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Quality of Health Care Provided for Hypertensive Disorders Pregnancy Women at Maternity Governmental Hospitals in Gaza strip: Women's Perspectives

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Dedication

This thesis is dedicated to:

Great beloved my father, my beloved mother, and my loved sincere husband whom have made every effort to support and motivate me, my wonderful sisters and brother whom I can't force me to stop loving. To all my family, the symbol of love and given I deeply appreciate that you were always there in spirit with me … gave me the support and space I needed to realize this accomplishment…and inspired me with your love and warm feelings.

Heartfelt thanks and appreciation to all those who contributed to the completion of this thesis … without your support, this work would not come to end**.**

Ferdos Ilhan Hasan Dogan

Declaration

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

Signed:

Ferdos Ilhan Hasan Dogan

Date: 22/11/2022

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Abstract

Hypertensive Disorders Pregnancy is the most common complication during pregnancy and the leading cause of perinatal and maternal morbidity and mortality. The overall purpose of this study was to assess the quality of health care for hypertensive disorders in pregnant women at maternity governmental hospitals in the Gaza Strip.

A descriptive-analytical cross-sectional study was used. The sample of the study was a non-probability, convenience sample design that consisted of 110 pregnant women who were admitted to the high-risk departments at maternity governmental hospitals (42 from Al Shifa Medical Complex, 32 from Nasser Medical Complex, 21 from ALemiratey Hospital, and 15 from Al-Aqsa Hospital) during data collection.

The participants completed the questionnaire that includes questions related to pregnant women's sociodemographic characteristic data and included questions related to Six domains (safety, patient-centered care, effectiveness, timely, efficient, and equitable) for assessment of the quality of healthcare. Cronbach's Alpha coefficient was 0.89) indicating high reliability. Various statistical procedures were used for data analysis including percentages, mean, one-sample independent t-test, and One-Way ANOVA test. The finding showed that the mean age of the pregnant women was 29.5 years, half of the study sample aged 20-30 years, more than 55% had a university degree, 38.2% of the study participants were from Al Shifa Medical Complex and 37.3% of the pregnant women have 39-40 weeks. About 42.7% of women have had 1-3 pregnancies, 44.5% of the women have 1-3 children, 20.9% have never lived birth, and the majority of the participants (93.6%) have never had a stillbirth. Furthermore, more than 60.9% of the participants have no previous medical diseases, more than half of the women have a history of hospital admission, and the majority of the women (80.9%) have preeclampsia.

The mean percentage for all quality of health care domains was 80.3%. The results revealed that the safety domain got the highest score (82.6%) followed by the patient-centered care domain (81.6%), effectiveness domain (81.4), timely domain (79.8%), efficient domain (79.2%) and the equitable domain ranked the last (77.5%).

Also, the results showed statistically significant differences between women's education level, hospitals, history of hospital admission, duration of pregnancy, classification of PIH , and different domains of quality of health care. Moreover, the results showed that no statistically significant differences were found between women's age, gravid, abortion, and quality of health care domains.

The study result highlighted the need for improving the patient environment and reducing the stimuli, ensuring an adequate number of qualified specialist doctors and ensuring safety measures at high-risk departments, supporting the hospitals with essential and required material and equipment, and encouraging to implementation of the standards of quality of healthcare at maternity hospitals.

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List of Abbreviations

ANA	American Nurse Association
ANOVA	Analysis of Variance
CTG	Cardio Toco Graphy
GHs	Governmental Hospitals
GS	Gaza Strip
ICN	International Council of Nursing
IOM	Institute of Medicine
LMICs	Low- and Middle-Income Countries
MoH	Ministry of Health
HDP	Hypertension Disorders in pregnancy
NGHs	Non-Government Hospitals
NGOs	Non-Governmental Organizations
PCBS	Palestinian Central Bureau of Statistics
PE	Pre-eclampsia
PHC	Primary Health Care
PHCS	Palestinian Health Care System
PMMS	Palestinian Military Medical Services
PNGO	Palestinian Non-Governmental Organizations
SPSS	Statistical Package for Social Sciences
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

Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with evidence-based professional knowledge. This definition of quality of care includes promotion, prevention, treatment, rehabilitation, and analgesia, and means that the quality of care can be measured and continually improved through the provision of evidence-based care that takes into account the needs and preferences of patients, families and communities. Multiple quality elements have been described over the past decades. There is no clear consensus that quality health services should be: effective, safe, patient-centered, timely, equitable, integrated and efficient (WHO, 2020).

Hypertensive Disorders Pregnancy (HDP) are the most common complications during pregnancy. There are various types of hypertensive disorders, including preeclampsia, chronic hypertension, gestational hypertension, chronic hypertension, and preeclampsia superimposed on chronic hypertension (Pandian Et al, 2013). High blood pressure during pregnancy and pre-eclampsia are major causes of maternal and perinatal morbidity and mortality, particularly in low- and middle-income (LMIC) countries where maternal and perinatal mortality rates remain high (Gunther, 2018).

Government maternity hospitals are a safe and affordable option for all pregnant women, including those with high-risk pregnancies. Main government maternity hospitals have facilities to care for women and children with complications during labor and delivery (South Australia Health, 2021).

Attitudes and perceptions about the quality of care by pregnant women influence the use of services. Women's perceptions are also crucial to the health-seeking behavior of pregnant women (Berry, 2008). Moreover, although the views of pregnant women are often relative, and sometimes ignored, they go a long way in issuing a warning and are usually indicative of what is on the ground (Prince et al., 2018).

Therefore, a study was conducted to assess the quality of health care provided for hypertensive disorders in pregnant women at governmental maternity hospitals in the Gaza Strip.

1.2 Research problem

Hypertension disorder in pregnancy (HDP) is common and complicates 10% of pregnancies (Fraser et al., 2016). HDP is one of the leading causes of maternal and perinatal morbidity and mortality, annually this equates to approximately 30,000 pregnancies in Australia and 13 million globally (Liu et al., 2014). In addition, poor assessment of maternal well-being, the progress of labor, and poor record keeping of midwifery interventions and care suggest an inadequate quality of midwifery care (Kabongo et al., 2017). In the Gaza strip, according to the Ministry of Health (MoH), the maternal mortality ratio is at 24.3/100,000 live births, MoH highlighted that severe staff shortage, and the resignation of midwives with experience affects the quality of midwifery care in the Gaza strip (MoH, 2020). Furthermore, no study was found on assessing of quality of health care at the maternity governmental hospital departments in the Gaza Strip.

So that the researcher conduct this study to assess the quality of health care provided for hypertensive disorders in pregnant women in maternity departments at governmental hospitals to identify and address gaps.

1.3 Justification of the study

Health institutions are the main focus in the interest of different countries and governments, and consequently, the competition between them to provide the best patient services according to quality standards is become a goal, that all try to achieve it.

This study would be the first one that focuses on identifying the effect of the quality of care among hypertensive pregnant women at governmental maternity hospitals.

Furthermore, this study provide information that lead to an understanding of the quality of care that pregnant women with hypertension were received in maternity hospitals.

In addition, the results of this study can also help policy and decision makers to develop innovative approaches that enhance the quality of quality care in the obstetric departments of the Ministry of Health in the Gaza Strip.

1.4 General objective

The overall aim of this study is to assess the quality of health care provided for hypertensive disorders in pregnant women as perceived by women at maternity governmental hospitals in the Gaza Strip.

1.5 Specific objectives

1. To assess the overall perception of quality health care provided for hypertensive disorders in pregnant women as perceived by women at maternity governmental hospitals.

2. To assess the pregnant women's perspectives toward quality health care in relation to the domains of the study (effective, safe, patient-centered, timely, equitable, integrated, and efficient).

3. To determine the differences in women's perspectives in relation to their sociodemographic characteristics.

1.6 Research Questions

1. What is the quality of health care provided for hypertensive disorders in pregnant women as women perspectives at maternity governmental hospitals?

2. Is there a significant difference in pregnant women's perspectives regarding quality health care in relation to the domains of the study (effective, safe, patient-centered, timely, equitable, integrated, and efficient)?

3. Is there a significant relationship Between women's views on health care quality and their sociodemographic characteristics?

1.7 Theoretical and operational definitions

1.7.1 Quality

Quality refers to meeting the healthcare needs of patients in relation to the attitude of care towards the healthcare provided, appropriate explanations, effective communication before procedures and treatment, sufficient skill and competence, effective participation,

organizational and administrative systems, and the participation of the patient and others significant in care.

The researcher defines the quality of care as the degree to which health services provided for hypertensive disorder pregnancy increase the likelihood of desired health outcomes. This study addresses 6 domains; namely effective, Time, equitable, efficient, patient-centered, and safe.

1.7.2 Hypertensive Disorders in Pregnancy

HDP refers to a group of medical conditions in pregnancy characterized by the presence of high blood pressure (BP≥140/≥90mmHg). The following hypertensive conditions:

• **Pre-eclampsia and eclampsia**, which are any hypertension (BP≥140/≥90mmHg) appearing for the first time after 20 weeks of pregnancy and associated with significant protein in urine; if a client with pre-eclampsia develops convulsion in the absence of any neurological cause, it is seen as eclampsia (NICE, 2019).

• **Chronic hypertension** in pregnancy, which is any hypertension (BP≥140/≥90mmHg) present before pregnancy or diagnosed before 20 weeks gestation.

• **Gestational hypertension**, any hypertension (BP≥140/≥90mmHg) appearing for the first time after the 20th week of pregnancy.

1.8 Context of the study

1.8.1 Geographical and demographical context

Palestine country is stretching from Ras Al-Nakoura in the north to Rafah city in the south. It is bordered by Lebanon country in the north, the Gulf of Aqaba in the south, Syria and Jordan countries in the east, and Egypt country and the Mediterranean Sea in the west. The entire area of historical Palestine is about 27,000 Km2 (PCBS, 2017). There are about 13.5 million Palestinians in the world, of whom about 5.1 million are in the State of Palestine; 2.59 million males and 2.51 million females. The population of the West Bank was 3.05 million people; of which 1.55 million were males and 1.50 million were females.

1.8.2 Gaza Strip

Gaza strip is a narrow zone of land bounded on the south by Egypt, on the west by the Mediterranean Sea, and on the east and north by the occupied territories in 1948 (PCBS, 2017). Gaza Strip is a very crowded place 46 kilometers long and 5 –12 kilometers wide and with a total area of 365 sq km. Gaza strip is administratively divided into five governorates: North, Gaza, Mid-zone, Khan-Younes, and Rafah. It consists of four cities, fourteen villages, and eight refugee camps. Gaza Strip has a population of 2,047,969 people, of which 1.04 million males and 1.01 thousand females. Population density is 5,453 persons/km2 (PCBS, 2021). In WB, the number of populations approximately 3.05 million 1.55 million males and 1.50 million females. with population density 528 persons/km2 (PCBS, 2021).

1.8.3 Palestinian Health Care System

The Palestinian healthcare system (PHCS) consists of four main providers: the Ministry of Health (MoH), the United Nations Relief and Works Agency (UNRWA), non-governmental organizations (NGOs), and the for-profit private sector (WHO, 2008). The Ministry of Health operates 13 hospitals and 52 primary health care facilities in the Gaza Strip (Ministry of Health, 2020). Another major component of UNRWA is the operation of 22 primary health care facilities. The number of beds in Gaza Strip hospitals reached 2,943 beds (2,240 beds affiliated with the Ministry of Health, 526 beds affiliated with non-governmental institutions, and 177 beds affiliated with the Ministry of Interior and National Security). The number of doctors working in the various centers and units of the Ministry of Health reached 3,100, at a rate of 14.6 doctors for every 10,000 residents of Palestine in the Gaza Strip, and the number of nurses working in the Ministry of Health in Gaza reached 3,682, representing 25.1% of the total workers in the Ministry of Health. 21.2 nurses per 10,000 Palestinian population in the Gaza Strip. The number of visitors to emergency departments in 2018 reached 1,402,222 visitors (MOH, 2020).

1.8.3.1 Nasser Medical Complex (NMC)

Nasser Medical Complex includes Naser hospital, which is dedicated to surgery, and internal medicine, Al Tahrir hospital for women, childbirth, and children, and Al Yassin hospital, which is located in Khan Younis. The hospital has (446) beds, and the total

number of employees is about 1205 divided as follows: Physician 299 (24.8%), Nursing 421 (34.9 %), Administrators & Support medical technicians 485 (40.2%).

1.8.3.2 Al Emaraty hospital

Al Emaraty crescent hospital in Rafah city is the only specialized hospital for women and childbirth in the city and includes four maternal departments and a delivery room, and serves the segment of the population living in the Rafah governorate. Its clinical capacity is 75 beds. The total number of employees in the complex is 285 (MoH, 2021).

1.8.3.3 Al-Shifa Medical Complex

Al Shifa Medical Complex is the largest and central hospital in the Gaza Strip, located in the neighborhood of North Rimal in Gaza City in the Gaza Governorate, which contains three hospitals: a medical hospital, a surgery hospital, and a maternity hospital. It is located in Gaza City. It serves Gaza Governorate in particular and covers the Gaza Strip in general. Its clinical capacity is 744 beds. The total number of employees in the complex is 2056 (MoH, 2021).

1.8.3.4 Aqsa Martyrs Hospital

A general hospital provides medical, surgical, pediatric, and women and obstetrics services, its located in the middle governorate of Deir Al-Balah and serves the segment of the population living in the central Gaza governorate. The hospital has a bed capacity of 291 beds, and it employs 825 employees of all categories (MoH, 2021).

Chapter Two

Conceptual framework and literature review

2.1 Introduction

In this chapter, the researcher explains the conceptual framework of the study, which reveals the main areas of health care quality provided for hypertensive disorders during pregnancy and the factors that may affect the quality of care.

2.2 Conceptual framework

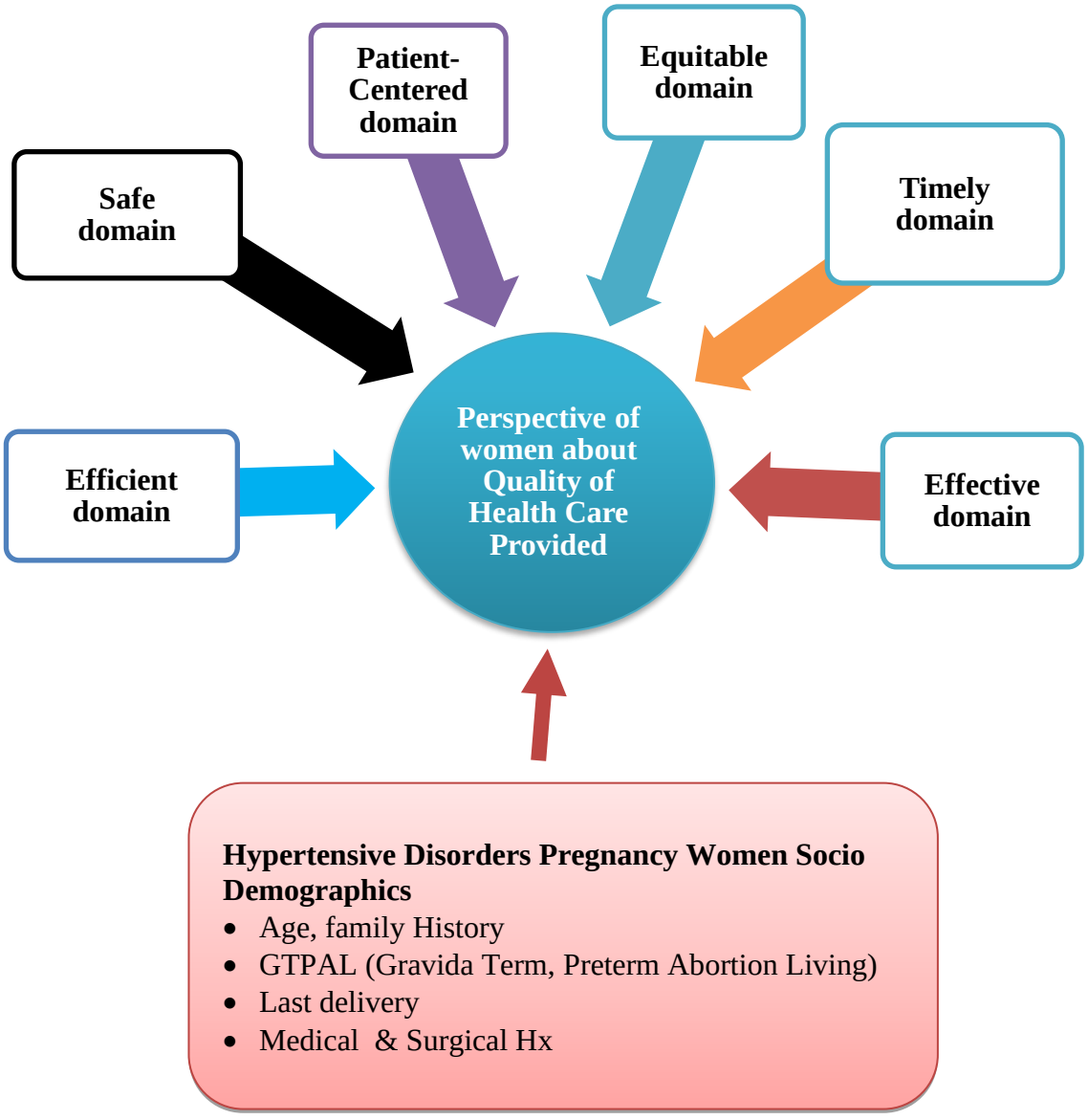

Figure (2.1): Conceptual Framework (developed by self-constructed)

2.2.1 Effectiveness

Effective is achieving an expected result productive or avoiding overuse and misuse of care. This means it would be offered based on scientific knowledge and evidence-based guidelines. The team would reassure the patient that he/she would be receiving evidence-based care (WHO, 2018).

