal care within the first six hours after birth.	Less than 1000	15	4.41	0.43	1.450	0.242
	1000-1500	46	4.41	.48		
	More than 1500	11	4.66	0.31		
	Total	72	4.45	0.45		
Total	Less than 1000	15	4.34	0.41	1.040	0.359
	1000-1500	46	4.42	0.42		
	More than 1500	11	4.57	0.34		
	Total	72	4.43	0.47		

Table 4.11 presents the mean differences in the study domains between income groups. The ANOVA test shows no statistically significant differences between income groups in the average of the study domains, such as care provided to the newborn for the first six hours after birth, midwives practicing maternal care within the first six hours after birth, and the domain as a whole (P>0.05).

Table (4.12): Mean difference of studied domains related to place of residence

Domains	Place of residence	N	Mean	SD	t	P-value
D1 Care is provided to the newborn for the first six hours after birth.	Central Gaza	65	4.38	0.48	-1.876	0.065
	Mid Zone	7	4.73	0.36		
D2 Midwives practicing maternal care within the first 6 hours after birth	Central Gaza	65	4.44	0.45	-0.584	0.561
	Mid Zone	7	4.55	0.51		
Total	Central Gaza	65	4.40	0.41	-1.406	0.164
	Mid Zone	7	4.63	0.36		

As presented in table 4.12, the t-test shows no statistically significant differences between the place of residence groups in the average of the studied domains as care provided to the newborn for the first six hours after birth domain midwives practicing maternal care within the first six hours after birth domain, and the domain as a total (P>0.05).

Table (4.13): Mean difference of studied domains related to having received special training in maternal and newborn care after childbirth

Domains	Received training	N	Mean	SD	t	P-value
D1 Care is provided to the newborn for the first six hours after birth	Yes	61	4.44	0.49	1.196	0.236
	No	11	4.25	0.43		
D2 Midwives practicing maternal care within the first six hours after birth	Yes	61	4.48	0.47	1.362	0.177
	No	11	4.28	0.35		
Total	Yes	61	4.45	0.41	1.045	0.300
	No	11	4.31	0.38		

Table 4.13 presents the meaning differences in the study domains between individuals who received special training in maternal and newborn care after childbirth and those who did not. The t-test shows no statistically significant differences between groups in the average of the studied domains, as care provided to the newborn for the first six hours after birth domain, midwives practicing maternal care within the first six hours after birth domain, and the domain as a total (P>0.05).

Table (4.14): Mean difference of study domains related to work system (shifts)

Domains	Work system (shifts)	N	Mean	SD	t	P-value
D1 Care is provided to the newborn for the first six hours after birth	Permanent morning	21	4.35	0.58	-0.633	0.528
	Different shifts (morning, evening, night)	51	4.43	0.44		
D2 Midwives practicing maternal care within the first 6 hours after birth	Permanent morning	21	4.44	0.46	-0.170	0.866
	Different shifts (morning, evening, night)	51	4.46	0.45		
Total	Permanent morning	21	4.36	0.43	-0.886	0.379
	Different shifts (morning, evening, night)	51	4.45	0.40		

Table 4.14 presents the mean differences between work systems (shifts) in the study domains. The t-test showed no significant differences between work system groups in the average of the studied domains, as care provided to the newborn for the first six hours after birth domain, midwives practicing maternal care within the first six hours after birth domain, and the domain as a total (P>0.05).

4.1.7 Correlation between study domains among the study participants

Table (4.15): Correlation between the study domains among the study participants

Domain		D1	D2
D1 Care is provided for the newborn for the first six hours after birth	R		
	P-value	-	
D2 Midwives practicing maternal care within the first six hours after birth	R	0.565	
	P-value	**0.000***	-
Total	R	0.881	0.813
	P-value	**0.000***	**0.000***

r: Pearson correlation & * indicates a statistically significant difference at P<0.05.

Table 4.15 presents the correlation analysis between the studied domains: care provided to the newborn in the first six hours after birth, and midwives' practice of maternal care within the first six hours after birth. The results illustrate a significant positive correlation between all studied domains ($P < 0.05$) and the highest correlation was observed between total care and care provided to the newborn in the first six hours after birth ($r = 0.881$, $P < 0.001$), Additionally, a strong positive correlation was found between total care and midwives practicing maternal care ($r = 0.813$, $P < 0.001$). In contrast, the correlation between midwives' practice care provided to the newborn ($r = 0.565$, $P < 0.001$) was moderate but still statistically significant.

4.2 Mothers' satisfaction with the quality of care provided after childbirth

4.2.1 Socio-demographic characteristics of mothers

Table (4.16): Socio-demographic data of participants

Socio-demographic data	Categories	N	%
Age groups	25 years or less	163	48.7%
	26-30 years	102	30.4%
	More than 30 years	70	20.9%
Hospital	AL Helou International Hospital	27	8.1%
	Patient's Friend Benevolent Society	63	18.8%
	Assahaba Medical Complex-Gaza, Palestine	195	58.2%
	Al-Awda Hospital	50	14.9%
Academic degree	Secondary school or less	42	12.5
	Diploma	127	37.9
	Bachelor’s degree	160	47.8
	Postgraduate studies	6	1.8
Marital status	Married	333	99.4
	Divorced/widow	2	0.6
Number of births	2 or less	149	44.5%
	3-4	143	42.7%
	More than 4	43	12.8%
Number of pregnancies	2 or less	98	29.3%
	3-4	150	44.8%
	More than 4	87	26.0%
Does the mother work (as an employee)	Yes	43	12.8%
	No	292	87.2%
Place of birth: Gaza	Central Gaza	291	86.9%
	Mid Zone	42	12.5%
	Southern area	2	0.6%

The study employed a cross-sectional design and included 335 participants. Table 4.16 presents the socio-demographic data of the participants. The results indicate that the largest age group was those aged 25 years or less (48.7%), followed by those aged 26-30 years (30.4%), while the smallest category was participants older than 30 years (20.9%). Regarding the hospital distribution, most participants were from the Assahaba Medical Complex in Gaza, Palestine (58.2%), followed by the Patients' Friend Benevolent Society (18.8%). In comparison, the lowest category was AL Helou International Hospital, with a rate of 8.1%. In terms of academic qualifications, the majority held a bachelor's degree (47.8%), followed by Diploma holders (37.9%), while the lowest percentage was for participants with postgraduate studies (1.8%). Most participants were married (99.4%), while divorced or widowed individuals accounted for only 0.6%. Regarding the number of births, the largest category consisted of two or fewer births (44.5%), followed by those with 3-4 births (42.7%), while the smallest category had more than four births (12.8%). Similarly, in terms of the number of pregnancies, the largest category was 3-4 pregnancies (44.8%), followed by those with two or fewer pregnancies (29.3%), while the smallest category was those with more than four pregnancies (26.0%). Concerning employment status, most mothers were not employed (87.2%), while only a small percentage were employed (12.8%). Regarding the place of birth, most participants were from Central Gaza (86.9%), followed by the Mid Zone (12.5%), while the lowest percentage was from South Gaza (0.6%).

4.2.2 Level of mothers' satisfaction with the quality of services

Table (4.17-A): Level of mothers' satisfaction with quality of services provided after childbirth

Mothers' satisfaction level		Never	Rarely	Sometimes	Often	Always	Mean	SD	% Mean	Rank
Q1 The midwife introduces himself and his role in providing health services	N	15	27	29	154	110	2.94	1.06	73.50	21
	%	4.5%	8.1%	8.7%	46.0%	32.7%				
Q2 The midwife encourages the mother to inquire and provides her with the correct and necessary information	N	2	8	51	174	100	3.08	0.77	77.00	19
	%	0.6%	2.4%	15.2%	51.9%	29.9%				
Q3 The midwife maintains the mother's privacy as much as possible	N	1	2	10	146	176	3.47	0.61	86.75	2
	%	0.3%	0.6%	3.0%	43.6%	52.5%				
Q4 The midwife gives the mother painkillers after childbirth if she requests it	N	23	10	11	142	149	3.14	1.09	78.50	17
	%	6.9%	3.0%	3.3%	42.4%	44.4%				
Q5 The midwife takes care of the mother in a room alone	N	10	3	24	192	106	3.13	0.82	78.25	18
	%	3.0%	0.9%	7.2%	57.3%	31.6%				
Q6 The midwife provides enough nursing care	N	10	20	25	174	106	3.03	0.94	75.75	20
	%	3.0%	6.0%	7.5%	51.9%	31.6%				
Q7 The midwife deals with any complaint independently and quickly	N	4	4	33	176	118	3.19	0.75	79.75	14
	%	1.2%	1.2%	9.9%	52.5%	35.2%				
Q8 The midwife places the mother in a well-ventilated room	N	2	2	24	186	121	3.25	0.66	81.25	9
	%	0.6%	0.6%	7.2%	55.5%	36.1%				
Q9 The midwife takes complete care of you after birth	N	2	0	12	159	162	3.42	0.62	85.50	4
	%	0.6%	0.0%	3.6%	47.5%	48.3%				
Q10, I find that the place where the midwife places you after birth is suitable for you and clean	N	2	1	20	175	137	3.32	0.65	83.00	5
	%	0.6%	0.3%	6.0%	52.2%	40.9%				

Table (4.17-B): Level of mothers' satisfaction with quality of services provided after childbirth

Mothers' satisfaction level		Never	Rarely	Sometimes	Often	Always	Mean	SD	% Mean	Rank
Q11 The midwife gives your health instructions about the safe and correct way to breastfeed with a simple explanation to you about the risks you may face after birth	N	10	2	27	169	127	3.19	0.84	79.75	13
	%	3.0%	0.6%	8.1%	50.4%	37.9%				
Q12 The midwife measures your vital processes after birth	N	2	0	12	153	168	3.44	0.62	86.00	3
	%	0.6%	0.0%	3.6%	45.7%	50.1%				
Q13 The midwife places the mother on a clean and comfortable mattress	N	2	1	19	186	127	3.29	0.64	82.25	7
	%	0.6%	0.3%	5.7%	55.5%	37.9%				
Q14 The midwife listens and hears inquiries and questions	N	8	4	23	165	135	3.23	0.82	80.75	10
	%	2.4%	1.2%	6.9%	49.3%	40.2%				
Q15 The midwife gives your health instructions about the safe and correct way to breastfeed	N	15	3	19	164	134	3.19	0.92	79.75	15
	%	4.5%	0.9%	5.6%	49.0%	40.0%				
Q16 The midwife gives the mother instructions about the importance of continuing breastfeeding	N	16	3	27	156	133	3.15	0.96	78.75	16
	%	4.8%	0.9%	8.0%	46.6%	39.7%				
Q17 The baby is placed on his mother's chest immediately after birth to practice breastfeeding	N	19	2	10	128	176	3.31	0.99	82.75	6
	%	5.7%	0.6%	3.0%	38.2%	52.5%				
Q18 The midwife explains to the mother the importance of personal hygiene and caring for the episiotomy	N	19	3	11	160	142	3.2	0.98	80.00	12
	%	5.7%	0.9%	3.2%	47.8%	42.4%				
Q19 The midwife provides advice to the mother before leaving about the diet	N	17	2	17	152	147	3.22	0.96	80.50	11
	%	5.1%	0.6%	5.1%	45.3%	43.9%				
Q20 The midwife advises the mother on how to care for the newborn before leaving.	N	16	3	18	133	165	3.27	0.96	81.75	8
	%	4.8%	0.9%	5.4%	39.6%	49.3%				
Q21 The baby is kept warm while with its mother.	N	5	0	11	90	229	3.6	0.69	90.00	1
	%	1.5%	0.0%	3.3%	26.8%	68.4%				
Total							**3.25**	**0.53**	**81.25**	

Table 4.17-A and B summarize the distribution of study participants according to their responses regarding satisfaction with the quality of services provided to them in hospitals after childbirth. According to the results, the highest-rated item was item number 21, "The baby is kept warm while with its mother," with a percentage mean of 90.0%. This was followed by item number 3, "The midwife maintains the mother's privacy as much as possible," with a percentage mean of 86.75%, and item number 12, "The midwife measures your vital processes after birth," with a percentage mean of 86.0%. On the other hand, the lowest-rated item was item number (1), "The midwife introduces himself and his role in providing health services," with a percentage mean of 73.5%. This was followed by item number (6), "The midwife provides a sufficient number of nurses," with a percentage mean of 75.75%. The overall satisfaction level had a mean percentage of 81.25%.

