Palestinian Women's Postpartum Quality of Life

رضى السيدات الفلسطينيات عن حياتهن في فترة ما بعد الولادة

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Table of Contents:

Index of Tables:

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ABSTRACT:

Introduction:

The postpartum period is a very important period for the health of the mother and the newborn. Despite its importance, research on this period is limited and tends to be more focused on biomedical aspects of the postpartum period. In the occupied Palestinian territory, little is known on how women experience the postpartum period and what women consider important during this period. This study assesses Palestinian women's postpartum quality of life by using a previously validated instrument, the MAPP-QOL instrument. It further explores Palestinian women's experiences and the dynamics of support available to women within a broad quality of life framework, seeking to identify important determinants of life quality during this period.

Methods:

The study utilizes both quantitative and qualitative methods. Focus group discussions were used to validate and adapt the instrument in the local context, and add possible determinants identified by women themselves. A cross sectional survey utilizing the adapted MAPP-QOL was then completed in the occupied Palestinian territory. The sample was drawn from the 2006 PAPFAM sample frame; all women reporting pregnant during the time of the PAPFAM survey were included in this study with a final sample size of 1020 women.

Results:

The qualitative findings indicate that the postpartum period is characterized by exhaustion, new pressures, emotional changes, and an 'open body.' For women, exhaustion and multitasking were the main sources of stress and accounted for the emotional changes that they were going through. The findings also indicate that female relatives still play a significant role as support providers in the postpartum period, although many women indicated a desire for greater involvement from their husbands during this period.

In terms of quality of life, the mean overall quality of life score for the sample was 21.53 (out of a maximum score of 30), with domain means ranging from 19.74 to 23.12; indicating an average slight satisfaction during the postpartum period. Main variations in quality of life scores were associated with regional district, refugee status, the loss of a relative due to occupation, standard of living, wanted-ness of pregnancy, and dissatisfaction scores on scales measuring various forms of support received by these women, and constructed based on the analysis of the findings of the focus group discussions. The scale scores accounted for a major part of the total R^2 when entered into the regression analysis, resulting in a change in the R^2 from 0.126 (without the addition of the scales) to 0.502 (when the scales were added).

Conclusion:

The importance of pregnancy wanted-ness in determining postpartum quality of life highlights the need for further research into unwanted pregnancies and family planning programs in the oPt. Also, in light of the sharp rise in R^2 after the addition of the scales into the regression analysis, it may be worthwhile to consider adding the scales as standard measures linked to postpartum quality of life.

ملخص البحث:

المقدمة:

تعتبر فترة ما بعد الولادة فترة مهمة لصحة الأم والمولود. و بالرغم من هذه الأهمية, إلا ان الأبحاث في هذا المجال ضَئيلة جدا و مركزة على الجانب الطبي فقط. وكذلك هو الحال في الأراضي الفلسطينية المحتلة حيث ان المعلومات حول صحة المرآة وتجربتها خلال هذه الفترة و حول ما تعتبره مهما فيها محدود جدا. تقوم هذه الدراسة بتقييم حياة السيدات الفلسطينيات خلال فترة ما بعد الولادة، وذلك من خلال استخدام أداة مصادق عليها سابقا ، أداة MAPP-QOL. كما أنّ الدراسة تستكشف تجارب المرأة الفلسطينية، وديناميكات تقديم الدعم المتاحة لها في إطار جودة الحياة واسع النطاق ، بهدف التعرف على المحددات الهامة لجودة الحياة خلال هذه الفترة.

طريقة التنفيذ :

تم تنفيذ الدراسة باستخدام أداتي بحث: كميه و كيفيّه. كما استخدمت طريقة نقاشات المجموعات البؤرية لمواءمة وتكييف الأداة في السياق المحلي وإضافة محددات أخرى التي يمكن أن تذكرها المرأة نفسها. ثم أنجز مسح شامل في الأراضي الفلسطينية المحتلة من باستخدام أداة MAPP-QOL. ضمت العينة جميع السيدات الوات ابلغن انهن حوامل خلال مسح الأسرة الفلسطينية(PAPFAM) الذي نفذ عام 2006 وعليه ضمّت العينة 1020 امرأة.