2.2.2 Safety

It minimizes harm, including preventable injuries and medical errors, to the patient. In every facility, there would be clear guidelines to prevent hospital-acquired infections and medical errors. For example, a thorough review of her outpatient medications at admission was made to prevent interactions with medications used during her inpatient care (WHO, 2018).

2.2.3 Equitable

Provide care that does not differ in quality due to personal characteristics such as ethnicity, geographic location, gender, and socioeconomic status (IOM, 2018).

2.2.4 Timely

Reducing waits and sometimes harmful delays for both those who receive and those who give care (IOM, 2018).

2.2.5 Efficient

Avoid waste, including waste of equipment, supplies, ideas, and energy (IOM, 2018).

2.2.6 Patient-centered

Provide care that respects and responsive to individual client's needs, values and preferences and guarantee that patient values guide all medical decisions (IOM, 2018).

2.3 Hypertension Disorder in pregnancy (HDP)

HDP is defined by the International Society for the Study of Hypertension in Pregnancy (ISSHP) as systolic blood pressure (BP) greater than or equal to 140mmHg and/or a diastolic BP greater than or equal to 90mmHg (NICE, 2019). The two disorders specific to

pregnancy are gestational hypertension and preeclampsia. High blood pressure in pregnancy (HDP) is diagnosed when high blood pressure is confirmed by repeating the measurement several times over several hours in a daily or overnight hospital stay (Payne et al., 2016). Both systolic and diastolic blood pressure levels in a woman are considered significant, as higher levels of either have been associated with adverse maternal and fetal outcomes (Magee et al., 2016). Hypertensive disorders during pregnancy include those that were present before pregnancy (chronic hypertension) and those that are specifically associated with and cause gestational hypertension and preeclampsia (Laun et al., 2016).

2.3.1 Chronic hypertension

Chronic hypertension is present before pregnancy or confirmed before the first 20 completed weeks of pregnancy (Nice, 2019). This category includes two main subgroups: primary hypertension and secondary hypertension (Nice, 2019). Essential hypertension is high blood pressure with no known cause (Magee et al., 2016), although there is often a family history of hypertension. Secondary hypertension is less common and results from an underlying health condition such as kidney disease, endocrine disorders, diabetes, or congenital vascular abnormalities (Paine et al., 2016). The subgroup within the classification of essential hypertension is known as white coat hypertension. This occurs when women have elevated blood pressure in the clinical setting, but blood pressure recordings are normal as measured by home monitoring or 24-hour ambulatory monitoring (Payne et al., 2016). Women with chronic hypertension need more monitoring during pregnancy because they have a 25% chance of developing superimposed PE. These rates may be higher for women with primary kidney disease (Jumathi et al., 2018).

2.3.2 Gestational hypertension

GH is defined as the new onset of hypertension after 20 weeks of gestation in the absence of proteinuria, without biochemical or hematological abnormalities, and not usually accompanied by fetal growth restriction (NICE, 2019). Pregnancy outcomes are usually good, however, 25% of women with GH will develop pre-eclampsia, with the greatest risk being for women who present at less than 34 weeks gestation (Gomathy et al., 2018).

2.3.3 Preeclampsia and Eclampsia

Pre-eclampsia (PE) is defined as the new onset of high blood pressure after 20 weeks of gestation plus involvement of at least one of the mother's organs (most commonly the kidneys) and/or the fetal blood pressure must return to normal within three months after birth (Nice, 2019). PE is a progressive disorder that gets worse over time, and the earlier it appears, the greater the risk of severe disease (Gomathy et al., 2018). Its course is unpredictable and increases the risk of negative outcomes for both the woman and her baby. These adverse outcomes include pulmonary edema, placental abruption, cerebral hemorrhage, intrauterine fetal death, preeclampsia (seizures) or stillbirth (Harman et al., 2015). PE contributes significantly to maternal, fetal, and neonatal morbidity and mortality, and the only known treatment is for the woman to give birth (Gomathy et al., 2018). This usually means that the baby is born prematurely, and requires care in a specialized nursery. Resolution of maternal illness usually occurs within a few days after delivery but may take weeks or months (Kaze et al., 2014).

Eclampsia, which is considered a complication of severe preeclampsia, is commonly defined as new onset of grand mal seizure activity and/or unexplained coma during pregnancy or postpartum in a woman with signs or symptoms of preeclampsia. It typically occurs during or after the 20th week of gestation or in the postpartum period (Michael G Ross, MD, MPH, 2022).

2.4 Implications of Hypertension Disorder for women and babies

Having HDP, particularly PE, can lead to a worrying and stressful time for the woman (WHO, 2019). This stress may be due to the increased surveillance and assessment that is required following diagnosis (Sulistyowati, 2017). Women diagnosed with HDP require frequent monitoring of themselves and their unborn babies (Sherman et al. 2015). This includes regular BP measurements, blood, and urine testing to monitor organ function, physical examination, and fetal well-being assessment through the cardio-toco graph (CTG) monitoring and ultrasound scanning including Doppler flow studies (Sulistyowati, 2017). This monitoring may be done in a day-stay setting where the woman attends several days a week for a few hours, or she may be admitted to the hospital for closer surveillance (Sulistyowati, 2017).

2.5 Literature Review

Nearly half of the estimated world population of 73 billion is female, about 52% of whom are between the ages of 15 and 49, and another 5% are girls between the ages of 12 and 14 (United Nations, Department of Economic and Social Affairs, 2015). Through an estimated 210 million pregnancies and 140 million live births annually, the sheer size of these numbers cannot be overlooked. Women want reproductive health services from adolescence through the end of their reproductive years, whether or not they have a birth, and those who give birth need essential care to protect their health and ensure their newborns survive (Singh et al., 2014).

The maternal mortality rate in the world is unacceptably high. In 2017, about 295,000 women died during and after pregnancy and childbirth; Approximately 810 women die every day from preventable causes related to pregnancy and childbirth. The majority of maternal deaths (94%) occurred in under-resourced settings. Complications during or after pregnancy and childbirth are the outcomes of maternal mortality. The major complications that cause approximately 75% of all maternal deaths are postpartum hemorrhage, puerperal toxemia, pre-eclampsia, prenatal hemorrhage, and obstetric complications. There may also be complications before pregnancy such as heart disease and other chronic diseases but they worsen during pregnancy, especially if they are not addressed as part of a woman's antenatal care. Skilled care before, during and after childbirth can save women's lives (World Health Organization, 2019).

The Health Care System of MoH in the Gaza Strip is responsible for the delivery of a significant portion of primary, secondary, and some tertiary healthcare services. It is also responsible for providing services for maternal care before, after, and during pregnancy and for tracking risky pregnancies such as hypertension, preeclampsia, infections, and heart problems. The total number of PHC facilities in the Gaza Strip is 159. Of these facilities, 52 PHC facilities are managed by the MoH (27 PHC level 2, 15 PHC level 3, and 10 level PHC 4), United Nations Relief and Works Agency for Palestine Refugees (UNRWA) manages 22 PHC facilities, Nongovernmental organizations (NGOs) provide management to 80 PHC facilities, and medical services runs 5 PHC facilities. Maternal and child health care is an integral component of health services provided in the Gaza Strip. Out of MoH 49 PHC facilities, 27 facilities provide Maternal and child health. MCH services are also provided by the 22 PHC facilities run by UNRWA. At-risk pregnancy

accounts for 32% of pregnant women at MoH and 26% - at UNRWA facilities. The maternal Mortality Ratio (MMR) in 2020 was 24.2 per 100,000 live births. According to the MoH (MOH, 2021). There are six maternity hospitals in the Gaza Strip, namely (Al-Tahrir (Khan Yunis Governorate), Al-Emirati (Rafah Governorate), Al-Aqsa (Central Region Governorate), Al-Shifaa (Gaza Governorate), (Babore et al., 2021). Al-Huraizeen (Gaza Governorate), and Kamal Adwan (North Gaza Governorate)). Also, 23 primary health care clinics provide maternal, newborn, and child health services (UNICEF, 2019).

2.5.1 Pregnancy-induced hypertension (PIH)

PIH is defined as a pregnant woman attending delivery service with high blood pressure (≥140/90mmHg) after 28 weeks of gestation was measured two times six hours apart by trained data collectors and with or without proteinuria. The diagnosis of PIH was confirmed by a doctor working in the labor ward. PIH includes pre-eclampsia, eclampsia, and gestational hypertension, pre-eclampsia, and eclampsia (Gudeta & Regassa, 2019).

2.5.2 Classification of Hypertension in Pregnancy

(American College of Obstetricians & Task Force on Hypertension in Pregnancy, 2013)

1. Preeclampsia: after 20 weeks. From pregnancy, SBP ≥140 mmHg or DBP 90 mmHg in previously normal proteinuria (protein excretion ≥0.3 g in the 24-hour urine group) or with other systemic manifestations.

2. High blood pressure during pregnancy (Gestational hypertension): High blood pressure (SBP 140 mm Hg or DBP 90 mm Hg) after 20 weeks. of pregnancy in a woman who was previously normal.

3. Chronic hypertension: SBP 140 mm Hg and/or DBP 90 mm Hg before or before 20 weeks of pregnancy. from pregnancy.

4. Chronic hypertension with superimposed preeclampsia: a new onset of proteinuria in hypertensive state before 20 weeks. In pregnancy, an increase in proteinuria (if it was present earlier), an increase in blood pressure onset of HELLP syndrome (hemolysis, elevated serum liver enzymes, decreased platelets, pulmonary edema).

Pregnancy-induced hypertension (PIH) complicates 6-10% of pregnancies. It is defined as systolic blood pressure (SBP) >140 mmHg and diastolic blood pressure (DBP) >90 mmHg. It is classified as mild (SBP 140-149 and DBP 90-99 mmHg), moderate (SBP 150-159 and DBP 100-109 mmHg) and severe (SBP ≥ 160 and DBP ≥ 110 mmHg) (Visintin et al., 2010). PIH refers to one of four conditions: a) pre-existing hypertension, b) gestational hypertension and preeclampsia (PE), c) pre-existing hypertension plus superimposed gestational hypertension with proteinuria and d) unclassifiable hypertension (Moutquin et al., 1997). PIH is a major cause of maternal, fetal, and newborn morbidity and mortality. Women with PIH are at a greater risk of abruption of placentae, cerebrovascular events, organ failure, and disseminated intravascular coagulation. Fetuses of these mothers are at greater risk of intrauterine growth retardation, prematurity, and intrauterine death (Sammour et al., 2011).

Pre-eclampsia (PE) is a pregnancy-associated multisystem disorder with no definite etiology, the primary cause of PE is still under investigation. However, it is thought to occur in two stages. The first stage encompasses the impairment of fetal trophoblastic invasion of the decidua and local placental hypoxia. The second stage is the release of placental blood-related factors into the maternal circulation and aberrant expression of pro-inflammatory, antiangiogenic, and angiogenic factors. PE is usually characterized by elevated blood pressure and proteinuria, with the clinical manifestation usually occurring during the 20th week of gestation or late in pregnancy and regressing post-delivery. It is grouped into two main types: early-onset PE (occurring before 34 weeks of gestation) and late-onset PE (occurring after 34 weeks of gestation). Although the presenting features of early- and late-onset PE may overlap, early-onset PE is associated with increased odds of complications, particularly preterm birth, fetal growth restriction, and maternal morbidity and mortality compared to late-onset PE. Women with PE also present with diverse signs and symptoms associated with multiple organ systems. Headaches, visual disturbances, abnormal kidney function, severe hypertension, chest pain, pulmonary edema and low oxygen saturation, nausea, and abnormal liver function are among the common outcomes of multi-organ system dysfunction in PE (Fondjo et al., 2019).

A study conducted in southern Ethiopia showed that the presence of a family history of pregnancy-induced hypertension, chronic kidney diseases, and gestational age were predictors of pregnancy-induced hypertension (Gudeta & Regassa, 2019). Another study

also showed that those with a history of pregnancy-induced hypertension, a history of renal disease, as well as a family history of hypertension have been identified as defining factors for hypertensive disorders of pregnancy. Furthermore vegetable, and fruit intake has been identified as protective factors for pregnancy-induced hypertension (Belayhun et al., 2021). The findings of another study indicated that women with past history of PIH had an increased risk of pregnancy-induced hypertension, whilst ≥ 3 past pregnancies and informal educational status reduced the odds of developing pregnancy-induced hypertension (Babore et al., 2021). Factors associated with pre-eclampsia include a personal or family history of high blood pressure, advanced age, and a family history of diabetes. It also indicated that encouraging pregnant women to health-seeking behavior during pregnancy will provide a chance for pre-eclampsia to be diagnosed as early as possible (Tessema et al., 2015).

2.5.3 Management of hypertension in pregnancy

According to the 2013 ESH/ESC guidelines, antihypertensive therapy is recommended during pregnancy when blood pressure levels are ≥150/95 mmHg. It is recommended to start antihypertensive therapy at values ≥ 140/90 mmHg in women with: a) gestational hypertension, with or without proteinuria, b) pre-existing hypertension with overlap of gestational hypertension or c) hypertension with damage Organs, either asymptomatic or asymptomatic at any time during pregnancy. Atenolol and metoprolol appear to be safe and effective in late pregnancy, while labetalol has an efficacy comparable to methyldopa. Methyldopa is the drug of choice in pregnancy. Angiotensin-converting enzyme (ACE) inhibitors and angiotensin II antagonists are contraindicated in pregnancy due to their association with an increased risk of fetopathy (Mancia et al., 2013).

The main health professionals who care for pregnant women are obstetricians, midwives, general practitioners (GP), and obstetric physicians. The GP has an important role in pre-conception counseling, especially with women who have chronic diseases such as hypertension or asthma (Steve, 2017).

Pregnant women with complications such as chronic hypertension or a previous pregnancy complicated by hypertensive disorders of pregnancy (HDP), however, need to be cared for by an obstetrician, who can monitor the progress of the pregnancy, blood pressure (BP), signs of pre-eclampsia, and fetal growth. The obstetric physician is usually involved in

prescribing and monitoring antihypertensive medication and BP control. Pregnant women who have had pre-eclampsia previously or who have chronic hypertension are at risk of developing pre-eclampsia (Steve, 2017). Timely administration of low-dose (81-100 mg) aspirin before 16 weeks' gestation has been found to reduce the risk of pre-eclampsia (Roberge et al., 2017).

Monitoring of BP occurs at each antenatal visit. If her BP is elevated, the woman may be referred to a day assessment unit for a 4-h assessment of BP, which involves taking BP readings every half an hour for 4 h to observe the pattern of the BP and decide whether a diagnosis of HDP and/or prescription of antihypertensive medication is warranted. In addition, tests for urinary protein, full blood examination, renal function tests, and fetal monitoring are performed. This 4-h assessment is seen as a favorable alternative to overnight inpatient stays, both in terms of patient satisfaction and public health economics (Dunlop et al., 2003).

2.5.4 Complications of hypertension in pregnancy

Hypertensive disorders during pregnancy may result in long-term effects on the mother and baby. These long-term outcomes include an increased risk for cardiovascular morbidity and mortality, cerebrovascular disease, peripheral artery disease, venous thromboembolism, as well as renal and neurological disease. Also, women with pre-eclampsia have an increased risk of developing chronic hypertension (Hutcheon et al., 2011; Lo et al., 2013). In addition to the maternal effects, there are numerous effects on the fetus and infant. Studies from industrialized countries show that women with pre-eclampsia have a 35% higher risk of stillbirth, while studies from less developed nations show that preeclampsia is associated with a double risk of stillbirth (Hutcheon et al., 2011). Women also have an increased risk for iatrogenic preterm delivery which is more likely to result in low birth weight (Hutcheon et al., 2011; Xiong et al., 2000). Neonatal mortality is about double higher among infants whose mothers have pre-eclampsia (Basso et al., 2006).