4.2.3 Differences in mothers' satisfaction with the quality of services provided after childbirth attributed to sociodemographic factors

Table (4.18): Differences in mothers' satisfaction with quality of services related to sociodemographic factors

Factor	Categories	N	Mothers' satisfaction level			Statistical Analysis		
			Mean	SD	%Mean	t	F	P-value
Age groups	25 or less	163	3.24	0.56	81.00		0.291	0.748
	26-30	102	3.23	0.55	80.75			
	More than 30	70	3.29	0.37	82.25			
Hospital	AL Helou International Hospital	27	3.31	0.50	82.75		0.429	0.732
	Patient's Friend Benevolent Society	63	3.25	0.27	81.25			
	AssAHABA Medical Complex- Gaza, Palestine	195	3.25	0.54	81.25			
	Al-Awda Hospital	50	3.18	0.70	79.50			
Academic degree	Secondary school or less	42	3.15	0.81	78.75		1.419	0.237
	Diploma	127	3.31	.51	82.75			
	Bachelor's degree	160	3.22	.40	80.50			
	Postgraduate studies	6	3.09	.11	77.25			
Marital status	Married	333	3.25	0.53	81.25	0.170		0.865
	Divorced/widow	2	3.31	0.37	82.75			
Number of births	2 or less	149	3.22	0.51	80.50		0.873	0.418
	3-4	143	3.29	0.57	82.25			
	More than 4	43	3.19	0.43	79.75			
Number of pregnancies	2 or less	98	3.17	0.50	79.25		2.004	0.136
	3-4	150	3.31	.48	82.75			
	More than 4	87	3.23	.61	80.75			
Does the mother work (employee)	Yes	43	3.23	0.49	80.75	-0.247		0.805
	No	292	3.25	0.53	81.25			
Place of birth Gaza	Central Gaza	291	3.25	0.53	81.25		0.215	0.807
	Mid Zone	42	3.23	0.51	80.75			
	South Gaza	2	3.02	0.03	75.50			

*Significant at P≤0.05; P>0 05: Not significant; N: number of subjects; SD: standard deviation; F: One-way ANOVA & t: independent t test.

Table 4.18 presents the mean differences in the mothers' satisfaction level with the quality of services provided in hospitals after childbirth, based on socio-demographic factors. The results from the ANOVA and t-tests indicate that there were no statistically significant differences in satisfaction levels across all examined socio-demographic variables mention socio-demographic variables such as age groups, hospital, academic degree, marital status, number of births, number of pregnancies, does the mother work (employee), place of birth Gaza ($P > 0.05$).

Chapter Five

Discussion

This chapter presents an in-depth discussion of the results, which were compared with previous studies and available literature.

5.1.1 Care provided to the newborn for the first six hours after birth

The results showed a high mean percentage for perceptions of newborn care. This result was consistent with previous studies that indicate effective newborn care is crucial for ensuring early health stability. Emergency response, safety monitoring, and documentation were the highest proportions, while observations such as urine monitoring and chest circumference measurement were the lowest proportions (Mokhtar et al., 2023; Begum et al., 2022). Rodrigues Monteiro et al. (2023) emphasized that immediate care practices, including monitoring and professional intervention, contribute significantly to newborn well-being.

In my opinion, quality care in the first six hours is critical in reducing neonatal morbidity and mortality. The high overall mean percentage for perceptions of newborn care in the first six hours after birth indicates that the care provided during this crucial immediate postnatal period is generally perceived as effective, timely, and appropriate by those involved midwives. This result reflected good practice adherence. It suggested that essential newborn care protocols such as thermal protection, early breastfeeding initiation, monitoring of vital signs, and hygienic practices are likely being followed consistently. This result is encouraging as it validates midwives' efforts and encourages continued adherence to newborn care standards.

5.1.2 Maternal care within the first 6 hours after birth

The results showed a high mean percentage for perceptions of midwifery care. Previous studies indicate that midwifery care practices play a good role in postnatal maternal care (Nyagah, 2020). Esan et al. (2020) and Taneja et al. (2021) reported that proper documentation and postpartum monitoring significantly enhance the quality and safety of maternal care services.

Conversely, lower results obtained by Pindani et al. (2020) showed that percentages reported by midwives regarding client monitoring varied and were below the 80% threshold. Midwives did not always follow the reproductive health standards on client examination, so that less than 75% of midwives inspected perineal wounds (52.2%), checked vital signs of neonate (66.7%) and mother (62.2%), and inspected lochia drainage (30.4%). Most

midwives (91.3%) never assessed the mother's emotional state. In addition, the results of Ali et al. (2022) showed that the vast majority of nurse-midwives expressed fair level of practices in IPP care, and poor practices was in items such as washing hands before contact with mothers, immediate assessment at birth; a complete clinical examination around one hour after birth and again before discharge, monitor and record mother vital signs during first hour after birth, educate the mother about breastfeeding, and encourage the mother to initiate breast feeding within 30 min. after birth.

From the researcher's point of view, the first six hours postpartum involve physical recovery (e.g., uterine monitoring, bleeding control, pain management), emotional reassurance, and support. High perception scores suggest that midwives are addressing these aspects well. High midwifery care within the first six hours after birth reflects positively on maternal care quality, attentiveness, and responsiveness during a critical recovery period. This suggests that midwives effectively meet postpartum women's immediate physical and emotional needs, which is essential for maternal wellbeing and early bonding with the newborn. This finding underscores the value of skilled, woman-centred midwifery care and its role in ensuring a safe and positive postpartum experience. It also provides a strong foundation for continued investment in midwifery training, support systems, and staffing to sustain high standards.

5.1.3 Association between quality of immediate postpartum care and sociodemographic factors

The results showed significant differences between hospitals in the average of QoPPC. Some previous studies showed differences in Qoppc between hospitals, which were attributed to hospital-specific factors affecting maternal and neonatal care. Also, these studies reported that institutional policies and healthcare provider practices influence these variations in neonatal care quality (Mortensen et al., 2019).

The significant differences between hospitals in the average quality of immediate QoPPC suggest that institutional factors are crucial in shaping the quality of care women receive, more than individual sociodemographic characteristics. This may imply variability in hospital practices. This finding shifts the focus from individual-level interventions (based on sociodemographics) to system-level improvements, potentially having a broader and sustainable impact on maternal care quality. Therefore, focus must be directed towards inconsistencies in protocols between different hospitals, staff training, resources, or management priorities that directly impact care quality.

The current study also indicated no statistically significant differences between age groups regarding QoPPC. These results differ from those of Mollart et al. (2025), who found that standardized midwifery care models lead to consistent birth outcomes across different age groups and that midwifery care and newborn care practices varied according to age group. Whereas Arba and Zana (2020) and Nove et al. (2021) reported that experience and training may have a greater influence on maternal and newborn care than age alone, they also showed that age did not play a significant role in the variations in the QoPPC.

The researcher believes that the absence of significant differences in the average QoPPC based on midwives' age suggests that midwives across all age groups deliver care at a comparable quality level. This could indicate that midwives are committed to professional standards, patient-centred care, and consistency in care delivery regardless of a midwife's

age. This finding supports the idea that ongoing professional development and institutional guidelines may be more influential in maintaining care quality than individual characteristics like age.

In addition, this study's results indicated no statistically significant differences in Qoppc related to the academic degree of the study participants. Similar results were obtained by Engstrom and Cockerham (2025), who found no association between the qualification of health care providers and the quality of care. Also, the results of Sendo et al. (2025) reflected that academic degree alone does not affect the level of practice, and that practical experience and training may have a greater influence on maternal and newborn care. In contrast, these results differ from the results of Escuriet et al. (2025), which indicated that midwifery care and newborn care practices were perceived differently based on academic qualifications and educational background.

Moreover, this study's results indicated no statistically significant differences in QoPPC related to marital status. This result was inconsistent with the results of Jolivet et al. (2025), which demonstrated that marital status influences maternal and newborn care and outcomes. Alanazy and Aljohani (2025) and Heidarian et al. (2025) showed that experience, training, and workplace factors may impact maternal and newborn care more than marital status alone.

This result suggests that midwives maintain a consistent care standard in the postpartum period regardless of marital status. That is a positive finding, as it points to the professionalism of the workforce and potentially to the effectiveness of training, guidelines, and institutional protocols that guide postpartum care delivery.

Also, the current study's results indicated no statistically significant differences in QoPPC related to years of experience. This result was inconsistent with the results of Gordon et al. (2025), which demonstrated that experience in maternal health settings significantly impacts the Qoc and decision-making processes. In addition, Chen et al. (2023) and Cardona-Arias et al. (2024) showed that other factors, such as training, institutional support, and continuous education, may impact maternal and newborn care more than years of experience alone.

This result suggests that when midwives enter the workforce, they are generally well-prepared to provide competent care and that institutional systems help maintain care quality across different experience levels. It also indicated that less experienced midwives can deliver postpartum care at a quality comparable to that of their more experienced counterparts. That could reflect the strength of pre-service education and training programs, clinical guidelines and protocols, and supportive supervision and mentoring practices.

The current study's results indicated no statistically significant differences in immediate care for the mother related to income. This result differs from the results of Nove et al. (2024), which showed that income levels and financial stability could impact the quality of midwifery care. While Kumar et al. (2023) reported that barriers related to income and economic conditions may not be solely influenced by midwives' ability to provide optimal care, they also suggested that training and institutional support may have a greater impact on maternal and newborn care than income alone.

This result may reflect a strong sense of professional responsibility and ethical standards among midwives, where income disparities do not influence the quality of care they provide. Regardless of what they earn, midwives still consistently deliver a consistent level of immediate postpartum care.

The results also indicated no statistically significant differences in QoPPC attributed to the place of residency. In this regard, Cummins et al. (2024) demonstrated that midwifery services, when structured within an evidence-based framework, can help bridge care quality gaps across different residential areas. They also suggested that institutional policies and healthcare models may influence maternal and newborn care more than the place of residence alone. In contrast, the results of Musaddiq (2023) illustrated that the place of residence can influence access to maternal healthcare and the availability of midwifery services, particularly in rural and urban settings.

This result suggests that midwives provide consistent postpartum care regardless of whether they live in the city or other rural areas. That points to a strong, standardized approach to training, practice, and care expectations across different geographic settings.