النتائج:

أظهرت نتائج البحث الكيفي أن فترة ما بعد الولادة تتميز بالإرهاق ,الضغوط الجديدة، والتغيرات العاطفية، والإحساس ب"جسد المفتوح". فإنّ الإرهاق وتعدد المسؤوليات كانت المصادر الأساسية للضغط بالنسبة للسيدات، وإليها عزيت التغيرات العاطفية التي يعشنها. كما أشارت النتائج أيضاً إلى أنّ النساء من ذوات القربى يلعبن دوراً مهماً في مجال تقديم الدعم خلال هذه الفترة، و بالرغم أنّ العديد من السيدات عبرن عن رغبتهنّ في مساهمة أكبر لأزواجهنّ خلال هذه الفترةً.

من ناحية جودة الحياة فإنّ كانت درجة المتوسط العام قد بلغت 21.53 للعينة المدروسة، مقارنةً مع أعلى درجة البالغة 30. وقد تراوح مجال "المتوسط" للمجالات المختلفة بين 19.74 و 23.12، مما يشير إلى قليل من الرضى بالمجمل بين السيدات خلال هذه الفترة عقب الولادة. اقترنت الاختلافات الأساسية في درجات جودة الحياة بالأقسام الجغرافية لمناطق السكن، وضع اللجوء، فقدان قريب على يد قوات الاحتلال، مستوى المعيشة، مدى الرغبة بالحمل، درجات عدم الرضى حسب مقاييس تقيس الأشكال المختلفة للدعم الذي تتلقاه هذه النسوة. وقد وضعت هذه المقاييس بناء على تحليل نتائج نقاش المجموعة البؤرية. لقد مثلت درجات المقياس جزئا أساسيا من مجمل R^2 عندما تم إدخالها في تحليل الانحدار ، مما تسبب في تغير في R^2 من 0.126 (بدون زيادة الموازنة) إلى 0.502 (عندما أضيفت المقاييس).

الختامة:

إن أهمية الرغبة في الحمل في تحديد جودة الحياة في الفترة ما بعد الولادة, تؤكد على الحاجة إلى دراسات وأبحاث مستقبلية حول عدم الرغبة بالحمل و في مشاريع تنظيم الأسرة في الأراضي الفلسطينية المحتلة. وأيضا، وفي ضوء الارتفاع الحاد في قيمة R^2 بعد إضافة المقاييس لتحليل الانحدار، وقد يكون من المثمر اعتبار إضافة المقاييس كمعيار مقياسي مرتبط بجودة الحياة بعد الولادة.

INTRODUCTION:

To women, the postpartum period reflects the transition into motherhood. While it can be a time of joy, it is also a time of tremendous physical, emotional, and social changes that impact the mother's quality of life (Hill et. al 2006). Complications and psychological distress are not uncommon in the postpartum period (MacArthur et al 2002). Women are in need of support and practical help in caring for themselves and the child (WHO 1998 and 2005; Wilkins 2006), especially where pain and fatigue may limit their ability to carry out regular tasks. This is particularly important for women lacking social support; for this is a time where their roles are being redefined, especially when the woman has given birth for the first time.

The majority of postpartum studies have focused on limited aspects of the experience (Hill et al 2006), with a greater portion of studies focusing on the incidence of postpartum depression and its measurement, postpartum complications, as well as the administration of postnatal care services (Dennis 2004; Gibb and Hundley 2006; Kaewsarn, Moyle, and Creedy 2003; Lawn, Cousens, and Zupanet 2005; Hill et. al 2006). While these are important issues for understanding the postpartum experience, they only provide us with insight into certain aspects of this experience, mostly within a biomedical outlook. The biomedical dimension of childbirth and postpartum is undeniable, but the social experience of postpartum and the transition to parenthood, which begins at the beginning of the postpartum period, are important social phenomena that cannot be fully understood within a narrow biomedical framework alone.