2.5.5 Perspectives of pregnant women for high blood pressure

A study conducted to find out women's perspectives and experiences in managing hypertensive disorders of pregnancy (HDP) shows that clinical management experiences for pregnant women with HDP are diverse. Many women did not feel well informed about management decisions and had a desire to be more informed and involved in decision-

making. The study recommended providing clear and concise information to pregnant women about various aspects of HDP management including monitoring blood pressure, prescribing an appropriate antihypertensive, and planning for a possible preterm birth (Helou et al., 2021).

A study found that women with pre-eclampsia, their partners, or relatives had no knowledge of pre-eclampsia before diagnosis, nor did they know how severe or life-threatening it was. The study showed that women wanted access to information about pre-eclampsia, and their lack of knowledge of pre-eclampsia or its risks lead to great concern about future pregnancies(East et al., 2011). Understanding these perceptions and experiences is imperative to the optimization of Hypertensive disorders of pregnancy (HDP) management (Ouasmani et al., 2018). It is important to have good, clear communication with women about the need for close monitoring, affirmation concerning their status as worthy of hospital care, provision of consistent information, inclusion in decision-making, and good social support (Barlow et al., 2008).

Counseling women before they become pregnant regarding potential risks during pregnancy allows them to be more aware of what to expect. Furthermore, talking with women with pregnancy hypertension about the information they need about the symptoms and risks of pregnancy hypertension would help improve understanding as well as avoid unnecessary confusion and anxiety (Seely & Ecker, 2014).

One study reports a high prevalence of insufficient knowledge of preeclampsia among the study population of pregnant women in Ghana (88.4%). Moreover, among the participants with sufficient knowledge (11.6%), only 2.3% had high knowledge of PE. But only a limited number had sufficient knowledge about the symptoms, risk factors, and complications of PE. The findings indicated that advanced age and having a higher level of education were significantly associated with greater odds of having adequate knowledge of PE (Fondjo et al., 2019).

UNICEF carried out a study and collect information on availability, accessibility, quality of delivery practices, and financing of the MNCH services with a strong focus on gender considerations through the key informant interviews conducted with head doctors/directors of PHC facilities, Maternity Hospitals, and NCUs. In addition, Focus Group Discussions were conducted among the end-users of the MNCH services. The result showed that the

service utilization/delivery is very limited and at the time of assessment amounted to 3 women. (UNICEF, 2019).

2.5.6 Quality

WHO (2018), describe the quality of care by specifying three main dimensions or attributes: effectiveness, safety, and responsiveness or patient-centeredness.

Quality of Care (QOC), as described by Donabedian, depends on three components: structure (adequacy of physical environment and systems), process (components of care delivered), and outcomes (satisfaction/status of clients). That is to say, facilities should be well stocked with essential commodities, services should be provided by competent healthcare workers, and clients should leave well-informed, satisfied, and respected (Donabedian, 2005).

Maternal deaths (hemorrhage, infections, and blood pressure during pregnancy (preeclampsia and pre-eclampsia)) can be prevented at many levels by different individuals and organizations, largely by addressing the contributions of systems defects that lead to poor maternal results. Social, Political, and clinical interest in the drivers of maternal mortality may reveal gaps in access to quality care and opportunities for improvement at the individual, clinician, health facility, or system level (Mitchell et al., 2014). Evidence-based, high-quality clinical practice guidelines aid appropriate diagnosis and treatment to improve outcomes(Bazzano et al., 2016).

Dual streams of poor-quality or inaccessible care coexist everywhere, and it is global covering low-, middle- and high-income countries, including fragile and conflict-affected states; and those who are considered economically and politically stable. Every woman, everywhere, has a right to quality maternity services, and the benefits of this access extend to the fetus, newborn, children and adolescents. (Koblinsky et al., 2016).

High-quality clinical practice guidelines enhance best practices in the management of gestation hypertension with the expected health benefits of decreasing perinatal and prenatal morbidity and mortality in women with or at risk of hypertensive pregnancy, as well as reducing mortality and morbidity in infants associated with these hypertensive disorders (Bazzano et al., 2016).

A study showed that the implementation of the quality improvement initiative for perinatal hypertension associated with pregnancy and postpartum has improved the provision of timely and appropriate treatment for severe hypertension and demonstrated the impact of multidisciplinary communication in this process(Schneider et al., 2021).

A study indicated that every facility where women give birth should ensure that clinical teams are aware and trained to recognize and respond to deteriorating clinical status in perinatal women to improve the quality of care provided to pregnant women. It also recommended the continuing need to educate and train clinicians about the care of women with complex comorbidities who develop complications in pregnancy, childbirth, and the postpartum period (Morton et al., 2019).

A study was conducted to clarified quality improvement opportunities (QIOs) associated with the five leading causes of pregnancy-related death in California. The researcher encoded and thematically organized QIO data using three of the four domains commonly applied in quality improvement initiatives for maternal health care: Readiness, Recognition, and Response. The findings showed key themes across the five leading causes of death. In the area of readiness, the topics were related to the general readiness of the facility and helping women prepare and learn about pregnancy and childbirth. The Recognition domain addressed the need for doctors to better recognize risk factors and women's signs and symptoms to ensure an accurate diagnosis. In the area of response, three themes were prevalent, and they were related to coordination of care, timing of treatment, and follow-up care (Morton et al., 2019).

Hypertensive disorders of pregnancy, including pre-eclampsia and eclampsia (PE/E), are between the major common causes of maternal and neonatal complications. PIH can lead to fatal complications for both the mother and fetus. This study was conducted to assess the quality of early detection and management of PE/E in health facilities and skilled birth attendants (SBAs) perceptions of their working environment. The findings showed marked gaps in SBAs' knowledge and clinical practices in the detection and management of PE/E in different health facilities rising the risk of maternal and perinatal mortality. The study recommended the necessity of continuing education for healthcare providers and increasing investment to enhance the quality of healthcare services provided to pregnant women(Ansari et al., 2019).

Hypertension and its complications are responsible for a significant proportion of maternal and neonatal morbidity and mortality worldwide. This study was conducted to determine spread of complications, risk factors, and social and demographic characteristics of hypertensive complications of pregnancy in Dora Nginza Hospital. The findings indicated that hypertensive disorders of pregnancy in Dora Nginza hospital are common and are an important cause of maternal and perinatal morbidity and mortality. And that improving socio-economic status and quality obstetric services which include early referral, proper prenatal care, proper documentation, and early booking can decrease the effects of hypertensive disorders of pregnancy (Ojodun, 2012).

Many factors influence skilled birth attendants' (SBAs') performance on quality intrapartum and postnatal care, such as, workload, access to training and supervision, living conditions, and salaries, access to well-equipped and well-organized health facilities and transport(Munabi-Babigumira et al., 2017).

Enabling environment, managerial culture, and organizational context as well as the overall health system also play interrelated critical roles in the quality of health service(Ollerhead & Osrin, 2014; World Health Organization, 2006). Factors including lack of teamwork, high workload, lack of medicines, unavailability of equipment and supplies, and lack of supervision and training opportunities can discourage health workers and thus affect the quality of health service(Dieleman & Harnmeijer, 2006). Moreover, factors such as resource allocation, planning and deployment of health workers, policy and regulatory framework, communication and decision-making processes, and accountability mechanisms also affect performance from the perspective of the broader health system(World Health Organization, 2006).

A study recommended that improving maternal health and ensuring the provision of quality health care requires actions and allocating policies and resources to address the many factors that affect the provision and use of maternal health care. These measures include prioritizing quality maternal health services, addressing emerging challenges; Increasing the resilience and strength of health systems through improving the health workforce and enhancing facility capacity; Promoting equality through universal coverage of quality maternal health services, including for the most vulnerable women; Ensuring sustainable funding for maternal and perinatal health; Accelerate progress through evidence, advocacy, and accountability (Koblinsky et al., 2016).

The unavailability of essential medicines increases the risk of maternal and perinatal mortality and morbidity(Ansari et al., 2019). A study recommended strengthening existing national logistics management systems to ensure adequate forecasting, supply, and availability of essential drugs and commodities(Sharma et al., 2015).

Maternal and neonatal deaths are usually associated with a poor health environment and a serious lack of healthcare resources, including medicines, healthcare professionals, and healthcare infrastructure(Chowdhury et al., 2009). Poor quality care during hospital births is a major contributing factor to maternal- and neonatal-related complications in developing countries(Koblinsky et al., 2006; Van Den Broek & Graham, 2009).

In the developing world, including African countries, healthcare systems suffer from various inadequacies related to staff training, prenatal screening, knowledge, and use of evidence-based protocols, prompt cesarean delivery, multidisciplinary care, and lack of quality improvement (QI) support. A weak healthcare system places women and their babies at risk for morbidity and mortality (Thaddeus & Maine, 1994).

The doctors and nurses in a study mentioned that they did not receive any formal training or refresher training after they graduated from medical colleges or nursing institutes, which promotes their lack of efficiency to provide quality care(Bookman et al., 2010).

Healthcare providers in Thakurgaon District Hospital expressed their concern about not receiving any in-service training and refresher courses in obstetric and neonatal care, in particular in general and emergency management. They noted that several important and new management issues in obstetrics are emerging, in which they need to be well versed. This critically affects the quality of care rendered to the women and often results in loss of life (Islam et al., 2015).

A study revealed that a shortage of personnel was the main barrier to ensuring the quality of care at different types of facilities. This shortage leads to work overload on the few available doctors, nurses, and support staff available, which further reduces morale and the ability to provide quality care (Islam et al., 2015)

Respondents in a study conducted in district hospitals in Bangladesh reported that training should be organized for all types of health care providers to help them maintain a level of high-quality health care services. In addition, several participants suggested that additional

incentives should be provided to health care providers to motivate them to improve the quality of their care (Islam et al., 2015).

The study was conducted to verify health workers' awareness of the quality of care and the factors that influence the provision of quality emergency obstetric care. The findings indicated that the general perception of health workers of the quality of emergency obstetric care provided was poor. Poor quality of care was identified as related to client and facility/staff factors. Patient factors that have emerged as contributing to poor quality of care are: client delays in seeking care: dependence on TBAs, reliance on traditional medicines, and lack of awareness regarding signs of an emergency obstetric condition. Topics related to facilities/staff that have emerged as a contribution to poor care are; Insufficient resources, inadequate staffing, poor teamwork, insufficient knowledge/ supervision (Chodzaza & Bultemeier, 2011).

The study was conducted to determine whether hospitals with good organization of care (such as improved nurse staffing and work environments) can affect patient care and nurse workforce stability in European countries. The main outcome measures Nurse outcomes (work environments, hospital staffing, dissatisfaction, burnout, patient safety, intention to leave job in the next year, quality of care), and patient outcomes (satisfaction overall and with nursing care, willingness to recommend hospitals). The findings showed that improved work setting and decreased patient-nurse ratios were associated with improving quality of care and patient satisfaction. Each additional patient for each nurse rises the odds that nurses will report poor or fair quality care and poor or failed safety scores. Patients in hospitals with better work environments were more likely to rate their hospitals highly and recommend their hospitals. Deficiencies in the quality of hospital care were common in all countries. Improving hospital work environments may be a relatively low-cost strategy to improve the safety and quality of hospital care and increase patient satisfaction (Aiken et al., 2012).

2.5.6.1 Safety

The study, conducted by UNICEF, revealed that both, auditory and visual privacies for patient consultations are available in two out of five assessed PHC centers (Al Rimal and Jabalia). The remaining three centers (Al Aqsa, Rafah, and Khan Younis) reported that privacy is not secured. also mentioned that 5 out of 6 maternity hospitals (in all except Al

Shifa) that privacy and security are ensured at their hospitals, however, according to the findings in the remaining hospital several patients are regularly served in the same room, violating privacy rules. (UNICEF, 2019). This contradicts the concepts of the quality of health services provided, which include safety, which means Avoid maleficence the people who are the target of care.

The shortage of essential life-saving pharmaceuticals for mothers and children in the Gaza Strip has increased the risks of disability and death among pregnant women and newborns(OCHA, 2019).

Hypertensive disorders of pregnancy are a leading contributor to maternal morbidity and mortality. Prompt and appropriate treatment can greatly reduce complications arising from these disorders (American College of Obstetricians and Gynecologists (ACOG), 2013).

The Safety Package for Severe Hypertension in Pregnancy and Postpartum was issued by the National Partnership for Maternal Safety. It is organized into four domains areas: preparedness, recognition and prevention, response, reporting and systems learning (Bernstein et al., 2017).

Safety Bundle for Severe Hypertension During Pregnancy and Postpartum:

Readiness

Create standards delineating early warning signs, diagnosis, monitoring, and treatment for women presenting with severe preeclampsia or eclampsia, provide education about protocols via an interdisciplinary team, ensure timely assessment and triage of women presenting with hypertension during pregnancy or postpartum in all potential care areas, such as outpatient and emergency departments, and enable rapid, easy access to standardized, premixed medications commonly used to treat severe hypertension or eclampsia (Wisner, 2018).

Recognition and Prevention

Implement standardized protocols for accurate blood pressure and urine protein measurement and assessment for women during pregnancy and postpartum along with staff education and skills monitoring, and implement systems for early detection of deterioration by creating a standard response to maternal early warning signs that includes prompt

bedside evaluation, and make patient education resources available in all areas caring for pregnant and postpartum women about relevant signs and symptoms and appropriate follow-up (Wisner, 2018).

Response

Develop standardized protocols for the management and treatment of severe hypertension, preeclampsia, or eclampsia in all areas caring for pregnant and postpartum women, including checklists and escalation policies as well as defining blood pressure criteria, response time, seizure prophylaxis, onset and duration of magnesium sulfate therapy, and guidelines for managing magnesium toxicity, clear strategies for educating women about care and follow up postpartum should also be included in protocol development along with a verification process to ensure that women are seen within 1 to 2 weeks postpartum, and for severe cases necessitating ICU admission, consider support needs for the woman, her family, and staff (Wisner, 2018).

Reporting and Systems Learning

Establish structured team huddles for high-risk patients and post-event debriefs to identify areas of strength and opportunity, implement a process for multidisciplinary review of all severe cases requiring an ICU admission to identify and respond to process and system issues, and routinely monitor and respond to structure, process, and outcome measures (Wisner, 2018).

The availability of essential pharmaceuticals and medical supplies was evaluated by UNICEF in primary health care facilities, and it was found that there are two types of essential medicines (dexamethasone and insulin) out of 11 essential pharmaceuticals, as well as a shortage of life-saving medicines. In maternity hospitals, according to the results of the evaluation, 12 different medicines and vaccines were available. Emirates Hospital reported the availability of medicines for the selected drugs was 100%, followed by Kamal Adwan with 75% of the selected drugs, and Al-Shifa Hospital reported the availability of 67% of the selected drugs (UNICEF, 2019).

2.5.6.2 Effective

The availability and use of the guidelines including guidelines for antenatal, postnatal, and pre-conception care and immunization) in primary healthcare facilities in the Gaza strip were evaluated by UNICEF. The findings revealed the need for additional investment in this area to ensure the delivery of high-quality services (UNICEF, 2019). The quality of care can be much better if patient management protocols are used such as preeclampsia protocols(Islam et al., 2015). Quality, evidence-based ANC plays a crucial role in improving the lives of pregnant women, and in setting the groundwork for healthy motherhood and infant development(WHO, 2016). High-quality antenatal care (ANC) plays a crucial role in the early detection and management of hypertensive disorders in pregnancy (HDPs). Increasing the utilization of quality ANC is essential to reducing maternal mortality caused by this class of diseases (Salomon et al., 2019).

A study showed that doctors, nurses, and other healthcare professionals did not always use medical protocols to provide standardized care in these medical settings(Islam et al., 2015). However, written protocols are a prerequisite for standardized patient care(Brainin et al., 2004).

2.5.6.3 Efficient

This study was conducted to determine the cost-effectiveness and to assess patient satisfaction with day care for the management of hypertensive disorders during pregnancy. Data was collected from near to 1,200 consecutive women with hypertensive disorder during pregnancy at the Pregnancy Day Care Centre, Royal Women's Hospital, Melbourne. The results demonstrated that pregnancy day care is a cost-effective way to provide care for women with hypertensive disorders during pregnancy. Women prefer day care to inpatient care (Dunlop et al., 2003).