The results also indicated no statistically significant differences in QoPPC between those who received special training in maternal and newborn care after childbirth and those who did not. Stoodley et al. (2023) and Norris et al. (2024) found that receiving training did not significantly influence the QoPPC, and they emphasized the role of academic study, such as specialist diplomas, in advancing midwifery practices; they also suggested that institutional policies and on-the-job experience may have a greater influence on maternal and newborn care than training alone. On the other hand, the results of Mwakawanga et al. (2023) reflected that specialized training enhances midwives' competencies and improves maternal and newborn care outcomes. In addition, the results of Abu Kwaik (2025) indicated significant improvement in midwives' practice about immediate postnatal care after the education program (m= 1.95) compared to practice before the educational program (m= 1.74). There was a statistically significant improvement in participants' practice about care provided to the mothers and babies after one hour post-delivery, after the education program (m= 1.97) compared to practice before the educational program (m= 1.68).

This result may reflect that pre-service education and on-the-job experience provide a strong enough foundation that additional training does not create a noticeable difference, at least not in measurable outcomes related to immediate postpartum care. Also, the content, delivery method, or duration of the special training might not have been sufficiently impactful, or it may not have been practically applied in the clinical setting. Sometimes training programs are more theoretical than hands-on, which limits their effect on real-world practice.

The current study indicated no statistically significant differences in QoPPC related to work shifts. This result was inconsistent with the results of Anjur and Darmstadt (2023), which revealed that shift-based work systems can affect the quality of maternal and newborn care due to variations in staff availability, workload distribution, and fatigue levels. Additionally, Jullien and Carai (2023) reported that healthcare inefficiencies, including work shift arrangements, can contribute to variations in patient care. They also concluded that standardized protocols and hospital management strategies may influence maternal and newborn care more than shift structures alone.

Moreover, Öjendal et al. (2023) revealed that factors affecting providing high-quality postpartum care services could be divided into three generic categories. Difficulty achieving high attendance comprised three subcategories: long waiting times, low awareness among women, and out-of-pocket payment. Lack of basic resources also comprised three subcategories: shortage of healthcare providers, lack of adequate space, and inadequate medical equipment. Insufficient care routines comprised two subcategories: lack of guidelines and deficient chain of information. In addition, Bune et al. (2023) reported that some factors influence the ability to provide quality IPPC, including receiving basic emergency obstetrics and newborn care training, and the availability of maternal and newborn care guidelines in the hospital.

This finding suggests that midwives maintain a consistent standard of care across different shifts, which reflects professionalism and dedication regardless of the time of day. It also implies that the structure of postpartum care processes is resilient, even during potentially more challenging night shifts. While shift timing might not influence measurable care quality, night shifts are often associated with fatigue, stress, and reduced alertness. These factors might not have been visible in the study's outcome measures but could affect long-term performance or well-being.

5.1.4 Correlation between studied domains among the study participants

The results of the current study indicated a statistically significant positive correlation between care provided to the newborn in the first six hours after birth and midwives' practice of maternal care within the first six hours after birth.

These results agreed with the results of Turan and Derya (2021), who found that midwifery care directly impacts maternal and neonatal outcomes, enhancing both postpartum care and maternal attachment. Whereas Liu et al. (2021) and Bagheri et al. (2021) emphasized that midwife-led care models improve patient satisfaction and overall maternal and newborn care, they also suggested that an integrated approach to midwifery practices can strengthen care continuity and improve health outcomes. They demonstrated that all maternal and newborn care aspects are interconnected, reinforcing the importance of a holistic approach to midwifery services.

The correlation points to a comprehensive, integrated approach to care, where attention to the mother’s needs is naturally linked with attentiveness to the newborn and the professionalism of the midwives. Also, this result revealed that rather than fragmented or task-focused care, this relationship implies a well-functioning care environment, where midwives are likely following standard procedures and prioritizing maternal and newborn health together.

5.2 Mothers' satisfaction with the quality of postpartum care

5.2.1 Level of mothers’ satisfaction with the quality of services provided to them

The results showed that the overall satisfaction level was high. Mothers were highly satisfied with keeping their babies warm, maintaining privacy, and assessing and following up after birth. These results were approximately the results of Al-Hussainy et al. (2021), which indicated that the mothers were generally satisfied with the postnatal care and overall maternity care provided in the King Khalid Hospital, and the results of Amu and Nyarko

(2019) found moderate satisfaction with IPPC. Also, the results of Ahmadinezhad et al. (2021) revealed that mothers had a good perception about postnatal care provided by health center staff, and the results of Bekele et al. (2022) concluded that mothers' satisfaction with IPPC was moderate (60.9%).

In contrast, the results of this study disagreed with those of Nuwabaine et al. (2024), which found that less than half of the mothers were satisfied with the quality of postnatal care, and Aboagye et al. (2022), which found that less than half of the mothers had skin-to-skin contact with their babies.

Eshetu et al. (2025) reported that enhancing communication and staffing can further optimize postnatal care experiences. In addition, Kidane et al. (2023) emphasized the significance of maternal satisfaction in assessing the quality of postnatal healthcare in maternity hospitals.

In my opinion, the high overall level of mothers' satisfaction with the service quality indicates that the care experience was positive, respectful, and responsive to mothers' needs. Satisfaction is a key indicator of not just how services are delivered, but how they are perceived by recipients, making it a vital component of quality assessment in maternal care. When the mothers reported satisfaction with their care, the health services met their expectations. Also, high satisfaction levels often suggest that mothers felt heard, supported, and safe during a vulnerable period, factors that are critical for emotional wellbeing and trust in the healthcare system.

The researcher believes that a high satisfaction level is a strong endorsement of the service delivery system. It suggests that the healthcare team effectively supports maternal care needs and provides a positive environment for recovery and transition into motherhood. Maintaining this high standard while proactively seeking feedback and areas for improvement will be key to sustaining and enhancing service quality over time.

5.2.2 Association between mothers' satisfaction with health services and socio-demographic factors

There were statistically no significant differences in satisfaction levels across all examined socio-demographic variables (age groups, hospitals, academic degrees, marital status, number of births, number of pregnancies, employment status, or place of birth). These results agreed with the results of Okorie et al. (2025), which demonstrated that maternal satisfaction with hospital services after childbirth was consistent across different socio-demographic groups. Also, Barman and Bhuyan (2024) found no statistically significant differences in mothers' satisfaction with care related to socio-demographic factors. In addition, the results of Nuwabaine et al. (2024) found that older women aged 35 - 49 years, those who made decisions to seek health care jointly, women who received quality antenatal care, older women aged 30 - 34 years at the time of their first childbirth, those who gave birth through cesarean section birth, those who gave birth at public health facilities, and those who received quality intrapartum care were more likely to be satisfied with QoPPC. Skin-to-skin contact with the newborn indicates mothers' satisfaction with the services they receive immediately after birth. Factors that contributed to the higher prevalence of skin-to-skin contact included male newborns, being the first baby for the mother, low birth weight babies, those who delivered through normal delivery, and babies who were not twins (Aboagye et al., 2022).

The absence of statistically significant differences in satisfaction levels across socio-demographic variables suggests that other factors may influence satisfaction more than individual or background characteristics. Factors such as interpersonal interactions, quality of care, expectations, attitudes, and waiting time may be more influential in determining satisfaction than demographic characteristics.

Chapter Six

Conclusion and Recommendations

6.1 Conclusion

The study included 72 midwives and 335 mothers from three maternity hospitals in GS. The result indicated high quality of newborn care immediately after birth (88.2%). The results reflected high maternal care practice within the first six hours after birth (89%). There were significant differences in the quality of immediate postpartum care between hospitals. In contrast, no significant differences existed in other factors (age, marital status, level of education, experience, income, previous training). There was a statistically significant relationship between care provided to the newborn and care provided in the first six hours after birth. Mothers expressed high satisfaction with the overall health services they received during their hospital stay (81.25%). There were no statistically significant differences in mothers' satisfaction with health services related to their age, hospital, level of education, marital status, number of births, number of pregnancies, work status, and place of birth. In general, the study reflected high quality of immediate postpartum care provided to mothers, and mothers reported high satisfaction with the services they received. The findings highlight the strengths of postpartum care while identifying key areas for enhancement, emphasizing the need for improved communication and staffing in maternal healthcare services.

6.2 Recommendations

Based on the study results, the researcher recommended the following:

Recommendation for midwives:

1. Midwives from different hospitals should receive unified training programs to ensure consistency in postpartum care provided to mothers.
2. There is a need to encourage effective communication and emotional support for mothers postpartum.
3. Midwives should give the mother adequate information about the danger signs for her and the newborn.
4. Midwives should monitor bleeding for all mothers every hour during the first 6 hours after birth.
5. Midwives should focus on educating and encouraging early breastfeeding as soon as possible.

Recommendation for policymakers:

1. The Ministry of Health should implement a unified protocol and guidelines for immediate postpartum care in all governmental and private maternity hospitals.
2. Allocate resources for regular workshops and training programs to ensure midwives remain updated on best practices in postpartum care.
3. Establish a steering committee to set plans and monitor the quality of postpartum care and maternal services in all the maternity departments.
4. To ensure safe and quality care in maternity hospitals, a key that determines the number of midwives according to workload should be adopted.

6.3 Suggestions for further studies

1. Conduct further studies involving all the maternity hospitals to gain a broader vision and the ability to generalize the results.
2. Conduct comparative studies to identify differences in postpartum care quality between governmental and private hospitals.
3. Conduct qualitative studies to gain deeper insights into mothers' experiences and satisfaction with postpartum care, which will inform patient-centred improvements.

References

Abebaw, W. A., Wolde, H. F., Tilahun, W. M., Gebreegziabher, Z. A., & Teshome, D. F. (2024). Quality of childbirth care and its determinants along the continuum of care among pregnant women who gave birth vaginally in Gondar town public health facility, Northwest Ethiopia, 2022: generalized structural equation modelling. *BMJ open*, *14*(4), e073199.

Aboagye, R., Okyere, J., Dowou, R., Adzigbli, L., Tackie, V., & Ahinkorah, B. (2022). Prevalence and predictors of mother and newborn skin-to-skin contact at birth in Papua New Guinea. *BMJ Open*, 12:e062422. doi:10.1136/bmjopen-2022-062422.

Abu Kwaik, D. (2025). Effect of a design training program on midwives' knowledge and practice regarding postnatal care at Al Helal Al Emaraty Maternity Hospital, Gaza Strip - Palestine (2021 – 2023). *Unpublished Doctoral Dissertation*, Al-Butana University, Republic of Sudan.

Ahmadinezhad, M., Vizeshfar, F., & Pakniat, A. (2021). Mothers' perceptions of the quality of postnatal care provided in health centers and the associated factors: A cross-sectional study. *IJCBNM*, 10(2),110-119.

Alanazy, W., & Aljohani, R. (2025). The Role of the Midwifery Workforce and Its Impact on Burnout in Hospitals in Saudi Arabia. *Advances in Human Biology*, 10-4103.

Albeit F. M. A. (2020). Effects of a Helping Mothers Survive Bleeding After Birth In-Service Training for Maternity Staff: A Cluster-Randomized Trial and Mixed-Methods Evaluation (Doctoral Dissertation), Karolinska Institute, Sweden.