The environmental and social context of postpartum women has been shown to play a role in the utilization of postpartum care services (Lagro et al 2006; Chakraborty et al 2002) as well as in postpartum morbidity (Gibb and Hundley 2006; Rodrigues et al 2003; Liamputtong and Naksook 2003; Warren 2005; Cronin 2003; Lee et al 2006; Van Bussel, Spitz, and Demyttenaere 2006) and psychosocial well-being (Hung and Chung 2001; Warren 2005; Escriba et al 1999; Walker and Sterling 2006). In addition, with increasing urbanization in the developing world (Kasarda, Crenshaw 1991), many women, like those in the developed world, have to adjust to decreasing levels of social support. Social support is a crucial determinant of a woman's psychosocial health, especially in early motherhood. Various studies have indicated that the lack of social support can have negative effects on the well-being of the mother (Rodrigues et al 2003; Liamputtong and Naksook 2003; Warren 2005; Cronin 2003; Lee et al 2006) and in some cases also on the child's behavioural outcomes (Lee et al 2006). Conversely, perceptions of positive support have been shown to have a positive effect on adaptive motherhood behavior, the transition to motherhood, and a predictor for postpartum health status (Hung and Chung 2001).

In the Palestinian context, childbearing and motherhood are closely interlinked with prevalent cultural beliefs and practices. Typically, mothers, sisters, mother and sister in laws or other women relatives, all engage in initiating new mothers into motherhood, from breastfeeding, to bathing and physically caring the child, learning about their cries, giving nutritional advice, and managing other aspects of health and well being, as well as care for the family. With increasing barriers to access due to geopolitical and financial reasons, (Taraki 2006; UNSCO 2007) there is a possibility that this support system has changed; especially as more young couples are leaving

their homes to seek employment in the cities (Taraki 2006). This could mean that new mothers must cope with motherhood in isolation from the traditional female support system.

The study also aims to assess women's postpartum quality of life through the use of the MAPP-QOL questionnaire developed by Hill et al (2006). This study will also explore the dynamics of the social support system available to women during the postpartum period in a changing social environment (Taraki 2006) and the role it plays in defining women's postpartum and early motherhood experiences. Social support will be examined within all four domains of quality of life: health & functioning; socioeconomic; psychological/spiritual; and family (Hill et al 2006). For the purposes of this study, social support is defined as any type of support provided in the areas of health maintenance, personal and child care; economic assistance; emotional support; as well as assistance with household chores and childcare. These forms of support are typically provided by members of a person's social support network and act as a coping resource for the mother (Hung and Chung 2001).

Understanding the social dynamics of postpartum and early motherhood experiences will serve as additional baseline information on the needs and desires of postpartum women. Because the dynamics of this support system seem to be changing, understanding support needs will help formulate policy recommendations for postpartum services that are geared towards women's needs and desires. It will also enhance our understanding of the social construction of early motherhood in the Palestinian setting.

RESEARCH QUESTIONS:

1. How do women experience the postpartum period and early motherhood in relation to care, support, family interactions, childrearing attitudes and practices?
    a. What types of support do women need during this period?
    b. What types of support do women desire during this period?
    c. What types of support do women receive during this period?
    d. Who gives this support?
    e. What role do they expect their spouse, mother, mother-in-law, and other family members to play in the postpartum and in child rearing?
    f. What roles do these people (spouse, mother, and mother-in-law) actually play?
    g. Where do women get information on caring for themselves and for the child during the postpartum period?
    h. What effect do social pressures have on women's well-being, attitudes, and practices during the first year postpartum?
    i. How do social norms and pressures define expectations and experience of motherhood?
2. How do women assess their postpartum quality of life?
    a. How do women score in terms of postpartum life quality based on the MAPP-QOL instrument?
    b. What are the main sources of variation in quality of life scores?

Chapter 1 LITERATURE REVIEW

1.1. Significance of the postpartum period:

The postpartum period is a critical time for a woman, her newborn and her family, on a physiological, emotional and social level. The postpartum period often refers to the period right after birth and up to 6 weeks (WHO 1998). However, there is growing awareness that new mothers may experience other postpartum health problems that persist well beyond the traditional 6-week postpartum recovery period (Gjerdingen and Center 2003).