2.5.6.4 Timely

The study was conducted in Bangladesh to assess the perceived level of quality of care in maternal and newborn health in public facilities through patient interviews, in-depth interviews with healthcare providers, and focus group discussions with stakeholders. Both patients and service providers expressed dissatisfaction with the quality of care due to long waiting times with less consultation time, poor hygiene, poor empathy by providers, an

insufficient supply of drugs and unobserved cost of services that vary by level of facilities, and inadequate human resources, absenteeism and poor laboratory service to exacerbate the situation, especially at the lowest level of service provision (Chowdhury et al., 2009).

The timing of delivery in women with HDP is dependent on many maternal and fetal factors, including an inability to stabilize BP, deteriorating liver and/or renal function, placental abruption, and severe fetal growth restriction. Fetal morbidity and mortality are linked to the gestational age at delivery (Lowe et al., 2015). Timely administration of low-dose (81-100 mg) aspirin before 16 weeks of gestation has been found to reduce the risk of pre-eclampsia (Roberge et al., 2017).

2.5.6.5 People-centered

Treating women with respect and participating in decisions about their care may motivate women to use health services (Callaghan-Koru et al., 2016). A study stated that poor communication between the provider and the patient can discourage the use of the health service (World Health Organization, 2013).

One of the most commonly used models within maternity service policies is Women Centered Care (WCC) which is viewed as the cornerstone of the partnership between the midwife and the woman (Carolan & Hodnett, 2007). The women-centered philosophy of care emerged after a set of modernizing reforms of the NHS and focus on individualized needs with the expectation that healthcare professionals would work in collaboration with the women to meet their needs (Pope et al., 2001). Women-centred care has been closely linked to the midwifery practice, as most women have a midwife as their primary healthcare provider throughout pregnancy, labour, and the postnatal period. Whilst the midwife is an expert in the care of uncomplicated pregnancies, she also provides a pivotal role in coordinating the journey through pregnancy for all women (NHS, 2010).

The RCM contributed to the developing philosophy of woman-centered care' and stated that it is the term used '[for a philosophy of maternity care] that gives priority to the wishes and the needs of the user, and emphasized the importance of informed choice, continuity of care, user involvement, clinical effectiveness, responsiveness, and accessibility (Royal College of Midwives, 2001).

Women-centered midwifery has been introduced by Leap (2000) as 1. It focuses on the needs, aspirations, and expectations of women, rather than the needs of the institution or professionals. 2. Awareness of the woman's need for selection, control and continuity from a well-known caregiver or providers. 3. It includes the needs of the child, the woman’s family and other persons important to the woman, as determined and negotiated by the woman herself. 4. Follow-up of women through the interface of society and acute situations. 5. Addressing social, emotional, physical, psychological, spiritual and cultural needs and expectations. 6. Recognize women's decision-making experience

Chapter Three

Material and Methods

This chapter describes the method and techniques used in the collection and analysis of the data. These include the research design, population, sample and sampling procedure, instruments used for data collection, data collection, and data analysis procedure.

3.1 Study design

Based on the nature of the study and the objectives, The researcher used the descriptive cross-sectional design to assess the quality of health care provided for hypertensive disorders pregnancy women at maternity governmental hospitals in the Gaza Strip. They are useful in describing research variables because they occur naturally without the intervention of the researcher and it allows us to describe and document a large amount of data about all factors contributing to the quality of care in a short time, also it cheap and economical (Polit and Beck, 2012).

3.2 Setting of the study

The study was conducted in high-risk departments at maternity governmental hospitals in Gaza Strip. (Nasser Medical Complex, Al-Emaraty Hospital, Al-Shifa Medical Complex, and Aqsa Martyrs Hospital), the number of high-risk departments at government hospitals in the Gaza Strip is four.

3.3 Study population

The population of the study included all hypertensive pregnant women who were admitted to high-risk departments for hypertension disorders management during the period of study.

3.4 Sample and sampling Technique

The sample of the study is non-probability, convenience sampling method was applied to select the sample of the study which includes pregnant women who are admitted to the high-risk departments at maternity governmental hospitals during the data collection period. The study population considered as the mean cases of those who were admitted to the high-risk departments with hypertensive disorders pregnancy at Nasser Medical

Complex, Shifa Medical Complex, EL Emaraety Hospital, and Al-Aqsa Hospital in the Gaza Strip.

the researcher reviewed the medical records to calculate the sample size, but there is a lack of documentation and according to the nursing managers, the estimated number of hypertension disorders pregnancy admissions at the four maternity governmental hospitals is between 100 -130.

The sample of the study included all hypertensive pregnant women who were admitted to high-risk departments for hypertension disorders management during the period of data collection between 15 May to 15 Jun 2022, The sample size was 110 hypertensive disorders pregnancy women (32 in Nasser Medical Complex, 42 in Shifa Medical Complex, 21 in EL Emaraety Hospital and 15 in Al-Aqsa Hospital).

3.5 Eligibility

3.5.1 Inclusion criteria

- Hypertensive Pregnant women who were admitted to the high-risk department.

3.5.2 Exclusion criteria

- Hypertensive pregnant women fatigue who can't fill in the questionnaire.

3.6 Data collection and study instrument

The researcher used a structured interviewing questionnaire with selected pregnant women regarding the quality of care at health services provided in high-risk departments at maternity governmental hospitals.

The women received an explanation of the aim of the study and were asked to participate in the study voluntarily. The women who agreed to participate in the study received and filled out the questionnaire as instructed by the researcher.

The questions were based on a structured questionnaire that was composed of two sections **Section 1**: consisted of demographic data (age, gender, GTPAL, etc.)

Section 2: consisted of domains' influence on the quality of care. It includes 6 domains (effectiveness, time, equitable, efficient, patient-centered, and safe).

3.7 Study period

The study was conducted in the period between Feb 2022, and Nov 2022.

3.8 Pilot study

A pilot study of 10% of the total sample size (n=12) was conducted before the actual data collection process begin and distributed to pregnant women in high-risk departments at maternity governmental hospitals as a pretest to determine the real-time needed to fill the questionnaire and identify areas of vagueness, to point out weaknesses in wording and translation to Arabic.

3.9 Validity

3.9.1 Face and content validity

The questionnaire was distributed to a panel of experts (Annex, 5) in research methodology to examine the validity, clarity, and suitability of its contents, and to determine whether the items in the questionnaire are relevant and suitable to the study purpose and whether their comments considered.

3.10 Reliability

The reliability of an instrument is the degree of consistency of the questionnaire. For this purpose, the researcher used the Cronbach alpha coefficient to estimate the reliability coefficients for the study instrument. The results are shown in table (3.1).

Table (3.1): Cronbach alpha for study domain questionnaires

Domains	**No. of items**	**Alpha coefficient**
Safety	10	0.876
Effectiveness	9	0.871
Patient-centered care	15	0.892
Timely	9	0.867
Efficient	8	0.782
Equitable	10	0.741
Total score	**61**	**0.893**

3.11 Ethical and administrative considerations

- An official letter was obtained from the Al-Quds University of Gaza.
- An approval from MOH in Gaza (Annex, 4).
- An ethical committee at Al. Quds University (Annex, 5)
- The informed consent was attached to the questionnaire; respondents were assured that the data will only be used for research purposes, and confidentiality was maintained. Participants have the right to refuse to participate or withdraw from the study at any time.

3.12 Data entry and statistical analysis

Data was entered into the computer using the statistical package for social sciences (SPSS) version 22. The stages of data analysis included: coding the questionnaire, data entry, and data cleaning. Data cleaning were performed by reviewing frequency tables, and random selection of questionnaire to ensure the accuracy of data entry.

The statistical analysis included:

- Frequencies and descriptive data (Means, ranges, percentages, and standard deviations) were conducted to assess the research variables.
- One-way ANOVA and t-test to examine differences between variables
- Post hoc analysis.

3.13 Limitations of the study

There are some limitations to conducting this study:

1. The difficulties of data collection because most of the participants are fatigued.
2. Limited time to conduct the study.
3. The sample size is limited and depends on the pregnant women's admission to high-risk departments at maternity hospitals.

Chapter Four

Results and Discussion

This chapter presents the results of the statistical analysis of the data including the description of the participants, and the women's perspective at maternity governmental hospitals in the Gaza Strip regarding the quality of health care provided for hypertensive disorders during pregnancy. In addition, the results of different variables were identified. Moreover, the differences between selected variables were explored and discussed in the literature review and previous studies.

4.1 Demographic nurse characteristics

Table (4.1): Sample distribution based on the participant's age, and level of education

Variables		**Frequency**	**Percentage**
Age (years)	less than 20	10	9.1
	20-30	53	48.2
	Above 30	47	42.7
	Total	110	100.0
	Mean age = 29.5 years		**S.D = 6.01**
Level of education	Prep school	11	10.0
	Secondary school	38	34.5
	University	61	55.5
	Total	110	100.0

Table (4.1) showed that the mean age of the participants was 29.5 years, the highest number of pregnant women age group was 53 (48.2%) aged 20 – 30 years, and 42.7% of pregnant women 47 (42.7%) were aged above 30 years. Also, regarding the level of education of the participants, more than half (55.5%) had a university degree.

The results of this study were relatively in line with one recent study conducted in the Gaza Strip to identify the adverse effect of HDP on newborn outcomes, which revealed that 9.8% of participants aged less than 20 years and 68.8% aged from 21 to 35 years (Eljedi & Elqatrawi, 2019). The findings of this study were inconsistent with the report from the Palestinian Central Bureau of Statistics (PCBS), which revealed that the percentages of completion of different educational levels (elementary education, secondary education, upper/senior secondary education) (PCBS, 2021).

Women's participation rate in formal and non-formal education and training increased and reached 17.2%, compared to 18.0% for men in 2021 (PCBS, 2021). The net enrollment ratio in the elementary stage increased for females compared to males, where it reached 98.4% among females compared to 95.4% among males. In addition, the percentage of females enrolled in the high school stage reached 84.8% compared to 65.9% among males (PCBS, 2021). According to researcher opinion these contradict findings may be explained by the small sample size.

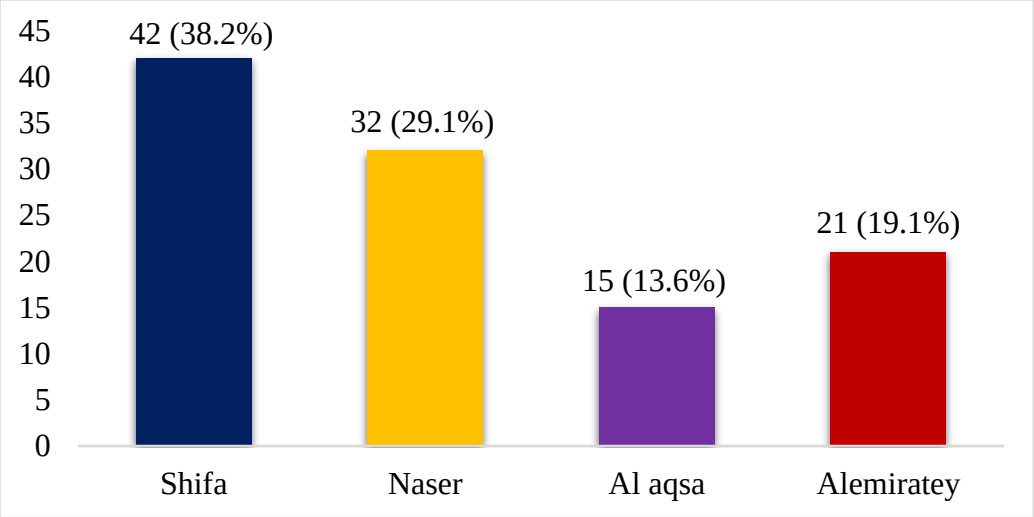

Figure (4.1): Distribution of participants by hospital

Figure (4.1) showed that 42 (38.2%) of the study participants were from Al Shifa hospital which is the largest hospital in GS, 32 (29.1%) from Naser hospital, 21 (19.1%) from Alemiratey hospital, and 15 (13.6%) from Al-Aqsa hospital.

Table (4.2): Obstetric History of the participants

Variables		Frequency n=110	Percentage
Gestational Period	20-36 weeks	38	34.5
	37-38 weeks	28	25.5
	39-40 weeks	41	37.3
	After 40	3	2.7
	Mean pregnancy duration = 37.2 weeks		**S.D = 2.98**
Gravida	1-3	47	42.7
	4-6	38	34.5
	More than 6	25	22.8
	Mean = 3.2		**S.D = 2.33**
Para	Zero	12	10.9
	1 – 3	51	46.4
	4 - 6	37	33.6
	More than 6	10	9.1
	Mean = 3.4		**S.D = 2.34**
Livebirth	0	23	20.9
	1-3	49	44.5
	4-6	32	29.1
	More than 6	6	5.5
	Mean = 2.7		**S.D = 2.26**
Stillbirth	No	103	93.6
	Yes	7	6.4
Abortion	Never	73	66.4
	Once	23	20.9
	Twice	9	8.2
	More than twice	5	4.5
Total		**110**	**100.0**

Table (4.2) shows the pregnancy duration of the women, 37.3% of the pregnant women in the current study have 39-40 weeks, one-third (34.5%) have 20-36 weeks, and the mean pregnancy duration is 37.2 weeks. About 42.7% of women have had 1-3 pregnancies, and 34.5% of them have 4-6 pregnancies, and the mean of pregnancies is 3.2. The results of this study were consistent with other studies, which indicated that 49.8% of participants have had 3 or less pregnancies and 34.0% have had 4-7 pregnancies (Eljedi & Elqatrawi, 2019). The mean Gravida in other study was 4 (Subki et al., 2018).

Also, 46.4% of the women have had 1-3 deliveries and 33.6% of them have had 4-6 deliveries, and the mean of deliveries is 3.4. While, 56.7% of women have three or less deliveries and 36.3% of women with HDP have from 4 to 7 deliveries in other studies (Eljedi & Elqatrawi, 2019).

Moreover, 44.5% of the women have 1-3 children, 20.9% have never lived birth, and the mean of live birth for the participants was 2.7. While, the majority of the participants (93.6%) have never stillbirth, and only 6.4% have had a stillbirth. Results of a recent study revealed that 99.1% of PHD women have a live birth, while only 0.9% of participants have a stillbirth (Eljedi & Elqatrawi, 2019). Two-thirds of the participants have never abortion, 20.9% of the women have one time of abortion, and only 4.5% have had abortions more than twice. The findings of this study were agree with other studies, which revealed that 55.3%, 22.8%, and 21.9% of PHD women have never abortion, one abortion, and twice and more abortions, respectively (Eljedi & Elqatrawi, 2019).

Table (4.3): Previous medical history of the participants

Variables		**Frequency**	**Percentage**
Previous Medical History	No previous medical disease	67	60.9
	Diabetes Mellitus	16	14.5
	Hypertension (HTN)	17	15.5
	Diabetic and HTN	7	6.4
	Others	3	2.7
Previous hospital admission	Yes	57	51.8
	No	53	48.2
Number of hospital admission	No	53	48.2
	Once	19	17.3
	Twice	15	13.5
	More than twice	11	10.0
	Mean = 1.46		**S.D = 2.17**
Classification of PIH	Chronic HTN	15	13.6
	Pre-eclampsia	89	80.9
	Eclampsia	4	3.6
	Gestational HTN	2	1.8
	Total	**110**	**100.0**

Table (4.3) shows the previous medical history of the participants, the majority of women (60.9%) have no previous medical diseases, nearly 15% have hypertension or diabetes mellitus and 15.5% have both disease hypertension and diabetes mellitus.

Also, more than half (51.8%) of women have a history of hospital admission. 17.3% of them were admitted to the hospital one time, and 10.0% were admitted to the hospital more than twice.

Regarding the classification of Pregnancy Induced Hypertension (PIH), the majority of the women 80.9% have preeclampsia, 13.6% have chronic hypertension, only 3.6% have eclampsia and 1.8% have gestational hypertension.

This result is consistent with (Duley, 2008) who found that Pre-eclampsia is more common among women likely to have a large placenta, such as those with multiple pregnancies, and among women with medical conditions associated with microvascular diseases, such as diabetes, hypertension, and collagen vascular disease.

The researcher believes, the reason for the increase in the percentage of preeclampsia cases is the study sample which includes the cases that need admission, follow-up, and treatment for PIH, while the percentage of cases of eclampsia decreased as a result of follow-up and treatment of PIH to prevent complications.

4.2 Analytical result the dimensions of the questionnaire

Table (4.4): Total women's mean perspectives, SD, and ranking of study Quality of Health Care provided for Hypertensive disorders (n=110).