Al-Hussainy, R. H., Fouly, H., Hashish, A., & Aly, E. (2022). Gap Analysis: Quality and Women's Satisfaction Regarding Postnatal Care. *The Open Nursing Journal*, *16*(1),1–9.

Ali, S. H., & Ghafel, H. H. (2022). Evaluation of nurse-midwives' practices about immediate postpartum care for mothers—Pakistan *Journal of Medical and Health Sciences, 16(3),* 1069.

Alkasseh, A., Mwaafy, S., Abu El Noor, N, Abu El Noor, M. (2020). Clients' perception toward quality of postnatal care in the Gaza Strip, Palestine: A direction for health policy. *Published Master's Degree Thesis*, Al Quds University, Palestine.

Amu, H., & Nyarko, SH. (2019). Satisfaction with maternal healthcare services in the Ketu South municipality, Ghana: A qualitative case study. *BioMed Res Int*, 2019: 2516469.

Anderson, R., Williams, A., Jess, N., Read, J. M., & Limmer, M. (2022). The Impact of Professional Midwives and Mentoring on the Quality and Availability of Maternity Care in Government Sub-District Hospitals in Bangladesh: A Mixed-Methods Observational Study. *BMC Pregnancy and Childbirth*, 22(1), 827.

Anjur, K. I., & Darmstadt, G. L. (2023). Separation of maternal and newborn care in US hospitals: a systemic threat to survival, health and well-being. *Health Systems & Reform, 9*(1), 2267255.

Arba, A., & Zana, Z. (2020). Knowledge of essential newborn care and associated factors among nurses and midwives: A cross-sectional study at public health facilities in Wolaita zone, Southern Ethiopia, 2019. *International Journal of Paediatrics, 2020*, 1, 3647309.

Ayalew, G., Gessesse, A. D., Tigabu, D., Admass, Z. E., Girma, B., Ayehu, M., & Gudayu, T. W. (2024). Timely initiation of breastfeeding and its associated factors among immediate postpartum mother-newborn pairs in Debre Tabor Comprehensive Specialized Hospital, South Gondar Zone, Northwest Ethiopia. *BMC Pregnancy and Childbirth*, *24*(1), 735.

Ayehu, T., Tiruneh, G. T., Tesfaye, C., Belete, M., Fesseha, N., Semahegn, A., ... & Emaway, D. (2025). Facility readiness and the experience of women and healthcare providers in receiving and delivering obstetric care in comprehensive health posts in Ethiopia: a mixed-methods study. *BMC Health Services Research*, *25*(1), 303.

Bagheri, A., Simbar, M., Samimi, M., Nahidi, F., Alavimajd, H., & Sadat, Z. (2021). Comparing the implications of midwifery-led care and the standard model on maternal and neonatal outcomes during pregnancy, childbirth and postpartum. *Journal of Midwifery & Reproductive Health*, 9(3).

Balde, M. D., Diallo, A., Soumah, A. M., Barry, F., Touré, A. O., & Camara, S. (2021). Barriers to Utilization of Postnatal Care: A Qualitative Study in Guinea. *Open Journal of Obstetrics and Gynecology*, *11*(04), 391.

Barman, S., & Bhuyan, H. (2024). Level of satisfaction and practices regarding antenatal care services among pregnant women under Panikhaiti Mini Primary Health Centre. *Journal of Perinatal, Pediatric and Neonatal Nursing*, 21–31.

Bawazir, A. A. (2023). Perspective Chapter: Contemporary Challenges in Postnatal Care in Low- and Middle-Income Countries. In *Contemporary Challenges in Postnatal Care*. IntechOpen.

Begum, R., Riaz, S., Munir, A., Ghaffar, T., & Bibi, S. (2022). Assessment of Nurses' and Midwives' Knowledge Regarding Immediate Newborn Care: Knowledge of Nurses Regarding Immediate Newborn Care. NURSEARCHER (*Journal of Nursing & Midwifery Sciences*), 06-10.

Bekele, S. B., Yirdaw, B. W., Abuhay, M., & Gebremichael, M. A. (2022). Immediate Postnatal Care Satisfaction and Associated Factors Among Postnatal Women in Public Health Facilities at Debre Markos Town, Northwest Ethiopia, 2021. *Patient preference and adherence*, 137-147.

Benova, L., Dennis, M. L., Lange, I. L., Campbell, O. M., Waiswa, P., Haemmerli, M., ... & Lynch, C. A. (2018). Two Decades of Antenatal and Delivery Care in Uganda: A Cross-Sectional Study Using Demographic and Health Surveys. *BMC Health Services Research*, *18*, 1–15.

Biswas, T. K., Sujon, H., Rahman, M. H., Perry, H. B., & Chowdhury, M. E. (2019). Quality of Maternal and Newborn Healthcare Services in Two Public Hospitals of Bangladesh: Identifying Gaps and Provisions for Improvement. *BMC pregnancy and childbirth*, *19*, 1–11.

Borovac-Pinheiro, A., Priyadarshani, P., & Burke, T. F. (2021). A Review of Postpartum Hemorrhage in Low-Income Countries and Implications for Strengthening Health Systems. *International Journal of Gynecology & Obstetrics*, *154*(3), 393–399.

Bune, A. G., Girmaye, E., Lemma, D., & Bekele, G. G. (2023). Implementing Immediate Postnatal Care Guidelines and Associated Factors among Healthcare Providers in East Shewa Zone Public Health Facilities, Oromia, Ethiopia, 2022: A Multicenter Cross-Sectional Study. *BMJ open*, *13*(12), e077434.

Cardona-Arias, J. A., Gómez-Mejía, N., & Patiño-Ocampo, M. (2024). Mixed study on barriers to access to prevention, diagnosis and treatment of gestational malaria in pregnant women at risk from an endemic region of Colombia. *Malaria Journal*, 23(1), 394.

Chen, S., Wang, R., Xu, N., Zhang, J., Liu, Y., Cong, S., & Zhang, A. (2023). Identifying Factors Influencing the Promotion of Core Competence Among Professional Nurses and Midwives: A Qualitative Study Using the COM-B Model. *Nurse Education in Practice*, *69*, 103619.

Cummins, A., Booth, C., Lennon, K., McLaughlin, K., Prussing, E., & Newnham, L. (2024). "A Safe Space": A Statewide Evaluation of Midwifery Antenatal and Postnatal Service (MAPS) Using the Quality Maternal Newborn Care, Evidence-Informed Framework. *Women and Birth*, *37*(5), 101642.

Daemers, D. O., van Limbeek, E. B., Wijnen, H. A., Nieuwenhuijze, M. J., & de Vries, R. G. (2017). Factors Influencing the Clinical Decision-Making of Midwives: A Qualitative Study. *BMC pregnancy and childbirth*, *17*, 1-12.

Dey, T., Ononge, S., Weeks, A., & Benova, L. (2021). Immediate postnatal care following childbirth in Ugandan health facilities: An analysis of Demographic and Health Surveys from 2001 to 2016. *BMJ global health*, *6*(4), e004230.

Dickson, K. S., Ayebeng, C., Adu-Gyamfi, A. B., & Okyere, J. (2023). Postnatal care service utilization for babies within the first two months after childbirth: an analysis of rural-urban differences in eleven Sub-Saharan African countries. *BMC Pregnancy and Childbirth*, *23*(1), 423.

Doctors without Borders (2024). Gaza: Maternal and child health suffer under a decimated system. https://www.doctorswithoutborders.org/latest/gaza-maternal-and-child-health-suffer-under-decimated-system.

Dona, A., Tulicha, T., Arsicha, A., & Dabaro, D. (2022). Factors Influencing the Utilization of Early Postnatal Care Services among Postpartum Women in Yirgalem Town, Sidama Regional State, Ethiopia. *SAGE Open Medicine*, *10*, 20503121221088098.

El-Khawaga, D. S, Ahmed, M. H., & Elwelely, M. Z. (2019). Effect of Implementing a Teaching Program on Nurses' Knowledge and Practice of Immediate Postpartum Care. *Tanta Scientific Nursing Journal*, *16*(1), 95–112.

Engstrom, J. L., & Cockerham, A. Z. (2025). An archetype for the doctoral-prepared advanced practice nurse: Mary Bristow Willeford (1900–1941), nurse-midwife and doctor of philosophy. *Journal of Professional Nursing*, 58, 10-16.

Esan, D. T., Adedeji, O. A., Bello, C. B., & Omolafe, M. C. (2020). Knowledge and Practices of Immediate Newborn Care among Midwives in Selected Healthcare Facilities in Ekiti State, Nigeria. *Pan African Medical Journal*, *37*(1).

Escuriet, R., Binfa, L., & Pantoja, L. (Eds.). (2025). *Quality of Sexual and Reproductive Health Care: Strengths, Gaps, and Challenges for Midwifery Care*. Frontiers Media SA.

Eshetu, T., Fekadu, E., Abdella, A., Mulushoa, A., Medhin, G., Belina, M., & Hanlon, C. (2025). Towards Person-Centred Maternal and Newborn Care in Ethiopia: A Mixed-Methods Study of Satisfaction and Experiences of Care. *BMC Pregnancy and Childbirth*, *25*(1), 85.

Chauhan, G., & Tadi, P. (2020). Physiology, postpartum changes. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK555904.

Girma, M., Robles, C., Asrat, M., Hagos, H., Gslassie, M., & Hagos, A. (2020). Community Perceptions Regarding Maternity Service Provision in Public Health Institutions in 2018 and 2019: A Qualitative Study. *International Journal of Women's Health*, 773-783.

Gordon, R. D. A., Kishi, A., Brown, J. A., Voisin, C., Thomas, N., Riley, S. R., & Brill, S. B. (2025). Rural Maternal Health Interventions: A Scoping Review and Implications for Best Practices. *The Journal of Rural Health*, 41(1), e70007.

Goshu, M., Godefay, H., Bihonegn, F., Ayalew, F., Haileselassie, D., Kebede, A., & Gidey, G. (2018). Assessing the Competence of Midwives to Provide Care During Labor, Childbirth, and the Immediate Postpartum Period: A Cross-Sectional Study in the Tigray Region, Ethiopia. *PloS one*, *13*(10), e0206414.

Hailemeskel, S., Alemu, K., Christensson, K., Tesfahun, E., & Lindgren, H. (2022). Midwife-led continuity of care increases women's satisfaction with antenatal, intrapartum, and postpartum care: North Shoa, Amhara Regional State, Ethiopia: A quasi-experimental study. *Women and Birth*, *35*(6), 553-562.

Heidari, M., Pour, H., Norouzzadeh, R., Temel, E., & Şahin, B. (2017). Assessment of patients' satisfaction related to the quality of care: A Cross-sectional descriptive study. *Asian Journal of Medicine and Health*, *5*(4), 1-8.

Heidarian, H., Mehrabi, M., Ghaemmaghami, P., & Janghorban, R. (2025). Effect of E-learning clinical management of substance-dependent pregnant women on the knowledge and clinical skill performance of midwives: a randomized controlled trial. *BMC pregnancy and childbirth*, *25*(1), 11.

Hug, L., Alexander, M., You, D., & Alkema, L. (2019). National, regional, and global levels and trends in neonatal mortality between 1990 and 2017, with scenario-based projections to 2030: a systematic analysis. *The Lancet Global Health*, *7*(6), 710-720.