Various studies have shown that care and support during this period may have long term effects on the well-being of both mother and child (Rodrigues et al 2003; Liamputtong and Naksook 2003; Warren 2005; Cronin 2003; Lee et al 2006; WHO 2005; van Bussel, Spitz, and Demyttenaere 2006). It is also a critical period where many health problems may arise, and where between 50% and 71% of all maternal deaths occur (WHO 1998; WHO 2005). Common health problems facing women during this period include backache, perineal pain, urinary incontinence, sexual problems, hemorrhoids, depression, bowel problems, breast infection, and exhaustion (Macarthur 1999; Gjerdingen and Center 2003). Although these problems face many women, many cases continue to go unreported and untreated (Kabakian-Khasholian, Jurdi, and El-Kak 2006; Macarthur 1999)

This period can be an important opportunity to counsel women on their health, caring for the newborn, as well as family planning methods. Postnatal care requires significant input from health professionals and although this period is crucial to the

overall health and well-being of mother and child, it is often neglected (WHO 1998; WHO 2005; Macarthur 1999) and there is some question as to the effectiveness of the care currently provided to postpartum women (Macarthur 1999).

1.2. Health Care during the Postpartum Period:

In many parts of the world, health care is inadequate. With the international trend towards medicalized care at childbirth, traditional systems for care and coping during the postpartum period are changing (Wang et al 2007; Ozsoy and Katabi 2006). Meanwhile, medical structures have not been able to cope with the needs of postpartum women (WHO 1998; WHO 2005; HDIP October 2002; MacLachlan et al 2006; Yelland et al 2007) and in some cases the structures themselves can act as obstacles to quality care in the postpartum period due to inadequate staff, ineffective division of tasks, and overcrowding (MacLachlan et al 2006). Many people living under poor conditions can not access health facilities, even if they are available, in order to receive needed care (Lagro et al 2003; Rodrigues et al 2003).

1.2.1 Coverage and Utilization of Care:

The World Health Organization (2005) recommends that maternity and postpartum care be accessible to women. Guidelines for proper care are provided by the WHO and oftentimes call for the inclusion of the woman's social support groups in order to promote postpartum health. Health structures, particularly in the developing world, are oftentimes not equipped to deal with postpartum care due to inadequate facilities, low resources, and inadequate staff. At times, hospital staff may be too busy to provide women with the care that they need (MacLachlan et al 2006; Yelland et al

2007), as in the government hospitals in Palestine (Hassan 2006) or they may not fully understand what women need in the post-natal period (Gibb and Hundley 2006).

Internationally, the percentage of women actually seeking post-natal care is less than 50%, and in the Palestinian setting the coverage is only one-third of mothers (PCBS 2007), for which, in addition, there is no reliable information on the content and appropriateness of what is being provided.

Results have also shown that many women have, but do not report, physical and emotional disorders after childbirth (MacArthur et al 2002; Lagro et al 2003). The results of a longitudinal study of the utilization of postnatal care in Bangladesh indicated that most women who had reported complications during the postpartum period did not receive treatment (Chakraborty et al 2002). In this study, the percentage of women reporting complication and not seeking care ranges between 51.6% and 89.4%, including women who faced life-threatening conditions. The factors associated with care utilization in this setting included the mother's age at marriage, the husband's occupation, and inadequate access to professional services especially in rural communities leading some to seek care from traditional healers. An analysis of postpartum attendance in Zambia showed that the national rate of postpartum attendance was 7.3% (Lagro et al 2006). Data from a study conducted in 2001 in a hospital in Zambia indicated that about 42% of women giving birth in the hospital returned for a postpartum check-up within 6 weeks. Reasons for coming into the hospital included routine postpartum care, infant vaccinations, infant health problems, and maternal health problems; while reasons for not returning to the hospital for the postpartum check-up included no knowledge about postpartum care,

not feeling well enough to walk to the hospital, no time or no transportation. Perhaps these results are an indication that there may be a deficiency in the information that women have about the care that they need after birth and also that there are factors other than the availability of services that affect a woman's ability to go to the hospital to receive care.

Data (unpublished) from the DHS 2004 survey in Palestine paints a similar picture of under-utilization of postpartum services despite the presence of complications (DHS 2004 data set, ICPH). The data from the DHS 2004 on self-reported maternal morbidity after childbirth indicated that not all potentially serious maternal morbidity in the postpartum is being treated. For example, 14% suffered from high fever and 37% of them were not treated; 13% reported depression and 70% received no treatment; 6% reported convulsions and 14% received no treatment Although there are limitations to the DHS self-reported morbidity data, it does indicate an unmet need in postpartum treatment. The results of the PAPFAM 2006 survey indicated that about 30% who have given birth during the last five years reported having a postpartum check-up in contrast to over 90% of women in the same survey that reported attending antenatal check-ups during the course of their pregnancy (PCBS 2007). These results are similar to the situation in Lebanon where, like Palestine, the rates of antenatal care utilization are high (87%), while only 39% of women have a 6-week postnatal check-up (Kabakian-Khasholian, Jurdi, and El-Kak 2006).