No.	Developmental Care Domains	No. of items	Mean	S.D.	%	Rank
1	**Safety**	10	4.13	0.47	82.6	**1**
2	**Effectiveness**	9	4.07	0.47	81.4	**3**
3	**Patient-centered care**	15	4.08	0.49	81.6	**2**
4	**Timely**	9	3.99	0.67	79.8	**4**
5	**Efficient**	8	3.96	0.48	79.2	**5**
6	**Equitable**	10	3.87	0.46	77.5	**6**
Total score		**61**	**4.01**	**0.37**	**80.*3***	

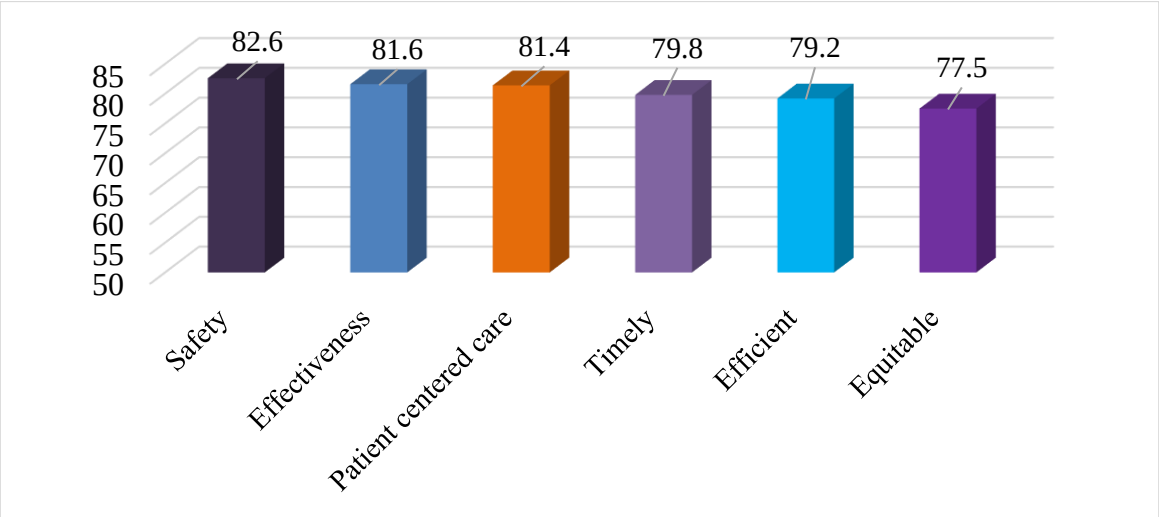

Figure (4.2): Distribution of study participants by mean percentage of the quality of Health Care provided for Hypertensive disorders

Table (4.4) and Figure (4.2), show the mean percentage for the quality of health care domains for hypertensive disorder women at maternity governmental hospitals in the Gaza strip, the total mean percentage for all quality of health care domains was 80.3% (mean = 4.01, S.D. = 0.37). The results also showed that the highest domain in women perspectives to quality of health care was safety domain (mean = 4.13, S.D. = 0.47) with relative weight equals 82.6%, followed by patient-centered care domain (mean= 4.08, S.D. = 0.49) with relative weight (81.6%), effectiveness domain (mean = 4.07, S.D.= 0.47) with relative weight 81.4%, timely domain (mean = 3.99, S.D. = 0.67) with relative weight 79.8%, efficient domain (mean = 3.96, S.D. = 0.48) with relative weight 79.2% and the last rank domain was equitable domain (mean = 3.87, S.D. = 0.46) with relative weight 77.5%.

The researcher found that the domain of patients centered care got second place. This result is explained that nurses and midwives deal with women uniquely, women feel involved in their treatment and care and can make informed choices to improve their compliance and satisfaction with the treatment. Women are informed about their rights and options for care and encouraged to ask questions. They are supported in making decisions about all aspects of their care and treatment; their values and beliefs are respected, and their consent is obtained before procedures are carried out.

The researcher believes that the domain of effectiveness got third place in the quality of healthcare and this indicates that the hypertensive women are immediately given intravenous or intramuscular magnesium sulfate and an antihypertensive, as appropriate. A

pre-referral loading dose of magnesium sulfate should be given if the woman is to be transferred. Signs of organ dysfunction and other danger signs (blood pressure, respiratory rate, fluid balance, urine output, tendon reflexes, and fetal heart rate) are monitored. Laboratory testing of urea and electrolytes determines the progression of the disease. If the woman is at term or the fetus is nonviable, labour is induced with instrumental intervention or cesarean section, as appropriate. For preterm pregnancies, proactive management with corticosteroids is undertaken if the condition is stable.

The researcher found that the domain of timely got fourth place in the quality of health care. This result is explained by essential equipment is available in the right places, at all times, with a system for regular maintenance and guidelines for the appropriate use of the equipment. Recognize cases that require referral rapidly to ensure that every patient receives timely, appropriate care and to avoid unnecessary complications. There is a triage system at admission and a mechanism on the wards to assess, identify and respond to emergencies immediately.

While the efficient domain got fifth place in the quality of health care. This is explained by: Up-to-date referral protocols and guidelines are in place are accessible, and reflect the health facility's capacity and resources. There is a triage system at admission, and a mechanism on the wards to assess, identify and respond to emergencies immediately and adequate stocks of medicines, supplies, and equipment are available for routine care and management of complications.

The researcher found that the equitable domain got the last place in the quality of healthcare and this indicates that every woman has the basic human right to the highest attainable standard of healthcare without discrimination. Healthcare staff treat all PIH women with kindness, compassion, courtesy, respect, understanding, and honesty and preserve their dignity. Women are free to complain without fear of repercussions.

All women have privacy around the time, and their confidentiality is respected. Rationale: Privacy and confidentiality of information make women and families feel respected at all times, and build trust in health care providers. Healthcare staff respects the privacy and confidentiality of care and information. Linen, curtains, and screens are available to ensure privacy, and verbal and written records of women's conditions are kept confidential.

Total women's mean perspectives, SD, and ranking of study Quality of Health Care provided for Hypertensive disorders

Table (4.5): Mean Score according on the Safety domain (n= 110).

No.	Safety items	Mean	S. D	%	Rank
1.	I feel safe as a patient when dealing with health service providers.	4.17	0.56	83.5	5
2.	The department has adequate and safe shower places from the risk of falling.	3.97	0.77	79.5	9
3.	The beds in the department are safe to prevent patients from falling.	4.05	0.79	80.9	7
4.	My personality is checked before giving the medicine	4.30	0.50	86.0	2
5.	The necessary ventilation, cooling, and heating are available in the department to prevent the transmission of infection	3.83	0.95	76.5	10
6.	The department has sufficient and good lighting to prevent the risk of falling.	3.98	0.83	79.6	8
7.	Clean sheets are always provided to prevent transmission of infection.	4.08	0.73	81.6	6
8.	The treatment services are provided to me without any errors	4.28	0.47	85.6	4
9.	Diagnostic services (laboratory tests such as kidney functions, etc.) are provided to me without any errors.	4.34	0.53	86.7	1
10.	All tests and blood pressure readings are constantly monitored.	4.30	0.61	86.0	2
	Total	**4.13**	**0.47**	**82.6**	

Table (4.5) shows that the overall mean for the safety domain was 4.13 and the total percent was 82.6%. According to the results, the highest three items are item number (9) "Diagnostic services (laboratory tests such as kidney functions, etc.) are provided to me without any errors." With a percentage of 86.7%, followed by items number (10 & 4) "All tests and blood pressure readings are constantly monitored" and "My personality is checked before giving the medicine" with percentage 86.0% for both items.

While the lowest three items are item number (5) "The necessary ventilation, cooling, and heating are available in the department to prevent the transmission of infection" with a percentage of 76.5%, followed by item number (2) "The department has adequate and safe shower places from the risk of falling" with a percentage of 79.5%, followed by item number (6) "The department has sufficient and good lighting to prevent the risk of falling" with percentage 79.6%.

The study conducted by OCHA, in 2019 is consistent with our results, which stated that the shortage of essential life-saving pharmaceuticals for mothers and children in the Gaza Strip has increased the risks of disability and death among pregnant women and newborns.

Table (4.6): Mean Score according on the Effectiveness domain (n= 110).

No.	Effectiveness items	Mean	S. D	%	Rank
1.	A sufficient number of qualified specialist doctors are available in the high-risk pregnancy department.	3.96	0.79	79.3	8
2.	The department has a sufficient number of qualified midwives.	4.06	0.78	81.3	4
3.	The hospital maintains the patient's medical file and is easily retrieved.	4.02	0.64	80.4	6
4.	The hospital department has a good reputation and standing among members of the community.	3.96	0.68	79.3	8
5.	The health staff provides the correct medical service to me from the first time.	4.14	0.68	82.7	3
6.	The health staff is actively following up on my condition.	4.21	0.51	84.2	1
7.	All nursing procedures are fully provided to me	4.21	0.53	84.2	1
8.	The health measures used have achieved the desired results.	4.05	0.63	81.1	5
9.	I am greeted with a smile on my face by the health staff.	3.98	0.75	79.6	7
	Total	**4.07**	**0.47**	**81.4**	

Table (4.6) shows that the overall mean for the effectiveness domain was 4.07 and the total percent was 81.4%. According to the results, the highest three items are items number (6 & 7) “The health staff is actively following up on my condition” and “All nursing procedures are fully provided to me” with a percentage of 84.2% for both items, followed by item number (5) “The health staff provides the correct medical service to me from the first time” with a percentage of 82.7%.

While the lowest three items are items number (1 & 4) “A enough number of qualified specialist doctors are available in the high-risk pregnancy department” and “The hospital department has a good reputation and standing among members of the community” with a percentage of 79.3% for both items, followed by the item number (9) “I am greeted with a smile on my face by the health staff” with a percentage 79.6%.

The study conducted by Islam et al. (2015) is consistent with our results and showed that the quality of care can be much better if patient management protocols are used such as preeclampsia protocols and if there is additional investment in this area to ensure the delivery of high-quality services.

Table (4.7): Mean Score according on the patient-centered care domain (n= 110).

No.	Patient-centered care items	Mean	S. D	%	Rank
1.	The medical staff meets the needs of patients.	4.55	38.3	91.1	1
2.	The health service providers behave well with me as a patient.	4.15	0.45	83.1	9
3.	The midwives in the high-risk pregnancy department follow up on my health status from arrival until discharge.	4.25	0.50	85.1	4
4.	Doctors follow your health condition from the moment you enter the department to the moment you leave.	4.16	0.57	83.3	8
5.	The health service providers in the High-risk Pregnancy Department understand my health conditions as a patient.	4.19	0.61	83.8	7
6.	The health staff works to take into account and respect the customs and traditions that belong to me.	4.20	0.59	84.0	6
7.	The health staff gives me personal attention.	3.75	0.93	74.9	14
8.	The health staff devotes enough time to sit with me to provide moral support.	3.47	1.08	69.5	15
9.	The health staff explains my health problems in a way that I can understand	3.83	0.82	76.5	13
10.	The health staff always listens to my medical complaints.	3.91	0.77	78.2	11
11.	The department provides clean waiting rooms and air-conditioned rooms.	3.89	0.87	77.8	12
12.	The hospital staff is ready to provide your required needs	4.15	0.59	83.1	9
13.	The signs and symptoms of high blood pressure are evaluated on an ongoing basis and asked about my symptoms.	4.26	0.55	85.3	2
14.	The health staff ask me about feeling a headache, stomach pain, vomiting, or blurred vision.	4.26	0.55	85.3	2
15.	The health staff is keen to maintain my privacy and not disclose my health condition.	4.22	0.51	84.4	5
	Total	**4.08**	**0.49**	**81.6**	

Table (4.7) shows that the overall mean for the patient-centered domain was 4.08 and the total percent was 81.6%. According to the results, the highest three items are item number (1) “The medical staff meets the needs of patients” with a percentage of 91.1%, followed by items number (13 & 14) “The signs and symptoms of high blood pressure are evaluated on an ongoing basis and asked about my symptoms” and “The health staff ask me about

feeling a headache, stomach pain, vomiting, or blurred vision" with a percentage of 85.3% for both items.

While the lowest three items are item number (8) "The health staff devotes enough time to sit with me to provide moral support." With a percentage of 69.5%, followed by item number (7) "The health staff gives me personal attention." With a percentage 74.9%, and followed by the item number (9) "The health staff explains my health problems in a way that I can understand" with a percentage 76.5%.

The study conducted by Callaghan-Koru et al., 2016 is consistent with our results and showed that treating women with respect and enabling them to participate in decisions about their care, has encouraged women to use health services.

The researcher believes that healthcare providers have effective communication with women and their families to help them feel more involved in their care, avoid unnecessary anxiety, and misunderstanding, and give them control of their condition, which contribute to a positive experience.

Table (4.8): Mean Score according on the Timely domain (n= 110).

No.	Timely items	Mean	S. D	%	Rank
1.	The department's health service providers respond immediately to my inquiries and complaints as a patient.	3.98	0.61	79.6	5
2.	The health service provider maintains a guarantee of speed in providing the health service.	3.99	0.63	79.8	4
3.	Special attention is given to your problems and inquiries as a patient and they are answered promptly.	3.98	0.61	79.6	5
4.	There is a constant readiness by the health staff to provide medical service quickly when needed.	4.02	0.66	80.4	2
5.	The health staff will inform me of the exact times of providing the medical service.	4.02	0.69	80.4	2
6.	The patient does not wait long to receive the service.	3.75	0.84	75.1	8
7.	The staff in the department are reliable in punctuality.	3.89	0.73	77.8	7
8.	Health service providers in the high-risk pregnancy department are always ready to cooperate with you as a patient.	4.36	3.87	87.3	1
9.	The immediate availability of midwives when you request them.	3.90	0.77	78.0	6
	Total	**3.99**	**0.67**	**79.8**	

Table (4.8) shows that the overall mean for the time domain was 3.99 and the total percent was 79.8%. According to the results, the highest three items are item number (8) "Health service providers in the high-risk pregnancy department are always ready to cooperate with you as a patient." With a percentage of 87.3%, followed by items number (4 & 5) "There is a constant readiness by the health staff to provide medical service quickly when needed" and "The health staff will inform me of the exact times of providing the medical service" with a percentage of 80.4% for both items.

While the lowest three items are item number (6) "The patient does not wait long to receive the service" with a percentage of 75.1%, followed by item number (7) "The staff in the department are reliable in punctuality" with a percentage 77.8%, and followed by the item number (9) "The immediate availability of midwives when you request them" with a percentage 78.0%.

The study conducted by Chowdhury et al., 2009 is consistent with our results and showed that both clients and service providers expressed dissatisfaction with the quality of care due to poor hygiene, long waiting times with less consultation time, poor empathy by providers, an insufficient supply of medication and unobserved cost of services that vary by level of facilities, and inadequate human resources, absenteeism and poor laboratory service to exacerbate the situation, especially at the lowest level of service provision.

In addition, a study conducted by Lowe et al., 2015 also consistent with our results which revealed that the timing of delivery in women with HDP is dependent on many maternal and fetal factors, including an inability to stabilize BP, deteriorating liver and/or renal function, placental abruption, and severe fetal growth restriction.

Table (4.9): Mean Score according on the Efficient domain (n= 110).

No.	Efficient items	Mean	S. D	%	Rank
1.	An efficient electronic blood pressure device is available in the department.	4.40	0.59	88.0	1
2.	The department has guiding panels that facilitate access to the facilities of the department and the hospital.	3.96	0.91	79.3	5
3.	There is no shortage of medication that the doctors order for me during my stay in the department.	3.98	0.79	79.6	4
4.	There is no complexity in work procedures to ensure speed in providing health services.	3.95	0.68	79.1	6

Table (4.9) Continued

No.	Efficient items	Mean	S. D	%	Rank
5.	The health staff has the skills and knowledge.	4.19	0.58	83.8	3
6.	The health staff is highly efficient in explaining the nutritional plan and explaining the types of foods and fruits that help lower blood pressure.	3.86	0.81	77.3	7
7.	The department has suitable medical devices that facilitate the provision of the service, such as the fetal electrocardiogram, electrocardiogram, glucose test, and others.	4.25	0.58	84.9	2
8.	I am placed in one quiet room to reduce environmental stimuli as much as possible.	3.13	1.23	62.5	8
	Total	**3.96**	**0.48**	**79.2**	

Table (4.9) shows that the overall mean for the efficient domain was 3.96 and the total percent was 79.2%. According to the results, the highest three items are item number (1) "An efficient electronic blood pressure device is available in the department" with a percentage of 88.0%, followed by item number (7) "The department has suitable medical devices that facilitate the provision of the service, such as the fetal electrocardiogram, electrocardiogram, glucose test, and others" with a percentage of 84.9% and followed by item number (5) "The health staff has the skills and knowledge." With a percentage of 83.8%.