Hussen, A. M., Semaan, A., Tilahun, B., Tunçalp, Ö., Grobbee, D. E., & Browne, J. L. (2023). Trends and factors associated with immediate postnatal care utilization in Ethiopia: analysis of the demographic and health surveys, 2011-2019. *Journal of Global Health Reports*, *7*, e2023022.

Jolivet, R. R., Gausman, J., & Langer, A. (2025). Measuring social, economic, policy, and health system determinants of maternal health and survival: An urgent global priority. *PloS one*, *20*(1), e0317095.

Jullien, S., & Carai, S. (2023). Wasting resources in healthcare– unnecessary hospitalizations and over-medicalization: The health workers' or the healthcare system's fault? Evidence from Romania and Tajikistan: Implications for Global Health. *Journal of Global Health*, *13*, 03018.

Institute of Palestine Studies (2025). Al Helou International Hospital. https://gazahcsector.palestine-studies.org/en/node/14.

Kebede, A. A., Taye, B. T., Wondie, K. Y., Tiguh, A. E., Eriku, G. A., & Mihret, M. S. (2021). Healthcare provider's adherence to immediate postpartum care guidelines in Gondar province hospitals, northwest Ethiopia: A multicenter study. *Plos one*, 16(10), e0259263.

Kikuchi, K., Yasuoka, J., Nanishi, K., Ahmed, A., Nohara, Y., Nishikitani, M., ... & Nakashima, N. (2018). Postnatal care could be the key to improving the continuum of care in maternal and child health in Ratanakiri, Cambodia. *PloS one*, *13*(6), e0198829.

Kimiaeimehr, F., Hosseini, S. M., Alimohammadzadeh, K., Bahadori, M., & Maher, A. (2019). The study of factors affecting the implementation of clinical guidelines in Iran. *Journal of military medicine*, *21*(3), 300-310.

Konje, E. T., Hatfield, J., Sauve, R., Kuhn, S., Magoma, M., & Dewey, D. (2021). Late initiation and low utilization of postnatal care services among women in rural settings in Northwest Tanzania: A community-based study using a mixed-methods approach. *BMC Health Services Research*, *21*(1), 635.

Koome, D. I. (2023). Effect of a Training Intervention on the Utilization of Maternal Health Quality of Care Standards Among Nurse-Midwives in Embu and Meru Teaching and Referral Hospitals, Kenya (*Doctoral Dissertation*), University of Nairobi.

Kumar, R., Mehraj, V., Ahmed, J., Khan, S. A., Ali, T. M., Batool, S., & Pongpanich, S. (2023). Barriers Experienced by Community Midwives to Providing Basic Emergency Obstetric and Newborn Care in Rural Pakistan *BMC Health Services Research*, 23(1), 1305.

Liu, Y., Li, T., Guo, N., Jiang, H., Li, Y., Xu, C., & Yao, X. (2021). A cross-sectional survey in China shows women's experience and satisfaction with midwife-led maternity care. *BMC pregnancy and childbirth*, 21, 1–10.

Lopez-Gonzalez, D. M., & Kopparapu, A. K. (2022). Postpartum care of the new mother. In *StatPearls [Internet]*. StatPearls Publishing.

Lwelamira, J., Stephen, A., & Safari, J. G. (2015). Utilization of maternal postnatal care services among women in selected villages of Bahi District, Tanzania. *Current Research Journal of Social Sciences*, 7(4), 106-111.

Mahato, P. K., van Teijlingen, E., Simkhada, P., & Angell, C. (2018). Determinants of Quality of Care and Access to Basic Emergency Obstetric and Neonatal Care Facilities and Midwife-Led Facilities in Low- and Middle-Income Countries: A Systematic Review. *Journal of Asian Midwives*, 4(2), 25-61.

Mihret, M. S., Alemu, K., Beshah, D. T., Gezie, L. D., Erlandsson, K., & Lindgren, H. (2025). Looking into opportunities for maternity continuum of care improvement within the primary health care system in Northwest Ethiopia: primary health care-oriented research. *BMC Health Services Research*, *25*(1), 518.

Ministry of Health (MoH). (2019). Press report, July 2019, Ramallah, Palestine [https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/ home.

Mokhtar, K. M., Farah, F. M., Ibrahim, A. A. M., & Alagabna, A. A. A. (2023). *Midwives' Knowledge and Practice Regarding the Immediate Care of Newborns at Khartoum State Hospitals, 2022*. In the Second International Nursing Conference, "Nursing Profession in the Current Era" (INC, 2023) (pp. 128-139). Atlantis Press.

Mollart, L., Gibberd, A., Prussing, E., Hainsworth, N., Gillett, K., & Cummins, A. (2025). Are the birth outcomes from a midwifery antenatal and postnatal service (MAPS) comparable to those from midwifery group caseload practice? A retrospective cohort study. *Women and Birth*, *38*(2), 101870.

Mortensen, B., Lieng, M., Diep, L. M., Lukasse, M., Atieh, K., & Fosse, E. (2019). Improving maternal and neonatal health through a midwife-led continuity model of care: an observational study in a governmental hospital in Palestine. *E Clinical Medicine*, *10*, 84-91.

Musaddiq, T. (2023). The Impact of Community Midwives on Maternal Health Care Utilization. *Health Economics*, 32(3), 697–714.

Muwema, M., Kaye, D. K., Edwards, G., Nalwadda, G., Nangendo, J., Okiring, J., & Nankabirwa, J. I. (2022). Perinatal care in Western Uganda: Prevalence and factors associated with appropriate care among women attending three district hospitals. *Plos one*, *17*(5), e0267015.

Mwakawanga, D. L., Rimoy, M., Mwanga, F., Massae, A. F., Mushy, S. E., Kisaka, L,. & Sirili, N. (2023). Strengthening Midwives' Competencies for Addressing Maternal and Newborn Mortality in Tanzania: Lessons from the Midwifery Emergency Skills Training (MEST) Project. *Midwifery*, *122*, 103695.

Namutebi, M., Nalwadda, G. K., Kasasa, S., Muwanguzi, P. A., & Kaye, D. K. (2023). Midwives' perceptions of the Ministry of Health guidelines for providing immediate postpartum care in rural health facilities in Uganda. *BMC Pregnancy and Childbirth*, *23*(1), 261.

Ndugga, P., Namiyonga, N. K., & Sebuwufu, D. (2020). Determinants of Early Postnatal Care Attendance: Analysis of the 2016 Uganda Demographic and Health Survey. *BMC pregnancy and childbirth*, *20*, 1-14.

Norris, G., Martin, C. J. H., Moylan, A., & Greig, Y. (2024). A qualitative descriptive training needs analysis of midwives' perceived continuous professional development in providing intranatal respectful maternal care. *Nurse Education Today*, *136*, 106144.

Nove, A., Boyce, M., Neal, S., Homer, C. S., Lavender, T., Matthews, Z., & Downe, S. (2024). Increasing the number of midwives is necessary but insufficient: using global data to support the case for investment in both midwife availability and the enabling work environment in low- and middle-income countries—Human *Resources for Health*, 22(1), 54.

Nuwabaine, L., Namulema, A., Sserwanja, Q., Kawuki, J., Amwiine, E., Amperiize, M., ... & Asiimwe, J. B. (2024). Factors Associated with the Quality of Postnatal Care in Kenya: An Analysis of the 2022 Kenya Demographic and Health Survey. *Archives of Public Health*, *82*(1), 227.

Nyagah, A. N. (2020). Postnatal care quality among mothers within 24-48 hours of delivery in postnatal wards at Machakos County Referral Hospital, Kenya (*Doctoral Dissertation*), University of Nairobi.

Nyondo-Mipando, A. L., Chirwa, M., Kumitawa, A., Salimu, S., Chinkonde, J., Chimuna, T. J., ... & Jackson, D. (2023). Uptake of Barriers and Enablers to Utilizing Postnatal Care Services in Thyolo, Malawi. *BMC pregnancy and childbirth*, *23*(1), 271.

Öjendal, A., Holter, H., Elden, H., Salim, S., & Bogren, M. (2023). Factors Affecting the Provision of High-Quality Postnatal Care Services in Zanzibar: A Qualitative Study. *BMC Pregnancy and Childbirth*, *23*(1), 714.

Okorie, H. U., Unachukwu, G. C., & Okeke, N. U. (2025). Socio-demographic variables as predictors of academic resilience among in-school adolescents in Imo State. *Journal of Guidance and Counselling Studies*, *9*(1), 16-28.

Palestinian Central Bureau of Statistics (PCBS) (2022). Annual report. Ramallah, Palestine.

Panga, R. T & Mosha, I. H. (2024). Barriers to Early Postnatal Care Attendance among Women in Ubungo Municipality, Tanzania: A Qualitative Study. *Tanzania Journal of Health Research*, *25*(1), 582-595.

PCBS (2021). Annual report. Ramallah, Palestine.

Pindani, M., Phiri, C., Chikazinga, W., Chilinda, I., Botha, J., & Chorwe-Sungani, G. (2020). Assessing the quality of postnatal care offered to mothers and babies by midwives in Lilongwe District. *South African Family Practice*, *62*(3).

Polit, D., & Beck, C. (2020). *Essentials of Nursing Research: Appraising Evidence for Nursing Practice*. Lippincott Williams & Wilkins.

Priyanka, S. S., Dasgupta, D. P., Abdullah, A. Y. M., Ali, N. B., Khatun, H., & Billah, S. M. (2024). Assessing the Quality and Coverage of Maternal Postnatal Care in Bangladesh: A Comparative Analysis of Quality Postnatal Care among Home and Facility Births. *International Journal of Environmental Research and Public Health*, *21*(3), 359.

Rajbanshi, S., Norhayati, M. N., & Nik Hazlina, N. H. (2021). Perceptions of good-quality antenatal care and birthing services among postpartum women in Nepal. *International Journal of Environmental Research and Public Health*, 18(13), 6876.

Requejo, J. H., Bryce, J., Barros, A. J., Berman, P., Bhutta, Z., Chopra, M., ... & Victora, C. G. (2015). Countdown to 2015 and Beyond: Fulfilling the Health Agenda for Women and Children. *The Lancet*, *385*(9966), 466–476.

Rodrigues Monteiro, B., Gomes Fernandes da Silva, V., da Silva Bezerra, C. D., Galvão Pinto, E. S., & Lima de Souza, N. (2023). Immediate contact between mother and newborn in the first hour of life: *Rev Rene*, *24*(1).

Ronniey, O., Ogutu, J., Munyoki, G., & Wambugu, M. (2023). Quality of healthcare provided to mothers during the immediate postpartum period at health facilities in Kakamega County, Kenya. *Journal of Women's Health Care*, 12(11), 696.

Sacks, E., & Langlois, É. V. (2016). Post-natal care: increasing coverage, equity, and quality. *The Lancet Global Health*, *4*(7), e442-e443.

Sandall, J., Turienzo, C. F., Devane, D., Soltani, H., Gillespie, P., Gates, S., & Rayment-Jones, H. (2024). Midwife continuity of care models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews* (4). CD004667.

Sendo, E. G., Teshome, G. S., Jirata, W. K., Gebrewold, L. A., & Gemechu, R. E. (2025). Effect of "Helping Babies Breathe" Training on Ethiopian Undergraduate Midwifery Students' Knowledge and Skills in Neonatal Resuscitation at Public Universities: A Non-Randomized Quasi-Experimental Study. *SAGE Open*, Vol. 15, No. 1.