1.2.2 Quality of Care and Content of the Postnatal Visit:

Aside from the utilization of care, some studies point to the need to re-examine the quality of care received and content of the postpartum visit. Macarthur (1999) argues

that many practices that are implemented during the postpartum visit include routine practices that have been in place for years and have not been thoroughly studied in terms of their effectiveness. A review of postnatal care in public hospitals in Victoria, Australia (Yelland et al 2007) indicated that the needs of women and their children during this period have often been eclipsed by attention given to pregnancy and birth. The review also indicated that the early postnatal period in these hospitals is characterized by diverse practices where psychosocial assessment and support are poorly coordinated aspects of postnatal care. In the UK, despite the frequent contact midwives and physicians have with women, many women reported their desire for more advice on dealing with health problems (Macarthur 1999), indicating that women are not getting what they need out of the postpartum visit.

The content of the postpartum visit has also been the question of one study in Lebanon set in three economically disadvantaged suburbs in Beirut (Kabakian-Khasholian, Jurdi, and El-Kak 2006). There was some fluctuation in the timing of the postnatal visit ranging between the first two weeks following delivery and at around 40-45 days post-delivery. The survey also indicated that there is wide variation in the content of the postnatal check-up. Thirty seven per cent of women reported that physicians did not feel their cervix during the physical examination; 57.2% indicated that they did not undergo a vaginal exam; 42.1% reported that their blood pressure was not measured; 67% reported not having their breasts examined; and 16% reported not being asked about their well-being. In terms of the information received during these visits, 17% of reported not being given information about their health; 30.5% reported not receiving information about contraception during that visit; and only 27% of women reported receiving information about their infant's health. It is clear

from this study that there are gaps in the care provided to postpartum women. It is alarming that key indicators are not being examined and information about personal and infant care is not adequately provided. Adequate information on personal and infant health is important for gaining maternal confidence (Ruchala and James 1997) as well as for being able to care for oneself and the baby adequately. This is especially important considering that research indicates that many women would like more information on how to care for themselves and for the child (Moran, Holt, and Martin 1997; Bull and Lawrence 1984).

Although detailed information on the content of the postpartum visit in Palestine is not available, there is some indication that care is inadequate and proper advice is not provided. There is some indication, based upon the lack of exclusive breastfeeding at 4-6 months (Barghouthi and Kalter 2006) that women are not provided with proper support and guidance in breastfeeding and infant nutrition. Additionally, half of the women that participated in the study received no maternal nutritional advice after childbirth, despite the prevalence of anemia among women and children in Palestine (PCBS 2003), or information on mother/infant danger signs (Barghouthi and Kalter 2006). In contrast, most women reported receiving information on mother-child wellness centers and were provided with information on immunization for their child. Thus, available evidence indicates that essential components of post-natal care are not being addressed adequately and this raises questions as to the quality of the care provided in cases where it is utilized.

1.2.3 Alternative Approaches to Care:

Community-based care has been shown to be an effective structure for the provision of post-natal care and for increasing availability to the more isolated and needy segments of society (WHO 1998; WHO 2005; Davis and Prater 2001). Various studies have investigated the benefits of community-based postpartum care (HDIP 2002; Morrell et al 2000; Davis and Prater 2001; Prater and Davis 2002; Zadoroznyj 2006; MacArthur et al 2002). The intervention project targeting American Indians (Davis and Prater 2001; Prater and Davis 2002) proved to be very beneficial to improving the overall health of urban American Indian mothers and their infants through the inclusion of the community and community-based centres in the improvement of overall care received by mothers and infants. MacArthur et al's (2002) randomised control trial where care was re-designed to be midwife-led, flexible, and tailored to the needs of women, demonstrated that the latter has helped improve women's mental health and contributed to reducing depression at 4 months postpartum. Also, Zadoroznyj's (2006) evaluation of women's assessments of a post-natal home-care program concluded that home-based support in the post-natal period is important to maternal well-being, successful bonding, and transition to motherhood.