While the lowest three items are item number (8) "I am placed in one quiet room to reduce environmental stimuli as much as possible" with a percentage of 62.5%, followed by item number (6) "The health staff is highly efficient in explaining the nutritional plan and explaining the types of foods and fruits that help lower blood pressure" with a percentage 77.3%, and followed by the item number (4) "There is no complexity in work procedures to ensure speed in providing health services" with a percentage 79.1%

The study conducted by Dunlop et al., 2003 to quantify the cost-effectiveness of and evaluate patient satisfaction with daycare for the management of hypertensive disorders of pregnancy is consistent with our results which showed that Pregnancy Daycare is a cost-effective method of providing care for women with hypertensive disorders during pregnancy. Women prefer daycare to inpatient care.

Table (4.10): Mean Score according on the Equitable domain (n= 110).

No.	Equitable items	Mean	S. D	%	Rank
1.	The health staff provides a health service without discrimination between patients.	3.84	0.74	76.7	6
2.	There is no disparity in access to health services.	3.95	0.63	79.1	2
3.	There is no discrimination in the behavior of health staff when dealing with patients.	3.87	0.71	77.5	5
4.	It provides distinctive health services, especially for some patients, while we are deprived of these health services*	2.87	1.13	57.4	8
5.	Health services are provided fairly, regardless of age.	4.01	0.66	80.2	1
6.	The health service is provided fairly, regardless of the social status of patients.	3.94	0.73	78.7	3
7.	There is no discrimination in providing health services based on the economic conditions of the patient.	3.89	0.65	77.8	4
8.	Doctors give more attention to some patients than others*	2.77	1.07	55.4	9
9.	Midwives take care of some patients but not others*	3.04	1.07	60.8	7
10.	Some needs (bedsheets – pillows – lunches) and others are provided to some patients and not others.	2.70	1.25	54.0	10
	Total	**3.87**	**0.46**	**77.5**	

* The mean was inverted due to the negative word or negative expression of the question

Table (4.10) shows that the overall mean for the equitable domain was 3.87 and the total percent was 77.5%. According to the results, the highest three items are item number (5) "Health services are provided fairly, regardless of age." With a percentage of 80.2%, followed by item number (2) "There is no disparity in access to health services. With a percentage of 79.1% and followed by item number (6) "The health service is provided fairly, regardless of the social status of patients" with a percentage of 78.7%.

While the lowest three items are item number (10) "Some needs (bedsheets – pillows – lunches) and others are provided to some patients and not others" with a percentage of 54.0%, followed by item number (9) "Doctors give more attention to some patients than others" with a percentage 55.4%, and followed by the item number (4) "It provides distinctive health services, especially for some patients, while we are deprived of these health services" with a percentage 57.4%.

The study conducted by Donabedian, 2005 is consistent with our results and showed that facilities should be well stocked with essential commodities, services should be provided by competent healthcare workers, and clients should leave well-informed, satisfied, and respected (Donabedian, 2005).

Furthermore, the study conducted by Koblinsky et al., 2016 is consistent with our study which revealed that every woman, everywhere, has a right to access quality maternity services, and the benefits of such access extend to the fetus, newborn babies, children, and adolescents.

4.3 Differences between the quality of health care provided for hypertensive disorders during pregnancy and women's demographic characteristics

Table (4.11): Differences between the quality of health care domains and women's age categories (n= 110)

Quality of Health Care Domains		N	Mean	S. D	%	F	p-value
Safety	Less than 20	10	4.12	0.46	82.4	.789	.457
	20-30	53	4.30	0.62	86.0		
	Above 30	47	4.03	0.54	80.7		
Effectiveness	Less than 20	10	4.03	0.43	80.5	3.505	.034
	20-30	53	4.43	0.68	88.7		
	Above 30	47	4.07	0.54	81.5		
Patient-centered care	Less than 20	10	4.06	0.49	81.2	2.263	.109
	20-30	53	4.39	0.55	87.9		
	Above 30	47	3.98	0.28	79.6		
Timely	Less than 20	10	3.99	0.68	79.7	1.228	.297
	20-30	53	4.21	0.65	84.2		
	Above 30	47	3.67	0.57	73.3		
Efficient	Less than 20	10	3.52	0.46	70.4	1.924	.151
	20-30	53	3.81	0.46	76.2		
	Above 30	47	3.63	0.41	72.7		
Equitable	Less than 20	10	3.97	0.50	79.3	.012	.988
	20-30	53	3.98	0.44	79.5		
	Above 30	47	3.94	0.29	78.8		

(One-way ANOVA test) *significant at 0.05

The mean difference in the women's perspectives of the quality of healthcare domains related to their age group is pointed out in the table (4.11). One-way ANOVA test showed there were no statistically significant differences in mean scores between age groups in all quality of health care domains($p>0.05$), This means the age group of the women did not affect women's perspectives on the domains of quality of health care for PIH women.

Table (4.12): Differences in the level of quality of health care regarding stillbirth (n = 110).

Admission to hospital		N	Mean	S. D	%	T	p-value
Safety	Yes	103	4.15	0.46	83.1	2.092	.274
	No	7	3.77	0.66	75.4		
Effectiveness	Yes	103	4.09	0.43	81.8	1.173	.007
	No	7	3.71	0.84	74.3		
Patient-centered care	Yes	103	4.11	0.48	82.1	1.741	.341
	No	7	3.77	0.64	75.4		
Timely	Yes	103	4.02	0.64	80.5	1.374	**.030***
	No	7	3.49	1.01	69.8		
Efficient	Yes	103	3.57	0.47	71.3	1.327	.169
	No	7	3.33	0.30	66.6		
Equitable	Yes	103	3.99	0.43	79.9	1.295	**.001***
	No	7	3.55	0.89	71.1		

(Independent t-test) *significant at 0.05

The mean difference in the women's perspectives of the quality of healthcare domains related to their stillbirth is pointed out in the table (4.12). Independent t-test illustrated there are statistically significant differences between stillbirth of women perspectives in the timely and equitable domain (p = 0.030 and 0.001) respectively in favor of the women having a stillbirth.

While there is no statistical significance difference between the rest of the domains.

Table (4.13): Differences between the quality of health care domains and women's education level (n= 110)

Quality of Health Care Domains		N	Mean	S. D	%	F	p-value
Safety	Prep school	11	3.87	0.30	77.5	1.828	.166
	Secondary school	38	4.17	0.52	83.4		
	University	61	4.15	0.46	83.0		
Effectiveness	Prep school	11	3.93	0.15	78.6	.859	.426
	Secondary school	38	4.03	0.47	80.6		
	University	61	4.11	0.51	82.3		
Patient-centered care	Prep school	11	3.85	0.15	77.1	4.248	.017
	Secondary school	38	3.96	0.42	79.3		
	University	61	4.20	0.55	84.0		
Timely	Prep school	11	3.97	0.05	79.4	.746	.477
	Secondary school	38	3.89	0.90	77.7		
	University	61	4.06	0.57	81.1		
Efficient	Prep school	11	3.55	0.28	71.1	.070	.932
	Secondary school	38	3.57	0.53	71.5		
	University	61	3.54	0.45	70.8		
Equitable	Prep school	11	3.82	0.19	76.4	5.851	**.004***
	Secondary school	38	3.79	0.53	75.9		
	University	61	4.10	0.44	82.0		

(One-way ANOVA test) *significant at 0.05

The mean difference in the women's perspectives of the quality of healthcare domains related to their educational level is pointed out in table (4.13). One-way ANOVA test showed there were statistically significant differences between women's perspectives of the equitable domain related to their educational level (p-value = 0.004).

While there is no statistical significance difference between the rest of the domains (p>0.05).

Post Hoc test matrix least difference (LSD) was done to know the direction of the differences between the women's educational levels. The results indicated that there is a statistically significant difference between education levels of the equitable domain between a university with a preschool level (mean =4.10, sig. at 0.004) in favor of women university level.

Table (4.14): Differences between the quality of health care domains and hospitals (n = 110).

Quality of Health Care Domains		N	Mean	S. D	%	F	p-value
Safety	Al Shifa hospital	42	4.10	0.51	81.9	3.378	**.021***
	Naser hospital	32	4.30	0.41	85.9		
	Al Aqsa hospital	15	3.85	0.51	76.9		
	Alemiraty hospital	21	4.15	0.40	83.0		
Effectiveness	Al Shifa hospital	42	3.99	0.48	79.8	2.609	.065
	Naser hospital	32	4.15	0.39	83.1		
	Al Aqsa hospital	15	3.87	0.44	77.3		
	Alemiraty hospital	21	4.23	0.53	84.7		
Patient-centered care	Al Shifa hospital	42	3.98	0.42	79.6	2.969	**.035***
	Naser hospital	32	4.28	0.61	85.7		
	Al Aqsa hospital	15	3.93	0.39	78.7		
	Alemiraty hospital	21	4.10	0.43	82.0		
Timely	Al Shifa hospital	42	3.84	0.58	76.9	1.688	.174
	Naser hospital	32	4.18	0.90	83.7		
	Al Aqsa hospital	15	3.90	0.51	78.1		
	Alemiraty hospital	21	4.04	0.50	80.8		
Efficient	Al Shifa hospital	42	3.41	0.33	68.1	3.888	**.011***
	Naser hospital	32	3.66	0.60	73.3		
	Al Aqsa hospital	15	3.44	0.42	68.8		
	Alemiraty hospital	21	3.75	0.36	75.0		
Equitable	Al Shifa hospital	42	3.81	0.49	76.3	2.491	.064
	Naser hospital	32	4.07	0.55	81.3		
	Al Aqsa hospital	15	4.01	0.44	80.2		
	Alemiraty hospital	21	4.09	0.27	81.8		

(One-way ANOVA test) *significant at 0.05

The mean difference in the women's views of the quality of health care domains related to their hospital is pointed out in the table (4.14). One-way ANOVA test showed there were statistically significant differences between women's perspectives of all quality of health care domains related to the hospital (safety, patient-centered care, and efficient) (p-value = 0.021, 0.035, and 0.011) respectively. While there is no statistical significance difference between the rest of the domains (p>0.05).

Post Hoc test matrix least difference (LSD) was done to know the direction of the differences between the hospitals. The results showed that there is a statistically significant difference between hospitals of the safety domain between Naser hospital with both Alemiratey and Al Shifa hospitals (mean =4.30, sig. at 0.021) in favor of Naser hospital. Also, the results showed that there is a statistically significant difference between hospitals of the patient-centered care domain between Naser hospital with Alemiratey hospital in favor of Naser hospital (mean =4.28 sig. at 0.035). In addition, the results showed that there is a statically significant difference between hospitals of the patient efficient domain between Alemiratey hospital with Naser hospital in favor of Alemiratey hospital (mean =3.75 sig. at 0.011).

Table (4.15): Differences in the level of quality of health care about admission to hospital (n = 110).

Admission to hospital		**N**	**Mean**	**S. D**	**%**	**T**	**p- value**
Safety	Yes	57	4.21	0.47	84.1	1.778	.626
	No	53	4.05	0.48	80.9		
Effectiveness	Yes	57	4.12	0.51	82.5	1.344	**.019***
	No	53	4.00	0.43	80.1		
Patient-centered care	Yes	57	4.12	0.45	82.5	.871	.867
	No	53	4.04	0.54	80.8		
Timely	Yes	57	4.09	0.80	81.8	1.602	.191
	No	53	3.88	0.50	77.7		
Efficient	Yes	57	3.61	0.50	72.1	1.035	.084
	No	53	3.49	0.42	69.9		
Equitable	Yes	57	4.00	0.51	80.1	.870	.557
	No	53	3.92	0.45	78.5		

(Independent t-test) *significant at 0.05

The mean difference in the women's perspectives of the quality of healthcare domains related to their history of hospital admission is pointed out in the table (4.15). Independent t-test illustrated there are statistically significant differences between hospital admission of women perspectives in the effectiveness domain (p = 0.019) in favor of the women admitted to the hospital. While there is no statistically significance difference among the rest of the domains.

Table (4.16): Differences between the quality of health care domains and duration of pregnancy by weeks (n= 110)

Quality of Health Care Domains		N	Mean	S. D	%	F	p-value
Safety	20-36 weeks	38	4.19	0.47	83.8	.588	.624
	37-38 weeks	28	4.12	0.53	82.4		
	39-40 weeks	41	4.07	0.38	81.3		
	After 40	3	4.30	1.13	86.0		
Effectiveness	20-36 weeks	38	4.14	0.42	82.8	.764	.517
	37-38 weeks	28	4.03	0.52	80.6		
	39-40 weeks	41	4.04	0.44	80.9		
	After 40	3	3.78	0.99	75.6		
Patient-centered care	20-36 weeks	38	4.09	0.44	81.7	.397	.756
	37-38 weeks	28	4.00	0.49	80.1		
	39-40 weeks	41	4.13	0.52	82.6		
	After 40	3	4.20	1.00	84.0		
Timely	20-36 weeks	38	4.18	0.85	83.5	1.995	.119
	37-38 weeks	28	3.77	0.57	75.5		
	39-40 weeks	41	3.97	0.46	79.4		
	After 40	3	3.89	1.24	77.8		
Efficient	20-36 weeks	38	3.61	0.36	72.2	.428	.734
	37-38 weeks	28	3.50	0.58	70.0		
	39-40 weeks	41	3.54	0.46	70.9		
	After 40	3	3.40	0.53	68.0		
Equitable	20-36 weeks	38	4.09	0.46	81.7	3.723	**.014***
	37-38 weeks	28	3.97	0.46	79.4		
	39-40 weeks	41	3.91	0.47	78.2		
	After 40	3	3.21	0.44	64.2		

(One-way ANOVA test) *significant at 0.05

The mean difference in the women's perspectives of the quality of health care domains related to their duration of pregnancy by weeks is mention in the table (4.16). One-way ANOVA test showed there were statistically significant differences between women's perspectives of the equitable domain related to their duration of pregnancy (p-value = 0.014). While there is no statistical significance difference between the rest of the domains (p>0.05).

Post Hoc test matrix least difference (LSD) was done to know the direction of the differences between the women's duration of pregnancy. The results showed that there is a statistically significant difference between the duration of pregnancy in the equitable domain between 20-36 weeks with 37-38 weeks (mean =4.09, sig. at 0.014) in favor of women's duration of pregnancy from 20-36 weeks.

Table (4.17): Differences between the quality of health care domains and classification of PIH (n = 110).

Quality of Health Care Domains		N	Mean	S. D	%	F	p-value
Safety	Chronic HTN	15	4.21	0.49	84.3	.238	.870
	Pre-eclampsia	89	4.11	0.49	82.2		
	Eclampsia	4	4.20	0.27	84.0		
	Gestational HTN	2	4.20	0.28	84.0		
Effectiveness	Chronic HTN	15	4.33	0.51	86.7	2.693	**.049***
	Pre-eclampsia	89	4.02	0.44	80.4		
	Eclampsia	4	3.94	0.74	78.9		
	Gestational HTN	2	4.50	0.71	90.0		
Patient-centered care	Chronic HTN	15	4.18	0.47	83.6	10.344	**.001***
	Pre-eclampsia	89	4.03	0.41	80.7		
	Eclampsia	4	3.98	0.67	79.7		
	Gestational HTN	2	4.52	1.18	90.4		
Timely	Chronic HTN	15	3.99	0.56	79.7	.258	.855
	Pre-eclampsia	89	3.99	0.69	79.7		
	Eclampsia	4	3.89	0.80	77.8		
	Gestational HTN	2	4.39	0.86	87.8		
Efficient	Chronic HTN	15	3.77	0.52	75.5	1.359	.260
	Pre-eclampsia	89	3.52	0.45	70.4		
	Eclampsia	4	3.48	0.30	69.5		
	Gestational HTN	2	3.50	0.42	70.0		
Equitable	Chronic HTN	15	3.99	0.55	79.8	.427	.734
	Pre-eclampsia	89	3.95	0.47	79.0		
	Eclampsia	4	4.13	0.43	82.5		
	Gestational HTN	2	4.25	0.71	85.0		

(One-way ANOVA test) *significant at 0.05

The mean difference in the women's perspectives of the quality of healthcare domains related to their classification of PIH indicate in table (4.17). One-way ANOVA test showed there were statistically significant differences between women's perspectives of all quality of health care domains related to the classification of HDP (effectiveness and patient-centered care) (p-value = 0.049, and 0.001) respectively. While there is no statistical significance difference between the rest of the domains (p>0.05).

Post Hoc test matrix least difference (LSD) was done to know the direction of the differences between the classification of HDP. The results showed that there is a statistically significant difference between the classification of HDP of the effectiveness domain between women who have Chronic HTN with Gestation HTN (mean =4.50, sig. at 0.049) in favor of Gestational HTN classification. Also, the results showed that there is a statistically significant difference between the classification of HDP of the patient-centered care domain between women who have Chronic HTN with Gestational HTN (mean =4.52, sig. at 0.001) in favor of Gestational HTN classification.