Sharrow, D., Hug, L., Liu, Y., & You, D. (2020). Levels and trends in child mortality. Report 2020, Estimates developed by the UN Inter-agency Group for Child Mortality Estimation (UN IGME). 2020. *UNICEF, WHO, World Bank Group*. https://www.unicef.org/media/79371/file/UN-IGME-child-mortalityreport 2020.pdf.

Sserwanja, Q., Musaba, M. W., Mutisya, L. M., Olal, E., & Mukunya, D. (2021). Continuum of Maternity Care in Zambia: A National Representative Survey. *BMC pregnancy and childbirth*, *21*, 1-10.

Stoodley, C., McKellar, L., Ziaian, T., Steen, M., Fereday, J., & Gwilt, I. (2023). The Role of Midwives in Supporting the Development of the Mother-Infant Relationship: A Scoping Review. *BMC psychology*, *11*(1), 71.

Taneja, G., Sarin, E., Bajpayee, D., Chaudhuri, S., Verma, G., Parashar, R., & Gera, R. (2021). Care Around Birth Approach: A Training, Mentoring, and Quality Improvement Model to Optimize Intrapartum and Immediate Postpartum Quality of Care in India. *Global Health: Science and Practice*, *9*(3), 590–610.

Tappis, H., Lak, R., Alhilfi, R., Zangana, A. H., Wadi, F., Hipgrave, D., & Ibrahim, S. (2023). Quality of Maternal and Newborn Health Care at Private Hospitals in Iraq: A Cross-Sectional Study. *BMC Pregnancy and Childbirth*, *23*(1), 331.

Tessema, Z. T., Yazachew, L., Tesema, G. A., & Teshale, A. B. (2020). Determinants of postnatal care utilization in sub-Saharan Africa: a meta and multilevel data analysis from 36 sub-Saharan countries. *Italian journal of paediatrics*, *46*, 1-11.

Tsegaye, B., Amare, B., & Reda, M. (2021). Prevalence and factors associated with immediate postnatal care utilization in Ethiopia: Analysis of the 2016 Ethiopian Demographic and Health Survey. *International Journal of Women's Health*, 257–266.

Turan, S. B., & Derya, Y. A. (2021). The effects of midwifery care provided to primiparous mothers during the postpartum period on maternal attachment and post-traumatic growth: midwifery, 103, 103140.

United Nations (2020). *The Sustainable Development Goals Report for 2020*. Geneva: United Nations. https://unstats.un.org/sdgs/report/2020/The-Sustainable-Development-Goals-Report-2020.pdf.

WHO (2018). Nurturing Care for Early Childhood Development: A Framework for Helping Children Survive and Thrive to Transform Health and Human Potential.

WHO (2018). *WHO recommendations: intrapartum care for a positive childbirth experience*. https://www.who.int/reproductivehealth.

WHO (2020). *Safe Motherhood: A Practical Guide to Postpartum Care of the Mother and Newborn*. WHO/ RHT/MSM. 1-58.

WHO. (2016). Sustainable Goals Development. https://apps.who.int/iris/bitstream/handle/10665/208272/sdg_poster_goal3_3.1_eng.pdf?sequence=1&isAllowed=y

Wickramasinghe, S. A., Gunathunga, M. W., & Hemachandra, D. K. N. N. (2019). Client perceived quality of the postnatal care provided by public sector specialized care institutions following a normal vaginal delivery in Sri Lanka: a cross-sectional study. *BMC pregnancy and childbirth*, *19*, 1-10.

World Health Organization - WHO. (2022). *WHO Antenatal Care Recommendations for a Positive Pregnancy Experience. Maternal and Fetal Assessment Update: Imaging with Ultrasound Before 24 Weeks of Pregnancy*. World Health Organization.

www.alsahaba.ps/en/index.html. Key Features of our hospital. Accessed 15.4.2025.

Zhao, S., Zhang, Y., Xiao, A., He, Q., & Tang, K. (2023). Key factors associated with postnatal care quality: a pooled analysis of 23 countries. *Clinical Medicine*, 62: 102090. www.thelancet.com.

Annexes

Annexe (1): Consent form

I am the researcher / Sohier Marouf, enrolled in the Maternal and Child Health Program.

I am conducting a study on the quality of immediate care provided to mothers and newborns after birth in the Gaza Strip's maternity hospitals.

Could you please complete the attached questionnaire honestly? Your answers will be crucial to accomplishing this research.

The information collected will be confidential and used only for scientific research purposes. Participation in the study is voluntary.

Thank you for your cooperation ‘‘‘‘

Sohier Nael Abdelrahman Marouf

Annexe (2): Quality of immediate postpartum care (Midwives' Questionnaire – English version)

Part I: Socio-demographic data of participants

Socio-demographic data	Categories
Hospital	□ Helou International Hospital
	□ Patient Friends Hospital
	□ AssAHABA Medical Complex- Gaza, Palestine
	□ Al-Awda Hospital
Age groups (years)	□ 30 or less
	□ 30-35
	□ More than 35
Academic degree	□ Diploma
	□ Bachelor's degree
	□ Postgraduate studies
Marital status	□ Single
	□ Married
	□ Divorced/widow
Number of years of experience in maternity departments/hospitals	□ 5 or less
	□ 6-10
	□ More than 10
Monthly income (NIS)	□ Less than 1000
	□ 1000-1500
	□ More than 1500
Place of residence: Gaza	□ Central Gaza
	□ Mid Zone
	□ South Gaza
Number of children in the family	□ 0 (No children)
	□ 1-3
	□ More than 30

Part II: Work status of participants

Work status	Categories
Have you received special training in maternal and newborn care after childbirth?	□ Yes
	□ No
Work system (shifts)	□ Permanent morning
	□ Different shifts (morning, evening, night)
Place of residence: Gaza	□ Central Gaza
	□ Mid Zone
	□ South Gaza
Number of training courses related to maternity and childcare	□ 2 or less
	□ More than 2
Number of cases handled daily	□ 20 or less
	□ More than 20

Part III (A): The level of care provided to the newborn for the first six hours after birth

The level of care provided to the newborn for the first six hours after birth.	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree
Q1 The newborn is placed on the mother's belly, and I make sure she is in good condition.					
Q2 The mother is sure to hold the newborn correctly.					
Q3 The EENC policy is applied, explaining its importance for the mother and newborn.					
Q4 The newborn is placed close to the mother's belly or chest for 90 minutes unless there is any impediment to that.					
Q5 The mother and newborn are kept in the delivery room for 90 minutes after birth for observation.					
Q6 The correct procedures are followed to resuscitate the newborn if he does not breathe or scream after 30 seconds of birth					
Q7 The nursery doctor is called for the newborn if I notice any abnormalities.					
Q8 My hands are washed before and after any procedure I do with the mother.					
Q9 The place is kept as clean as possible.					
Q10 The patient's privacy is maintained as much as possible					

Q11 Preventive methods are followed in dealing with cases if they are infected with infectious diseases					
Q12 The newborn's warmth and airway safety are maintained, and the color is monitored. Breathing and movements					
Q13 The newborn's identification bracelet is checked every shift and before leaving (Color according to gender, placed on the wrist, details)					
Q14 The newborn's urine is monitored					
Q15 The midwife confirms the newborn's gender					
Q16 The newborn's spine is checked for safety					
Q17 The benefits of breastfeeding are explained to the mother, and its importance is stated					
Q18 Mothers are helped and encouraged to breastfeed a third of an hour after birth					
Q19 The mother is directed to wear her clothes after birth					
Q20 The hygiene protocol and maintaining the stitches after birth are explained					
Q21 The mother is given sufficient information about the danger signs for her and the newborn					
Q22 The mother is encouraged to carry the newborn and pay attention to her					
Q23 The midwives in the postpartum department are informed and asked about their readiness to receive the mother and her child, and to transfer them					
Q24 The midwife gives the newborn a vitamin K injection after birth					
Q25 The ABGAR Score is checked for the first minute and then after 5 minutes					
Q26 The midwife takes the child to the nursery to give the vaccination if the mother is infected with Hepatitis B					
Q27 The midwife measures the weight of the newborn after birth and records it in the file					
Q28 The midwife measures the length of the newborn and records it in the file					
Q29 The midwife measures the circumference of the newborn’s head and records it in the file					

Q30 The midwife measures the circumference of the newborn's chest and records it in the file					
Q31 Everything you did is recorded in the memo					
Q32 Sufficient time is provided to listen to the mother's concerns or inquiries					
Q33 The newborn's vital signs (temperature, heart rate, respiratory rate, and oxygen saturation) are assessed and documented accurately after birth.					

Part III (B): The level of midwives practicing maternal care within the first 6 hours after birth

The level of midwives practicing maternal care within the first six hours after birth	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
Q1 The midwife measures the safe transfer policy for the mother and her newborn from the delivery room to the postpartum department after 90 minutes of birth using a wheelchair.					
Q2 The midwife applies the policy of handing over and receiving cases using the ISBAR form.					
Q3 The midwife informs the mother of the transfer of the newborn to the nursery if necessary.					
Q4 The midwife informs the mother of the department to which the baby will be transferred.					
Q5 The midwife takes vital signs every hour during the four hours after the first hour after birth.					
Q6 The midwife informs the doctor of any abnormal signs in the vital signs.					
Q7 The midwife massages the uterus and assesses its contraction or relaxation.					
Q8 The midwife assesses the amount of blood coming out of the vagina after birth every hour for 4 hours after birth.					
Q9 The mother is provided with sufficient information about the danger signs to look out for herself and the newborn.					
Q10 The midwife monitors bleeding every hour during the first 6 hours after birth.					

Q11 The midwife encourages going to the bathroom and emptying the bladder every hour during the first 6 hours after birth.					
Q12 The midwife encourages mothers to empty their bladders for the first time in the postpartum department with a reminder.					
Q13 The midwife checks for vaginal stitches, if any.					
Q14 The midwife ensures safe breastfeeding.					
Q15 The midwife ensures that the uterus is in its natural place after birth by massaging it.					
Q16 The midwife monitors signs of bleeding every quarter of an hour during the first hour after birth.					
Q17 The midwife encourages mothers to use the bathroom and empty their bladders every quarter of an hour during the first hour after birth.					
Q18 The midwife discusses self-care and hygiene with the mother, especially around the perineum. This includes care of any stitches, mobility, and the importance of drinking fluids and maintaining a healthy diet.					
Q19 The midwife encourages the mother to hold the newborn and pay attention to her.					
Q20 The midwife informs the midwives in the postpartum department and inquires about their readiness to receive the mother and her baby for transfer.					
Q21 The midwife records everything she has done in the memo.					
Q22 The midwife provides psychological support to the mother after birth.					
Q23 The midwife documents well every procedure and any new developments in the mother's condition after birth.					

جودة الرعاية المقدمة للسيدات والمولود ما بعد الولادة (استبانة القابلات)

أختي القابلة الفاضلة/ السلام عليكم ورحمة الله وبركاته ،،،،،

أنا الباحثة/ سهير نائل عبد الرحمن معروف ملتحقة ببرنامج ماجستير تمريض صحة الام والطفل في جامعة القدس، حيت اقوم بأجراء دراسة لقياس جودة الرعاية التمريضية الاولية المقدمة للام والمولود بعد الولادة في قطاع غزة من وجهة نظر القابلات في أقسام الولادة.

إن إجابتكِ على أسئلة الاستبانة سيكون له بالغ الأهمية في إنجاز هذا البحث.