Morell et al (2000) showed that there was no health benefit from the intervention that included additional home visits by community post-natal support workers when compared to traditional community midwifery visiting. In this study, both the control and intervention groups were provided with home-based midwifery care. The intervention group was provided with 10 additional visits from community post-natal support workers during the first 4 weeks postpartum. However, there was no

comparison made between those who received no home-based care and those who received some sort of home-based care.

The project conducted in the West Bank by the Center for Development in Primary Care (2003) included reaching low parity women through a second home visit by community health workers, involving women's husbands and influential males, and creating outreach linkages with hospitals. The study showed that the second home visit by the community health workers was associated with an increase in the likelihood of women visiting the maternal and child health clinic at 40 days postpartum, an increase in support provided by the husband, and an increased likelihood of husband-wife communication about the timing of the next pregnancy. However, the intervention was not associated with improved knowledge of practices of mothers regarding their own health and the health of the newborn. This sample, however, is not necessarily representative of the Palestinian population and there were differences in age, employment status, family expenditure, and service provider amongst the intervention and control groups that may have biased the findings.

HDIP's study (December 2002) also concluded that the inclusion of men in postpartum care might have positive effects on the mother's postpartum health. The interviews indicated that oftentimes men were not aware of their wives' needs and did not know how they could be helpful to their wives. This was partly due to traditional gender roles in Palestinian society that restrict the area of postpartum care and support to female relatives rather than the spouse. These investigations, although not representative, do indicate that there may be an added benefit to community-based care, especially where the role of the spouse in postpartum care is enhanced.

1.3. The postnatal period as transition: changing family relations and the need for adjustments

Some studies have focused on how the challenges of the postpartum affect family life and the parents' marital relationship. One US study examining the effects of first-time parents' prenatal to postpartum changes in health found that both fathers and mothers in the sample experienced declines in physical and mental well-being after giving birth to their first child (Gjerdingen and Center 2003). Parents also reported more sick-days, reduced sleep and declines in perceived quality of life. Men were also more likely to report reduced marital satisfaction. Knauth's (2001) survey of studies examining marital change during the transition to parenthood found that the transition to parenthood causes various changes to the marital relationship. In some cases the changes in the daily lives of the parents causes strain on the marital relationship, while a nurturing, positive atmosphere prior to the arrival of the infant can mitigate the effects of the new strains on the marital relationship and at times create a more positive atmosphere.

A few qualitative studies have examined the experiences of women during the postpartum period (Liamputtong, Naksook 2003; DiMatteo, Kahn, Berry 1993; Barclay et al 1997). These studies provide some insight into the challenges as well as the paradoxes in emotion that women undergo during this period. In general, the three studies reveal that women describe this period both positively and negatively. While women view this period as one of fulfillment and pride, it is also seen as a difficult time of adjustment, a loss of self and autonomy, fatigue, physical and emotional strain, and loneliness.

Barclay et al (1997) have divided the process of becoming a mother into five categories based on focus group discussions they conducted with postnatal women. These categories include “working it out”, “drained”, “alone”, “loss”, and “realizing”. “Working it out” referred to the development of skills and gaining confidence in being mothers and caring for their babies over time. “Drained” was the term used by the women to describe a sense of having given everything, of being emptied out, while “alone” characterizes feelings of loneliness and social isolation. “Loss” refers to the experience of loss in different areas of a woman’s life like time available for self, partner, and friends as well as the loss of control over one’s own life. “Realizing” refers to facing the process of becoming a mother and the consequences this has on one’s life.

The other two studies mentioned above (Liamputtong and Naksook 2003; DiMatteo, Kahn, Berry 1993) reveal a similar picture. These stages that women went through were important for their transition into motherhood and affected their well-being during this period. What is striking in these studies is that all the women participating seem to have gone through varying degrees of these experiences. Although the problems they face may not, traditionally, be categorized as health problems, they do have an effect on their overall well-being during this period. It is also clear that the postpartum period to women is not only a period of increased health risk, but it is also an important transitional period that shapes a new mother’s sense of self and her relationship with the newborn.