Table (4.18): Differences between the quality of health care domains and Para "number of pregnancies" (n= 110)

Quality of Health Care Domains		N	Mean	S. D	%	f	p-value
Safety	1-3	47	4.10	0.45	81.9	1.536	.220
	4-6	38	4.23	0.51	84.7		
	More than 6	25	4.04	0.46	80.7		
Effectiveness	1-3	47	4.04	0.42	80.9	.324	.724
	4-6	38	4.05	0.49	81.1		
	More than 6	25	4.13	0.54	82.7		
Patient centered care	1-3	47	4.07	0.57	81.4	.961	.386
	4-6	38	4.03	0.43	80.5		
	More than 6	25	4.20	0.44	84.0		
Timely	1-3	47	4.03	0.82	80.5	1.481	.232
	4-6	38	3.85	0.56	77.0		
	More than 6	25	4.13	0.51	82.7		
Efficient	1-3	47	3.44	0.46	68.8	3.293	**.041***
	4-6	38	3.58	0.48	71.5		
	More than 6	25	3.72	0.39	74.5		
Equitable	1-3	47	3.95	0.45	79.0	1.419	.246
	4-6	38	3.89	0.56	77.9		
	More than 6	25	4.10	0.37	82.0		

(One-way ANOVA test) *significant at 0.05

The mean difference in the women's perspectives of the quality of healthcare domains related to their number of pregnancies is refer in the table (4.18). One-way ANOVA test showed there were statistically significant differences between women's perspectives of the efficient domain related to their number of pregnancies (p-value = 0.041). While there is no statistical significance difference between the rest of the domains (p>0.05).

Post Hoc test matrix least difference (LSD) was done to know the direction of the differences between the women's number of pregnancies. The results showed that there is a statistically significant difference between the number of pregnancies of the efficient domain between women who have 4-6 with more than 6 pregnancies (mean =3.72, sig. at 0.041) in favor of women's number of pregnancies with more than 6.

Table (4.19): Differences between the quality of health care domains and Gravid "number of pregnancies" (n= 110)

Quality of Health Care Domains		N	Mean	S. D	%	F	p-value
Safety	Zero	12	4.03	0.19	80.7	.394	.758
	1 – 3	51	4.15	0.54	82.9		
	4 – 6	37	4.16	0.48	83.3		
	More than 6	10	4.03	0.35	80.6		
Effectiveness	Zero	12	3.93	0.19	78.5	.403	.751
	1 – 3	51	4.08	0.53	81.6		
	4 – 6	37	4.09	0.42	81.9		
	More than 6	10	4.07	0.58	81.3		
Patient-centered care	Zero	12	3.86	0.38	77.1	1.033	.381
	1 – 3	51	4.12	0.54	82.3		
	4 – 6	37	4.09	0.47	81.8		
	More than 6	10	4.17	0.45	83.5		
Timely	Zero	12	3.88	0.25	77.6	.186	.906
	1 – 3	51	4.01	0.85	80.2		
	4 – 6	37	3.97	0.51	79.4		
	More than 6	10	4.08	0.60	81.6		
Efficient	Zero	12	3.31	0.47	66.2	1.629	.187
	1 – 3	51	3.59	0.46	71.8		
	4 – 6	37	3.54	0.47	70.7		
	More than 6	10	3.70	0.33	74.0		
Equitable	Zero	12	3.74	0.44	74.8	1.590	.196
	1 – 3	51	4.04	0.51	80.9		
	4 – 6	37	3.91	0.45	78.2		
	More than 6	10	4.04	0.43	80.8		

(One-way ANOVA test) *significant at 0.05

The mean difference in the women's perspectives of the quality of healthcare domains related to their number of deliveries is pointed out in the table (4.19). One-way ANOVA test showed there were no statistically significant differences in mean scores between women's perspectives in all quality of health care domains (p>0.05), this means the number of deliveries did not affect women's perspectives of the domains of quality of health care.

Table (4.20): Differences between the quality of health care domains and abortion (n= 110)

Quality of Health Care Domains		N	Mean	S. D	%	F	p-value
Safety	Never	73	4.09	0.47	81.8	1.028	.383
	Once	23	4.27	0.49	85.5		
	Twice	9	4.06	0.53	81.1		
	More than twice	5	4.22	0.20	84.4		
Effectiveness	Never	73	4.03	0.47	80.6	1.089	.357
	Once	23	4.08	0.41	81.6		
	Twice	9	4.15	0.55	83.0		
	More than twice	5	4.40	0.63	88.0		
Patient centered care	Never	73	4.07	0.52	81.3	1.932	.129
	Once	23	4.17	0.46	83.4		
	Twice	9	3.82	0.25	76.4		
	More than twice	5	4.43	0.47	88.5		
Timely	Never	73	3.99	0.74	79.7	1.003	.395
	Once	23	3.95	0.56	79.0		
	Twice	9	3.84	0.29	76.8		
	More than twice	5	4.47	0.49	89.3		
Efficient	Never	73	3.53	0.46	70.6	.710	.548
	Once	23	3.57	0.55	71.3		
	Twice	9	3.52	0.35	70.4		
	More than twice	5	3.84	0.21	76.8		
Equitable	Never	73	3.96	0.49	79.3	3.018	.033
	Once	23	3.86	0.44	77.2		
	Twice	9	3.93	0.36	78.6		
	More than twice	5	4.55	0.33	91.0		

(One-way ANOVA test) *significant at 0.05

The mean difference in the women's perspectives of the quality of health care domains related to their abortion is pointed out in the table (4.20). One-way ANOVA test showed there were no statistically significant differences in mean scores between women's perspectives in all quality of health care domains (p>0.05), which means abortion did not affect women's perspectives on the domains of quality of health care.

Chapter Five

Conclusion and Recommendations

5.1 Conclusion

This chapter displays the main conclusions of this research, after interpreting the results of the statistical analysis of the data collected from pregnant women with HDP at maternity government hospitals in the Gaza Strip. Moreover, this study policymakers to improve the quality of healthcare services provided to HDP women at maternity governmental hospitals.

The results showed that the mean age of the pregnant women with HDP was 29.5 years, and half of the study sample aged 20-30 years, more than 55% had a university degree, 38.2% of the study participants were from Al Shifa Medical Complex, 29.1% from Naser hospitals. In addition, 37.3% of pregnant women have 39-40 weeks, one-third have 20-36 weeks, and the mean pregnancy duration is 37.2 weeks. About 42.7% of women have had 1-3 pregnancies, and 34.5% of them have 4-6 pregnancies. Moreover, 44.5% of the women have 1-3 children, 20.9% have never lived birth, the majority of the participants (93.6%) have never had a stillbirth, and only 6.4% have a stillbirth.

Furthermore, more than 60.9% of the participants have no previous medical diseases, nearly 15% have hypertension or diabetes mellitus and 15.5% have both disease hypertension and diabetes mellitus. More than half of women have a history of hospital admission, 17.3% of them were admitted to the hospital one time, and 10.0% were admitted to the hospital more than twice. The majority of the women (80.9%) have preeclampsia, 13.6% have chronic hypertension, only 3.6% have eclampsia and 1.8% have gestational hypertension.

The mean percentage for all quality of health care domains was 81.3%. The results revealed that the safety domain got the highest score (82.6%) followed by the patient-centered care domain (81.6%), effectiveness domain (81.4), timely domain (79.8%), efficient domain (79.2%) and the equitable domain ranked the last (77.5%).

Also, the results showed statistically significant differences between women's education level, stillbirth, hospitals, history of hospital admission, gestational period of pregnancy, classification of PIH and para, and different domains of quality of health care. On the other hand, the results showed that no statistically significant differences were found between women's age, gravid, and abortion and quality of health care domains.

In conclusion, the results indicated that HDP women at maternity governmental hospitals have a good perception of the quality of health care provided especially concerning safety, effectiveness, patient-centered care, time, efficiency, and equity.

5.2 Recommendations

5.2.1 General Recommendation for Policy Makers

Based on the findings of the present study, key suggestions are proposed to improve the quality of health care provided for Hypertension Disorders Prenancy women at maternity governmental hospitals in the Gaza Strip:

1. Improving the patient environment in terms of ventilation, cooling, heating, and supplies for patient care.
2. Reducing the environmental stimuli to HDP women as much as possible and placed in one quiet room.
3. Ensuring safety measures at high-risk pregnancy departments at maternity hospitals.
4. Providing a sufficient number of qualified specialist doctors in high-risk departments at maternity hospitals.
5. Supporting the hospitals with essential and required materials and equipment for health care such as (bedsheets – pillows – lunches).
6. Support the education and training of midwives and doctors to deepen their understanding of the needs of HDP women and their perceptions of care.
7. Psychosocial support should be scheduled for HDP women.
8. Implement the standards of quality of healthcare for HDP women at maternity hospitals such as Joint Commission International (JCI) Accreditation or other programs.
9. Encourage communication skills for healthcare providers at maternity hospitals.
10. Policy-makers should consider regulatory, educational, financial, and personal and professional support interventions to recruit and retain qualified health workers.

5.2.2 Recommendations for further research

The following research studies are recommended

- Evaluate the quality of health care provided for Pregnancy Induce Hypertension: Health Care Provider Perspective.
- Evaluate the quality of health care provided for Hyerptenion Disorders Pregnancy: Family Perspective.
- Assess the Quality of Health Care Provided for HDP women: Qualitative research
- Evaluate the quality of health care provided for HDP women: Safety domains.

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Annexes

Annex (1): Map of Historical Palestine

Annex (2): Questionnaire (Arabic version)

استبانة لقياس جودة الرعاية الصحية المقدمة لاضطرابات ارتفاع ضغط الدم للحومل في مستشفيات الولادة الحكومية في قطاع غزة من وجهة نظر السيدات الحوامل

عزيزتي المريضة

السلام عليكم ورحمة الله وبركاته،

أضع بين أيديكم استبانة دراسة ميدانية خاصة برسالة ماجستير بعنوان: "جودة الرعاية الصحية المقدمة لاضطرابات ارتفاع ضغط الدم للحومل في مستشفيات الولادة الحكومية في قطاع غزة من وجهة نظر السيدات الحوامل"

وتأتي هذه الاستبانة في إطار إتمام متطلبات التخرج ضمن برنامج ماجستير إدارة التمريض كلية المهن الصحية

الرجاء التكرم بتعبئة الاستبانة ووضع إشارة (//) أمام الخانة التي توافق رأيك

علما بأن هذه المعلومات سوف تستخدم لغرض البحث العلمي وهي محاطة بسرية تامة

ولكم جزيل الشكر لحسن تعاونكم رغم الألم.

إعداد الباحثة / فردوس الهان حسن دوغان

أولا: المعلومات الشخصية للسيدات الحوامل:

1. العمر: _____ سنة
2. المستوى التعليمي: ابتدائي ☐ إعدادي ☐ ثانوي ☐ جامعي ☐
3. مدة الحمل: _____ بالأسابيع
4. عدد مرات الحمل: _____
5. عدد مرات الولادة: _____
6. عدد المواليد الأحياء ( ) عدد ولادة جنين ميت ( )
7. عدد مرات الإجهاض ( )
8. المستشفى: مجمع الشفاء الطبي ☐ مجمع ناصر الطبي ☐

   مستشفى شهداء الأقصى ☐ مستشفى الهلال الإماراتي ☐

   مستشفى كمال عدوان ☐
9. تاريخ السجل المرضى السابق:

   مريض سكر ☐ مريض ضغط ☐ مريض كلى ☐ مريض قلب ☐

   أخرى ☐ تحديد الأمراض: _____.
10. هل تم ادخالك للمستشفى قبل ذلك: نعم ☐ لا ☐

    إذا كانت الإجابة بنعم

10.1 ماهي عدد مرات الدخول في المستشفى سابقا: _____مرة

11. ما هو تصنيف اضطراب ارتفاع الضغط للمريض:

    ارتفاع ضغط الدم الموجود مسبقا ☐

    ارتفاع ضغط دم حملي ☐

    ارتفاع ضغط دم حملي وتسمم حمل مع بيلة بروتينية ☐

    ارتفاع ضغط دم غير قابل للتنصيف ☐

ثانيا: محاور جودة الرعاية الصحية

		موافق بشدة	موافق	محايد	غير موافق	غير موافق بشدة
البعد الأول: مأمونية الخدمة الصحية Safety						
.1	أشعر كمريضة بالأمان عند التعامل مع مقدمي الخدمة الصحية					
.2	يتوفر في القسم أماكن استحمام ملائمة وآمنه من خطر السقوط					
.3	الأسرة الموجودة في القسم امنة لمنع سقوط المرضى.					
.4	يتم التأكد من شخصيتي قبل إعطاء الدواء					
.5	يتوفر في القسم التهوية والتبريد والتدفئة اللازمة لمنع انتقال العدوى					
.6	يتوفر في القسم اضاءة كافية وجيدة لمنع خطر السقوط					
.7	يتم توفير شراشف نظيفة باستمرار لمنع نقل العدوى					
.8	يتم تقديم الخدمات العلاجية لي دون أي أخطاء					
.9	يتم تقديم الخدمات التشخيصية (تحاليل مخبرية كوظائف الكلية وغيرها) لي دون أي أخطاء					
.10	يتم متابعة جميع التحاليل وقراءات الضغط باستمرار					
البعد الثاني: فعالية الخدمة الصحية Effectiveness						
.1	يتوفر في قسم الحمل الخطر عدد كاف من الأطباء المتخصصين الاكفاء					
.2	يتوفر في القسم عدد كاف من القابلات الأكفاء					
.3	تحتفظ المستشفى بالملف الطبي للمريض ويتم استرجاعه بسهولة					
.4	يمتاز القسم المستشفى بسمعة ومكانة					

	جيدة لدى أفراد المجتمع					
.5	يقوم الطاقم الصحي بتقديم الخدمة الطبية الصحيحة لي من المرة الأولى					
.6	يقوم الطاقم الصحي بمتابعة حالتي بشكل فعال					
.7	يتم تقديم جميع الإجراءات التمريضية لي بشكل كامل					
.8	الإجراءات الصحية المستخدمة حققت النتائج المرجوة					
.9	يتم الترحيب بي والابتسامة بوجهي من قبل الطاقم الصحي					

		موافق بشدة	موافق	محايد	غير موافق	غير موافق بشدة
البعد الثالث: التركيز على رعاية المريض Patient centered care						
.1	يقوم الكادر الطبي بتلبية الاحتياجات للمرضى					
.2	يتسم سلوك مقدمي الخدمة الصحية بحسن المعاملة معي كمريضة					
.3	تتابع القابلات في قسم الحمل الخطر حالتي الصحية منذ وصولك حتى خروجك					
.4	يتابع الأطباء حالتك الصحية من لحظة دخولك للقسم الى لحظة الخروج					
.5	يتفهم مقدمي الخدمة الصحية في قسم الحمل الخطر ظروفي الصحية كمريضة.					
.6	يعمل الطاقم الصحي على مراعاة واحترام العادات والتقاليد التي تخصني					
.7	يعطي الطاقم الصحي اهتمام شخصيا لي					
.8	يخصص الطاقم الصحي وقتا كافيا بالجلوس معي لتقديم الدعم المعنوي					
.9	يوضح الطاقم الصحي لي المشاكل الصحية التي أعاني منها بطريقة أفهمها					
.10	يصغى الطاقم الصحي بشكل دائم لشكواي المرضية					
.11	يوفر القسم صالات انتظار نظيفة وغرف مكيفة					

12.	استعداد موظفي المستشفى لتوفير احتياجاتك المطلوبة					
13.	يتم تقييم علامات وأعراض ارتفاع ضغط الدم بشكل مستمروالسؤال عن الأعراض التي أشعر بها					
14.	سؤالي عن الشعور بالصداع او ألم المعدة والقيء او زغللة بالرؤية					
15.	يحرص الطاقم الصحي على المحافظة على خصوصيتي وعدم الافشاء عن حالتي الصحية.					
البعد الرابع: تقديم الخدمة الصحية في الوقت المناسب Timely						
1.	يقوم مقدمو الخدمة الصحية بالقسم بالرد الفوري على استفساراتي وشكواي كمريضة					
2.	يحافظ مقدمة الخدمة الصحية على ضمان السرعة في تقديم الخدمة الصحية					
3.	يتوفر اهتماما خاصا بمشاكلك واستفسارك كمريضة ويتم الإجابة عليها في الوقت المناسب					
4.	يوجد هناك استعداد دائم من قبل الطاقم الصحي لتقديم الخدمة الطبية بشكل سريع عند الحاجة لها					
5.	يقوم الطاقم الصحي بإبلاغي بمواعيد تقديم الخدمة الطبية بدقة					
6.	لا ينتظر المريض وقتا طويلا للحصول على الخدمة					
7.	يتحلى الموظفين في القسم بالمصداقية في المواعيد					
8.	يبدي مقدمو الخدمة الصحية في قسم الحمل الخطر الاستعداد الدائم للتعاون معك كمريضة					
9.	سرعة تواجد القابلات عند طلبك لهم					
البعد الخامس: الكفاءة Efficient						
1.	يتوفر في القسم جهاز ضغط الكتروني يعمل بكفاءة					
2.	يتوفر في القسم لوحات إرشادية تسهل الوصول الى المرافق الخاصة بالقسم والمستشفى					
3.	لا يوجد نقص في الأدوية التي يطلبها الأطباء لي أثناء مكوثي في القسم.					
4.	لا يوجد تعقيدات في إجراءات العمل لضمان السرعة في تقديم الخدمة الصحية					
5.	يتوفر لدى الطاقم الصحي المهارة والمعرفة					
6.	يتمتع الطاقم الصحي بكفاءة عالية في شرح الخطة					