ستكون المعلومات الواردة في الاستبانة في سرية تامة، ولأغراض البحث العلمي فقط، ولكم مطلق الحرية في المشاركة أو عدمها.

أشكركم على حسن تعاونكم،،،،

الباحثة

سهير نائل عبد الرحمن معروف

الرقم التسلسلي: .....

المستشفى: .....

المحور الأول: المعلومات الشخصية

.1	العمر:	..... سنة
.2	الدرجة العلمية:	□ دبلوم □ بكالوريوس □ دراسات عليا
.3	الحالة الاجتماعية:	□ آنسة □ متزوجة □ مطلقة / أرملة
.4	عدد سنوات الخبرة في أقسام / مستشفيات الولادة:	..... سنة
.5	الدخل الشهري:	..... شيكل
.6	هل تلقيت تدريب خاص برعاية الأمهات والمواليد بعد الولادة؟	□ نعم □ لا
.7	نظام العمل (مناوبات):	□ صباحي دائم □ مناوبات مختلفة (صباحي، مسائي، ليلي)
.8	مكان السكن	غزة( ) الوسطى ( ) الجنوب ( )
.9	اسم المستشفى	
.10	عدد الأطفال في الأسرة (للموظفات)	
.11	عدد الدورات التدريبية المتعلقة برعاية الأم والطفل.	
.12	عدد الحالات التي يتم التعامل معها يوميًا.	

المحور الثاني: رعاية الأم ما بعد الولادة من قبل القابلة

الرقم	المجال / الفقرات	مستوى الممارسة				
	الرعاية المقدمة للمولود اول ست ساعات بعد الولادة	**اوافق بشدة**	**اوافق**	**محايد**	**لا أوافق**	**لا أوافق بشدة**
.1	يتم وضع المولود على بطن الام وأتأكد انها بحالة جيدة					
.2	يتم التأكد من امساك الام للمولود بطريقة صحيحة					
.3	يتم بتطبيق سياسة EENC وبيان اهميته للام والمولود					
.4	يتم بوضع المولود ملاصق لبطن او صدر أمه لمدة 90 دقيقة مالم يطرأ أي مانع من ذلك					
.5	يتم بإبقاء الأم والمولود في غرفة الولادة لمدة 90 دقيقة بعد الولادة للملاحظة					
.6	يتم بالإجراءات الصحيحة لإنعاش المولود إذا لم يتنفس أو يصرخ بعد 30 ثانية من الولادة					
.7	يتم باستدعاء طبيب الحضانة للمولود ادا لاحظت أي امور غير طبيعية					
.8	يتم غسل يدي قبل وبعد أي اجراء أقوم به مع الأم					
.9	يتم الحفاظ على نظافة المكان قدر المستطاع					
.10	يتم المحافظة على خصوصية المريضة قدر المستطاع					
.11	يتم اتباع اساليب الوقاية في التعامل مع الحالات ادا كانت مصابة بالأمراض معدية					
.12	هيتم المحافظة على دفء المولود وسلامة مجرى الهواء ومراقبة اللون والتنفس والحركات					
.13	يتم فحص على أسورة التعريف للمولود كل فترة دوام وقبل الخروج (اللون حسب الجنس، وضعها بمعصم القدم، التفاصيل)					
.14	يتم متابعة بول المولود					
.15	يتم التأكد من جنس المولود بواسطة القابلة					
.16	يتم التأكد من سلامة العمود الفقري للمولود					
.17	يتم شرح فوائد الرضاعة الطبيعية للام وبيان أهميته					
.18	يتم بمساعدة وتشجيع الامهات على الرضاعة الطبيعية بعد ثلث ساعة من الولادة					
.19	يتم توجيه الأم على ارتداء ملابسها بعد الولادة					
.20	يتم توضيح بروتوكول النظافة والمحافظة على الغرز بعد الولادة					
.21	يتم اعطاء الام المعلومات الكافية حول علامات الخطورة لها وللمولود					
.22	يتم تشجيع الام على حمل المولود والانتباه لها					
.23	يتم ابلاغ القابلات بقسم ما بعد الولادة والاستفسار عن جهوزيتهم لاستقبال الام وطفلها لنقلهم					
.24	تقوم القابلة اعطاء المولود حقنة فيتامين K بعد الولادة					
.25	يتم بفحص APGAR Score أول دقيقة ثم بعد 5دقائق					
.26	تقوم القابلة بعرض الطفل على الحضانة للإعطاء تطعيم ادا كانت الام مصابة بالتهاب الكبد الوبائي					
.27	تقوم القابلة بقياس وزن المولود بعد الولادة وتدوينه بالملف					
.28	تقوم القابلة بقياس طول المولود وتدوينه بالملف					
.29	تقوم القابلة بقياس محيط الرأس للمولود وتدوينه بالملف					
.30	تقوم القابلة بقياس محيط الصدر للمولود وتدوينه بالملف					
.31	يتم تدوين بتدوين جميع ما قمت بها في التذكرة					
.32	يتم توفير الوقت الكافي للاستماع إلى مخاوف الأم أو استفساراتها					

.33	يتم تقييم العلامات الحيوية للمولود (درجة الحرارة، معدل ضربات القلب، معدل التنفس، وتشبع الأكسجين) وتوثيقها بدقة بعد الولادة.					
	ممارسة القابلات للرعاية المقدمة للأم خلال 6 ساعات الاولى بعد الولادة	**اوافق بشدة**	**اوافق**	**محايد**	**لا أوافق**	**لا أوافق بشدة**
.1	أطبق سياسة النقل الامن للام ومولودها من غرفة الولادة لقسم ما بعد الولادة بعد 90 دقيقة من الولادة باستخدام كرسي متحرك					
.2	تقوم القابلة بتطبيق سياسة تسليم واستلام الحالات باستخدام نموذج ISBAR					
.3	تقوم القابلة بأخبار الام بنقل المولود للحضانة اذا لزم الامر					
.4	تقوم القابلة بأعلام الام عن القسم المراد نقله عليه					
.5	تقوم القابلة باخد العلامات الحيوية كل ساعة خلال الاربعة ساعات بعد الساعة الاولى ما بعد الولادة					
.6	تقوم القابلة بأخبار الطبيب عن أي علامة غير طبيعية في العلامات الحيوية					
.7	تقوم القابلة بعمل مساج للرحم وأقيمه من ناحية الانقباض أو الارتخاء					
.8	تقوم القابلة بتقيم كمية الدم الدي يخرج من المهبل بعد الولادة كل ساعة خلال 4 ساعات بعد الولادة					
.9	يتم اعطاء الام المعلومات الكافية حول علامات الخطورة لها وللمولود					
.10	تقوم القابلة بمتابعة النزيف كل ساعة خلال 6 ساعات الاولى بعد الولادة					
.11	تقوم القابلة بتشجيع على الذهاب للحمام والمحافظة على المثانة فارغة كل ساعة خلال 6 ساعات بعد الساعة الاولى من الولادة					
.12	تقوم القابلة بتشجيع الأم لتفريغ للمثانة من قبل الامهات في قسم ما بعد الولادة في التذكرة					
.13	تقوم القابلة بفحص الغرز المهبلية ان وجد ت					
.14	تقوم القابلة بالتأكد من الرضاعة الطبيعية الآمنة					
.15	تقوم القابلة بالتأكد من وجود الرحم في مكانه الطبيعي بعد الولادة عبر تدليك الرحم					
.16	تقوم القابلة بمتابعة علامات النزيف كل ربع ساعة خلال الساعة الاولى بعد الولادة					
.17	تقوم القابلة بتشجيع الامهات على الذهاب للحمام والمحافظة على المثانة فارغة كل ربع ساعة خلال الساعة الاولى بعد الولادة					
.18	تقوم القابلة بمناقشة مع الأم (العناية الذاتية والنظافة خاصة حول منطقة العجان، العناية بالغرز ان وجد، التنقل، أهمية شرب السوائل والنظام الغذائي السليم)					
.19	تقوم القابلة تشجيع الام عل ى حمل المولود والانتباه لها					
.20	تقوم القابلة بالإبلاغ القابلات بقسم ما بعد الولادة والاستفسار عن جهوزيتهم لاستقبال الام وطفلها لنقلهم					
.21	تقوم القابلة بتدوين جميع ما قامت به في التذكرة					
.22	تقوم القابلة بتقديم الدعم لنفسي للام بعد الولادة					
.23	تقوم القابلة بالتوثيق الجيد لكل إجراء أو ما يستجد على حالة الام بعد الولادة في التذكرة					

أشكركم على حسن تعاونكم ،،،،،

Annexe (3): Satisfaction with quality of services after childbirth (Mothers' Questionnaire)

A questionnaire to assess the mothers' satisfaction level with the quality of services provided to them in hospitals after childbirth

Dear Mrs., Assalam Alaikum, God's mercy and blessings …..

I am the researcher / Soheir Marouf, enrolled in the Master's degree program of nursing Maternal and Child Health, where I am conducting a study on the quality of immediate postpartum care provided to the mother and newborn after childbirth in the Gaza Strip from the point of view of midwives in maternity departments.

Your answer to the questions in the questionnaire will be of great importance in completing this research.

The information in the questionnaire will be strictly confidential and used for scientific research purposes only, and you are free to participate or not.

Thank you for your cooperation ‘‘‘‘

Researcher

Soheir Marouf

Part I: Socio-demographic data of participants

Factor	Categories
Age groups	□ 25 or less
	□ 26-30
	□ More than 30
Hospital	□ AL Helou International Hospital
	□ Patient's Friend Benevolent Society
	□ Assahaba Medical Complex- Gaza, Palestine
	□ Al-Awda Hospital
Academic degree	□ Secondary school or less
	□ Diploma
	□ Bachelor’s degree
	□ Postgraduate studies
Marital status	□ Married
	□ Divorced/widow
Number of births	□ 2 or less
	□ 3-4
	□ More than 4
Number of pregnancies	□ 2 or less
	□ 3-4
	□ More than 4
Does the mother work (as an employee)	□ Yes
	□ No
Place of birth: Gaza	□ Central Gaza
	□ Mid Zone
	□ South Gaza

Part II: Mothers' satisfaction with the quality of services provided after childbirth

Mothers' satisfaction level	Never	Rarely	Sometimes	Often	Always
Q1 The midwife introduces himself and his role in providing health services.					
Q2 The midwife encourages the mother to inquire and provides her with the correct and necessary information.					
Q3 The midwife maintains the mother's privacy as much as possible.					
Q4 The midwife gives the mother painkillers after childbirth if she requests it.					
Q5 The midwife takes care of the mother in a room alone.					
Q6 The midwife provides enough nursing.					
Q7 The midwife deals with any complaint independently and quickly.					
Q8 The midwife places the mother in a well-ventilated room.					
Q9 The midwife takes complete care of you after birth.					
Q10 I find that the place where the midwife places you after birth is suitable for you and clean					
Q11 The midwife gives you health instructions about the safe and correct way to breastfeed, with a simple explanation to you about the risks you may face after birth					
Q12 The midwife measures your vital processes after birth					
Q13 The midwife places the mother on a clean and comfortable mattress					
Q14 The midwife listens and hears inquiries and questions					
Q15 The midwife gives your health instructions about the safe and correct way to breastfeed					
Q16 The midwife gives the mother instructions about the importance of continuing breastfeeding					
Q17 The baby is placed on his mother's chest immediately after birth to practice breastfeeding					
Q18 The midwife explains to the mother the importance of personal hygiene and caring for the episiotomy					
Q19 The midwife provides advice to the mother before leaving about the diet					
Q20 The midwife advises the mother before leaving about caring for the newborn.					
Q21 The baby is kept warm while with its mother.					

رضى الأمهات عن جودة الرعاية المقدمة بعد الولادة (استبانة الأمهات)

السيدة الفاضلة/ السلام عليكم ورحمة الله وبركاته ...

أنا الباحثة/ سهير نائل عبد الرحمن معروف ملتحقة ببرنامج صحة الأم والطفل في جامعة القدس، حيت أقوم بأجراء دراسة عن جودة الرعاية التمريضية الأولية المقدمة للام والمولود بعد الولادة في قطاع غزة من وجهة نظر العاملين في أقسام الولادة.

إن إجابتكِ على أسئلة الاستبانة سيكون له بالغ الأهمية في إنجاز هذا البحث.

ستكون المعلومات الواردة في الاستبانة في سرية تامة، ولأغراض البحث العلمي فقط، ولكم مطلق الحرية في المشاركة أو عدمها.

أشكركم على حسن تعاونكم،

الباحثة

سهير نائل عبد الرحمن معروف

الرقم التسلسلي: .....

المستشفى : .....

المعلومات الشخصية للأم في غرفة الولادة.

.1	العمر:	..... سنة
.2	الدرجة العلمية:	□ دبلوم □ بكالوريوس □ دراسات عليا
.3	الحالة الاجتماعية:	□ آنسة □ متزوجة □ مطلقة / أرملة
4	عدد الولادات	.....
٦	عدد الحمولات	.....
5	هل الام تعمل (موظفة)	□ نعم □ لا
6	مكان الولادة	غزة( ) وسطى ( ) جنوب ( )

	رضى الامهات عن جودة الخدمات المقدمة لها في المستشفيات بعد الولادة	دائما	غالبا	احيانا	نادراً	أبداً
.1	تقوم القبالة بتعريف عن نفسه ودوره في تقديم الخدمة الصحية					
.2	تقوم القبالة بتشجيع الام على الاستفسار وتزويدها بالمعلومات الصحيحة والضرورية					
.3	تقوم القبالة الحفاظ على خصوصية الام قدر المستطاع					
.4	تقوم القابلة بإعطاء الام مسكنات بعد الولادة عند الحاجة لذلك					
.5	تقدم القابلة رعاية الام مع مراعاة خصوصية الأم					
.6	من وجهة نظرك، يتوفر عدد كافي من القابلات في القسم					
.7	تقوم القابلة بالتعامل مع اي شكوى بشكل مستقل وبشكل سريع					
.8	تقوم القابلة بوضع الام في غرفة جيدة التهوية					
.9	تقوم القابلة برعايتك بشكل كامل بعد الولادة					
.10	المكان الذي تضعك به القابلة بعد الولادة مناسب لك ونظيف					
.11	تقوم القابلة بإعطاء ارشادات حول طريقة الرضاعة الآمنة والصحيحة بشرح مبسط					
.12	تقوم القابلة بقياس العمليات الحيوية لك بعد الولادة					
.13	تقوم القابلة بوضع الام على فرشة نظيفة ومريحة					
.14	تصغي القابلة لاستفساراتي وتساؤلاتي					
.15	تقوم القابلة بتشجيعي على الرضاعة الطبيعية					
.16	تقوم القابلة بشرح أهمية الرضاعة الطبيعية لي ولطفلي					
.17	يتم وضع الطفل على صدر امه مباشرة بعد الولادة للممارسة الرضاعة الطبيعية					
.18	تقوم القابلة بتوضيح أهمية النظافة الشخصية والاهتمام بشق العجان					
.19	تقدم القابلة النصائح لي حول النظام الغذائي قبل خروجي من المستشفى					
.20	تقدم القابلة المعلومات الكافية حول رعاية المولود قبل خروجي من المستشفى					
.21	يتم الحفاظ على تدفئة الطفل أثناء وجوده مع امه					

Annexe (4): Experts Committee

Dr. Ali al Khateeb	College University of Applied Sciences
Dr. Ayman Abu Mustafa	Ministry of Health
Dr. Ayda Khadir	Ministry of Health

Annex (5): Approval to conduct the study

Al Quds University
Faculty of Health Professions
Nursing Dept. –Gaza

جامعة القدس
كلية المهن الصحية
دائرة التمريض – غزة

التاريخ: ١٠/٠٢/٢٠٢٥

الأخ / مدير عام وحدة المعلومات الصحية بوزارة الصحة ... حفظه الله

تحية طيبة وبعد

الموضوع/ تسهيل مهمة الباحثة سهير معروف

تهديكم إدارة برامج ماجستير التمريض بجامعة القدس أطيب التحيات، وأرجو من حضرتكم تسهيل مهمة جمع البيانات للدراسة البحثية للطالبة ضمن برنامج ماجستير تمريض صحة الأم والطفل وهي بعنوان:

Quality of immediate midwifery care for mother and newborn in the first six hours

وذلك من خلال إستبانة خاصة بالممرضات والقابلات وأخرى بالأمهات بأقسام الولادة في مستشفيات الولادة بوزارة الصحة والمستشفيات الأهلية (مستشفى الحلو الدولي– م. أصدقاء المريض– م. العودة بجباليا– م. الصحابة– م. العودة بالنصيرات).

وتفضلوا بقبول وافر الاحترام والتقدير

د. حمزة محمد عبد الجواد
أستاذ مساعد في علوم التمريض
منسق برامج ماجستير التمريض بغزة
كلية المهن الصحية - جامعة القدس
hamjawad1@gmail.com
تلفون: +972 8 2644220
خلوي: +972 599 852755

Annex (6): Approval to Ministry of Health

State of Palestine
Ministry Of health
Health Information Unit

دولة فلسطين
وزارة الصحة الفلسطينية
وحدة المعلومات الصحية

2523874
2025-02-19

السيد/ة هاني سلطان ارميح الوحيدي

مدير عام نظم المعلومات الصحية

السلام عليكم ورحمة الله وبركاته ،،،

الموضوع/ تسهيل مهمة الباحثة سهير معروف

السلام عليكم

نهديكم أطيب التحيات ونود منكم تسهيل مهمة الباحث/ة سهير معروف الملتحق/ة ببرنامج الماجستير في صحة الام والطفل بجامعة القدس أبو ديس بغزة في إجراء بحث بعنوان

Quality of immediate midwifery care for mother and newborn in the first six hours

حيث الباحث/ة بحاجة لتعبئة استبانة عشوائية من عدد من العاملين في مرافق وزارة الصحة والمرافق الصحية الأخرى (تقدم خدمات الولادة) ، دون اجراء أي تدخل طبي او سحب عينات دم و بما لا يتعارض مع مصلحة العمل وضمن أخلاقيات البحث العلمي، ودون تحمل الوزارة أي أعباء أو مسئولية ، نأمل توجيهاتكم لذوي الاختصاص بضرورة الحصول على الموافقة المستنيرة (Consent Form)من المشاركين.

ملاحظات /

تسهيل المهمة الخاص بالدراسة أعلاه صالح لمدة 3 أشهر من تاريخه.

يرجى التأكد من توافق الاستبانة المرفقة والتي يتم تعبئتها ميدانيا على ان لا يتم أي إضافة او تعديل على الاستبانة المرفقة

يجب اطلاع دائرة البحث الصحي على النتائج قبل النشر

وتفضلوا بقبول التحية والتقدير

علي حسن عبد القادر البلبيسي
رئيس قسم البحوث

التحويلات

المرسل اليه: هاني سلطان ارميح الوحيدي

عنوان الدراســـــة: جودة رعايـة مـا بعد الولادة الفوريـة المقدمـة من قبـل القـابلات للأمـهـات في مستشفيات الولادة في قطاع غزة.

إعداد الطالبة: سهير نائل عبد الرحمن معروف

إشراف: د.عريفة الكسيح

الملخص:

نظرة عامة: تعد جودة الرعاية المباشرة بعد الولادة التي تقدمها القابلات عاملاً مؤثراً في النتائج الصحية للأمهات والمواليد الجدد. تقيّم هذه الدراسة جودة الرعاية المباشرة بعد الولادة في المستشفيات الحكومية في غزة. تركز الدراسة على تصور القابلات فيما يتعلق برعاية الأمهات والمواليد الجدد خلال الساعات الست الأولى بعد الولادة. تستكشف الدراسة المجالات الرئيسية، بما في ذلك رعاية الأمهات الفورية ورعاية المواليد الجدد وممارسات القبالة. كما تمت دراسة رضا الأمهات عن خدمات ما بعد الولادة.

المنهجية: تم استخدام تصميم دراسة مقطعية مستعرضة شملت 72 قابلة و335 أمًا بعد الولادة من مختلف المستشفيات الحكومية في غزة. تم جمع البيانات باستخدام استبيانات منظمة تستهدف القابلات والأمهات. تم إجراء التحليل الإحصائي باستخدام الحزمة الإحصائية للعلوم الاجتماعية) SPSS الحزمة الإحصائية للعلوم الاجتماعية .V25 (تم الحصول على الموافقة الأخلاقية من وزارة الصحة وضمان السرية والمشاركة الطوعية. تم تحديد الدلالة الإحصائية عند$P < 0.05$.

النتائج: أشارت النتائج إلى وجود تصورات عامة عالية لجودة الرعاية بعد الولادة بين القابلات في جميع المجالات المدروسة (88.6%). كان المجال الأعلى تقييمًا هو ممارسات رعاية الأمومة لدى القابلات (89.0%)، تليها رعاية حديثي الولادة (88.2%). وجدت الدراسة فروقًا كبيرة في جودة الرعاية عبر المستشفيات ($P < 0.05$) ولكن لم توجد فروق كبيرة بناءً على المؤهلات الأكاديمية، أو الحالة الاجتماعية، أو سنوات الخبرة، أو الدخل، أو مكان الإقامة ،أو التدريب الذي تلقته ($P> 0.05$). بالإضافة إلى ذلك، لوحظ وجود علاقة إيجابية قوية بين إجمالي الرعاية بعد الولادة ورعاية حديثي الولادة ($r = 0.881, P < 0.001$) ، بلغت نسبة رضا الأمهات عن خدمات الرعاية بعد الولادة 81.25%. أظهر التحليل الإحصائي عدم وجود فروق ذات دلالة إحصائية في مستويات الرضا بناءً على الخصائص الاجتماعية والديموغرافية ($P > 0.05$).

الخلاصة: تسلط الدراسة الضوء على الجودة المرتفعة بشكل عام للرعاية المباشرة بعد الولادة التي تقدمها القابلات في المستشفيات الحكومية في قطاع غزة. ومع ذلك، تُظهر الاختلافات في جودة الرعاية بين المستشفيات الحاجة إلى برامج تدريب موحدة وتخصيص الموارد لضمان الاتساق في خدمات الرعاية بعد الولادة.

التوصيات: إن تعزيز تدريب القابلات، وضمان التطوير المهني المستمر، وتحسين التواصل بين القابلات والأمهات، لا سيما في التعريف بدورهن وتعزيز توافر الموظفين، يمكن أن يزيد من تحسين رضا الأمهات.