	الغذائية وشرح أنواع الأطعمة والفواكه التي تساعد على خفض ضغط الدم					
7.	يوجد في القسم اجهزة طبية مناسبة تسهل تقديم الخدمة مثل جهاز تخطيط الجنين، تخطيط القلب وفحص سكر وغيرها					
8.	يتم وضعي في غرفة واحدة هادئة لتقليل المحفزات البيئية قدر الإمكان					

البعد السادس: عدالة الخدمة الصحية Equitable						
1.	يقوم الطاقم الصحي بتقديم خدمة صحية دون تمييز بين المرضى					
2.	عدم وجود تفاوت في الحصول على الخدمة الصحية					
3.	لا يوجد تمييز في سلوك الطاقم الصحي عند التعامل مع المرضى					
4.	تقدم خدمات صحية مميزة وخاصة لبعض المرضى في حين نحرم من هذه الخدمات الصحية					
5.	تقدم الخدمات الصحية بعدالة بغض النظر عن العمر					
6.	تقدم الخدمة الصحية بعدالة بغض النظر عن المكانة الاجتماعية للمرضى					
7.	لا يوجد تمييز في تقديم الخدمة الصحية بناء على الظروف الاقتصادية للمريض					
8.	يعطي الأطباء اهتمام أكبر لبعض المرضى دون غيرهم					
9.	تهتم القابلات ببعض المرضى دون غيرهم					
10	يتم توفير بعض الاحتياجات (شراشف– مخدات– وجبات غداء) وغيرها لبعض المرضى دون غيرهم					

من وجهة نظرك: ما هو تقييمك لجودة الرعاية الصحية المقدمة في قسم الحمل الخطر؟

Annex (3): Questionnaire (English version)

Deanship of Postgraduate Studies

Al-Quds University

College of Public Health

A questionnaire to measure the Quality of Health Care Provided for Hypertensive Disorders Pregnancy Women at Maternity Governmental Hospitals in the Gaza strip: Women's Perspectives

Dear patient,

Peace be upon you,

I present to you a field study questionnaire for a master's thesis entitled: "**The Quality of Health Care Provided for Hypertensive Disorders Pregnancy Women at Maternity Governmental Hospitals in Gaza strip: Women's Perspectives**."

This questionnaire comes within the framework of completing the graduation requirements within the Master of Nursing Management program, which I participate in Faculty of Health profession at Al-Quds University

Please kindly fill out the questionnaire and put a tick (✓) in front of the box that agrees with your opinion

If you accept to join this study, you have the right to withdraw from the study.

However, your answer will be respected and confidentially taken as it will be used for the study purposes only

Thank you very much for your cooperation

Researcher

Ferdos Ilhan Hassan Dogan

Personal Information:	
1.	Age of mothers: …… years.
2.	Education level: ☐ Primary ☐ preparatory ☐ Secondary ☐ University
3.	Gestational age at the first antenatal visit: ……weeks.
4.	Gravida: ……
5.	Para: ……
6.	Number of live children: ……
7.	Number of still birth: ……
8.	**History of previous abortion**: ☐ Yes ☐ No, if yes, how many times: ……
8.	**Place of delivery:** ☐ Al Shifa hospital ☐ Nasser hospital ☐ Al Aqsa Hospital ☐ Emirates Hospital
9.	**History of the previous patient record:** ☐ Diabetic patient ☐ HTN patient ☐ kidney patient ☐ Cardiac patient ☐ Other Other identified diseases: ……
10.	**Have you been hospitalized before**: ☐ ☐ If the answer is yes **10.1** What was the number of hospital admissions previously: …… times
11.	**What is the classification of hypertensive disorder of the patient:** Pre-existing high blood pressure ☐ Gestational hypertension and preeclampsia ☐ Pre-existing hypertension in addition to gestational hypertension superimposed with proteinuria ☐ Unstable high blood pressure ☐

Strongly disagree	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly agree**
1	2	3	4	5

Statement		1	2	3	4	5
The First Domain: Safety of the health service						
1.	I feel safe as a patient when dealing with health service providers.					
2.	The department has adequate and safe shower places from the risk of falling.					
3.	The beds in the department are safe to prevent patients from falling.					
4.	My personality is checked before giving the medicine					
5.	The necessary ventilation, cooling, and heating are available in the department to prevent the transmission of infection					
6.	The department has sufficient and good lighting to prevent the risk of falling.					
7.	Clean sheets are always provided to prevent transmission of infection.					
8.	The treatment services are provided to me without any errors					
9.	Diagnostic services (laboratory tests such as kidney functions, etc.) are provided to me without any errors.					
10.	All tests and blood pressure readings are constantly monitored.					
The Second Domain: The effectiveness of the health service						
1.	A sufficient number of qualified specialist doctors are available in the high-risk pregnancy department					
2.	The department has a sufficient number of qualified midwives					
3.	The hospital maintains the patient's medical file and is easily retrieved					
4.	The hospital department has a good reputation and standing among members of the community					
5.	The health staff provides the correct medical service to me from the first time					
6.	The health staff is actively following up on my condition					
7.	All nursing procedures are fully provided to me					
8.	The health measures used have achieved the desired results					
9.	I am greeted with a smile on my face by the health staff					
The Third Domain: Patient centered care						
1.	The medical staff meets the needs of patients.					
2.	The health service providers behave well with me as a patient.					
3.	The midwives in the high-risk pregnancy department follow up					

	on my health status from arrival until discharge.					
4.	Doctors follow your health condition from the moment you enter the department to the moment you leave.					
5.	The health service providers in the High-risk Pregnancy Department understand my health conditions as a patient.					
6.	The health staff works to take into account and respect the customs and traditions that belong to me.					
7.	The health staff gives me personal attention.					
8.	The health staff devotes enough time to sit with me to provide moral support.					
9.	The health staff explains my health problems in a way that I can understand					
10.	The health staff always listens to my medical complaints.					
11.	The department provides clean waiting rooms and air-conditioned rooms.					
12.	The hospital staff is ready to provide your required needs					
13.	The signs and symptoms of high blood pressure are evaluated on an ongoing basis and asked about my symptoms.					
14.	The health staff ask me about feeling a headache, stomach pain, vomiting, or blurred vision.					
15.	The health staff is keen to maintain my privacy and not disclose my health condition.					
The Fourth Domain: Providing health services in a timely manner						
1.	The department's health service providers respond immediately to my inquiries and complaints as a patient.					
2.	The health service provider maintains a guarantee of speed in providing the health service.					
3.	Special attention is given to your problems and inquiries as a patient and they are answered promptly.					
4.	There is a constant readiness by the health staff to provide medical service quickly when needed.					
5.	The health staff will inform me of the exact times of providing the medical service.					
6.	The patient does not wait long to receive the service.					
7.	The staff in the department are reliable in punctuality.					
8.	Health service providers in the high-risk pregnancy department are always ready to cooperate with you as a patient.					
9.	The immediate availability of midwives when you request them.					
The Fifth Domain: Efficient						

1.	An efficient electronic blood pressure device is available in the department.					
2.	The department has guiding panels that facilitate access to the facilities of the department and the hospital.					
3.	There is no shortage of medication that the doctors order for me during my stay in the department.					
4.	There is no complexity in work procedures to ensure speed in providing health services.					
5.	The health staff has the skills and knowledge.					
6.	The health staff is highly efficient in explaining the nutritional plan and explaining the types of foods and fruits that help lower blood pressure.					
7.	The department has suitable medical devices that facilitate the provision of the service, such as the fetal electrocardiogram, electrocardiogram, glucose test, and others.					
8.	I am placed in one quiet room to reduce environmental stimuli as much as possible.					
The Sixth Domain: Equitable health service						
1.	The health staff provides a health service without discrimination between patients.					
2.	There is no disparity in access to health services.					
3.	There is no discrimination in the behavior of health staff when dealing with patients.					
4.	It provides distinctive health services, especially for some patients, while we are deprived of these health services.					
5.	Health services are provided fairly, regardless of age.					
6.	The health service is provided fairly, regardless of the social status of patients.					
7.	There is no discrimination in providing health services based on the economic conditions of the patient.					
8.	Doctors give more attention to some patients than others.					
9.	Midwives take care of some patients but not others.					
10.	Some needs (bedsheets - pillows - lunches) and others are provided to some patients and not others.					

From your point of view: What is your assessment of the quality of health care provided in the high-risk pregnancy department?

Annex (4): MOH Approval

State of Palestine
Ministry of health

دولة فلسطين
وزارة الصحة

السيد : جهاد عبدالقادر عكاشه المحترم

التاريخ:30/10/2022

رقم المراسلة 1098777

مدير دائرة /الإدارة العامة للوحدات الإدارية المساعدة /وزارة الصحة

السلام عليكم ,,,

الموضوع/ تسهيل مهمة الباحثة فردوس الهان دوغان

التفاصيل // السلام عليكم نهديكم أطيب التحيات ونود منكم تسهيل مهمة الباحث/ة فردوس الهان حسن دوغان الملتحق/ة ببرنامج ماجستير إدارة التمريض – جامعة القدس أبو ديس في اجراء بحث بعنوان: جودة الرعاية الصحية المقدمة لاضطرابات ارتفاع ضغط الدم للحومل في مستشفيات الولادة الحكومية في قطاع غزة من وجهة نظر السيدات الحوامل حيث الباحث/ة بحاجة لتعبئة استبانة من عدد من المرضى المراجعين في مرافق وزارة الصحة (المستشفيات)، دون اجراء أي تدخل طبي او سحب عينات دم ، نأمل توجيهاتكم لذوى الاختصاص بضرورة الحصول على الموافقة المستنيرة من المشاركين ، بما لا يتعارض مع مصلحة العمل وضمن أخلاقيات البحث العلمي، ودون تحمل الوزارة أي أعباء أو مسئولية وتفضلوا بقبول التحية والتقدير 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

علي حسن البلبيسى
حكيم جامعي

المرفقات

- أدوات البحث فردوس الهان دوغان.final tool.docx

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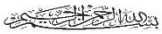
Annex (5): Ethical approval letter



Al Quds University
Faculty of Health Professions
Jerusalem –Abu Dis

جامعة القدس
كلية المهن الصحية
القدس – أبو ديس

Research Ethics Subcommittee of Faculty of Health Professions
Letter of approval

Jan. 6, 2023
Ref. No.: RESC/2023-2

Dear Applicants, (**Dr. Mutasem Salah and Ms. Ferdous Doughan**)

Program: **MSc Nursing Management Program**

The Research Ethics subcommittee of the Faculty of Health Professions has recently reviewed your proposal entitled (**Quality of Health Care Provided for Hypertensive Disorders Pregnancy Women at Maternity Governmental Hospitals in Gaza strip: Women's Perspectives**) submitted by (**Dr. Mutasem Salah**). Your proposal is deemed to meet the requirements of research ethics at Al-Quds University, but further assessment is required by the Central Research Ethics Committee of Al-Quds University in case of journal submission for publication. We wish you all best for the conduct of the project.

Hussein ALMasri, PhD
Associate Professor of Medical Imaging
Research Ethics Subcommittee Chair
Faculty of Health Professions

Hussein ALMasri

CC: File
CC: Committee members

Tel. Fax: 02 2791243 Email: dean@hpro.alquds.edu تلفاكس: 02 2791243

Annex (6): Table of Expert

No.	Name of expert	Work title
1.	Dr. Hamza Abd Jawad	Al-Quds University
2.	Dr. Akram Abu Salah	Palestine Collage of Nursing
3.	Dr. Ahmed Ashaer	Islamic university
4.	Dr. Soha Balosha	Al –Shefa Hospital
5.	Bassam Musalam	Medical Nasser Complex
6.	Khawlah Al Madhoun	Medical Nasser Compelex

عنوان الدراسة: تقييم جودة الرعاية الصحية المقدمة للسيدات الحوامل اللواتي لديهن إضطرابات ارتفاع ضغط الدم في مستشفيات الولادة الحكومية في قطاع غزة من وجهة نظر السيدات الحوامل

الباحثة: فردوس الهان حسن دوغان

إشراف: د. معتصم سعيد صلاح

ملخص الدراسة

اضطرابات ارتفاع ضغط الدم للحوامل هو أكثر المضاعفات شيوعًا أثناء الحمل والسبب الرئيسي لوفيات ومراضة الأمهات الحوامل في الفترة المحيطة بالولادة. الهدف العام لهذه الدراسة هو تقييم جودة الرعاية الصحية لاضطرابات ارتفاع ضغط الدم لدى النساء الحوامل في مستشفيات الولادة الحكومية في قطاع غزة.

أظهرت النتائج أن متوسط عمر المرأة الحامل المصابة باضطراب ارتفاع ضغط الدم كان 29.5 سنة، ونصف عينة الدراسة تتراوح أعمارهم بين 20–30 سنة، وأكثر من 55٪ حاصلات على شهادة جامعية، و38.2٪ من المشاركات في الدراسة من مجمع الشفاء الطبي. 29.1٪ من مستشفيات ناصر. بالإضافة إلى ذلك، فإن 37.3٪ من النساء حوامل في الأسبوع 39–40، والثلث لديهن 20–36 أسبوعًا، ومتوسط مدة الحمل 37.2 أسبوعًا. حوالي 42.7٪ من النساء كان لديهن حمل سابق ما بين 1–3 مرة، و34.5٪ حمل سابق من 4–6 مرة. علاوة على ذلك، فإن 44.5٪ من النساء لديهن 1–3 أطفال، و20.9٪ لم يسبق لهن الولادة، وغالبية المشاركات (93.6٪) لم يسبق لهم ولادة جنين ميت، و6.4٪ سجلوا حالات وفاة للجنين.

علاوة على ذلك، أكثر من 60.9٪ من المشاركات ليس لديهم أمراض صحية سابقة، وحوالي 15٪ كانت تعاني من ارتفاع ضغط الدم أو داء السكري و15.5٪ يعانون من ارتفاع ضغط الدم ومرض السكري معا. أكثر من نصف النساء لديهن دخول سابق للمستشفى، 17.3٪ منهن تم إدخالهن إلى المستشفى مرة واحدة، و10.0٪ تم إدخالهن إلى المستشفى أكثر من مرتين. غالبية النساء (80.9٪) لديهن تسمم حمل، 13.6٪ مصابات بارتفاع ضغط الدم المزمن، 3.6٪ فقط لديهن تسمم وتشنج في الحمل و1.8٪ مصابات بارتفاع ضغط الدم الحملي.

وبلغت النسبة المئوية لإجمالي جودة الرعاية الصحية 81.3٪. وأظهرت النتائج أن مجال السلامة حصل على أعلى الدرجات (82.6٪) يليه مجال الرعاية المتمحورة حول المريض (81.6٪)، ومجال الفعالية (81.4)، والوقت المناسب (79.8٪)، والفعالية (79.2٪) والعدالة في المرتبة الأخيرة (77.5٪).

كما أظهرت النتائج فروق ذات دلالة إحصائية بين مستوى تعليم المرأة، وولادة جنين ميت، والمستشفيات، وتاريخ دخول المستشفى، ومدة الحمل، وتصنيف الحمل وعدد مرات الحمل، والمجالات المختلفة من جودة الرعاية الصحية. من ناحية أخرى، أظهرت النتائج عدم وجود فروق ذات دلالة إحصائية بين عمر المرأة، وعدد مرات الإنجاب، والإجهاض ومجالات جودة الرعاية الصحية.

في الختام، أشارت النتائج إلى أن نساء الحوامل اللواتي لديهن اضطرابات وارتفاع ضغط الدم في مستشفيات الولادة الحكومية لديهن تصور جيد لجودة الرعاية الصحية المقدمة خاصة فيما يتعلق بالسلامة والفعالية والرعاية التي تركز على المريض والوقت والكفاءة والعدالة.