1.4. Social support and postpartum health:

In recent years, social support has been increasingly studied as a determinant of health status. Social relationships can provide individuals with access to resources during

times of life stress and transition as well as a general sense of self-worth, psychological well-being, and control over their environment (Feldman et al 2000). Pregnancy, labor, and the postpartum are important physical events that typically bring about increased life stress and change, and social support can be an important factor in determining maternal and child well-being (Belsky and Rovine 1984; Feldman et al 2000).

Various studies examining the relationship between social support and postpartum well-being have been conducted; where indicators such as maternal depressive symptoms, maternal confidence, postpartum stress, infant birth weight, and child early behavioral problems have been examined in relation to social support

1.4.1 Social support and maternal wellbeing:

Studies examining maternal well-being have primarily been focused on the correlation between social support and depressive symptoms, maternal confidence, and postpartum stress. Depression and depressive symptoms have been the focus of a majority of these studies.

Some researchers have suggested that the depression of childbearing women reflected disturbances in cultural and social structuring, i.e. changes in the social environment, of the postpartum period that lead to inadequate support (Hung 2007). These social and cultural structures have traditionally acted as important coping resources for women during the postpartum period and as buffers against depressive symptoms. The continuous changes to these structures throughout the world resulting in reduced

social support for the new mother may provide some insight into the occurrence of depressive symptomology and feelings of loneliness.

Hung's (2007) study of 435 primipara mothers in their postpartum found that the presence of social support reduces the likelihood of depression. A study of 83 postnatal Taiwanese couples found that the lack of social support and stress were significant predictors of depressive symptoms (Wang and Chen 2006). A US national study of 1216 families found that social support reduces the likelihood of maternal depressive symptoms and that the presence of support alleviates the effects of maternal depression on early childhood behavioral problems (Lee et al 2006). In a longitudinal study of 526 postpartum women in Taiwan, social support was found to significantly reduce postpartum stress and was directly tied to postpartum health status (Hung and Chung 2001).

A study of Bangladeshi women living in Tower Hamlets in the UK (Parvin, Jones, Hull 2004) indicated that women experienced hardship due to the lack of social support provided by the traditional social networks that they were unable to access in the UK. Consequently they were unable to undertake the traditional 40-day rest period common in Bangladesh and in turn, these women experienced difficulty in their transition and in coping with their various roles without the availability of support. The women in this study experienced feelings of loneliness, despair, and hardship.

Two other studies have pointed to the correlation between spousal support and postpartum depression. A study of psychological distress among Spanish mothers found that women with poor relationships with their spouse were more likely to be

depressed (Escriba et al 1999). Similarly, a qualitative study of postpartum women in the Goa region of India found that women who suffered from postnatal depression had poor levels of emotional and practical support. They were also more likely to state that they were not supported or listened to by their husbands whereas non-depressive women were more likely to state that they had adequate support and were less likely to complain of an unsupportive spouse (Rodrigues et al 2003).

Some studies have examined the role of social support in affecting maternal role attainment and confidence in infant care. Hung's study (2007) also found that access to social support is related to satisfaction in the parenting role and infant care. Another study conducted among first-time mothers in southern Ireland (Warren 2005) found that appraisal and informational support were positively associated with maternal confidence in infant care practices. When confidence in infant care practices was correlated with instrumental and emotional support, a positive yet statistically insignificant relationship was found. Another study conducted in China (Loo et al 2005) found that rather than social support and demographic factors, maternal confidence was based on the infant's behaviors and responses. Increased infant irritability was associated with decreased maternal confidence and vice versa. Although the lack of a statistically significant association between social support factors and maternal confidence may be related to the small size of the sample, the strength of the relationship between maternal confidence and infant neurobehavioral characteristics is striking.

1.4.2 Social Support and infant health:

A few studies have focused on the association between maternal social support and infant health. Within these studies, there has been some focus on the relationship between social support during pregnancy and infant birth weight. A prospective study of 247 women in their early trimester (Feldman et al 2000) found that social support during pregnancy was positively associated with infant birth weight. Another study conducted in urban neighborhoods in the US (Buka et al 2003) examined the relationship between neighborhood support and the birth weight of urban infants as one possible explanation for the lower birth weights among infants of African American women compared to the birth weight of White American women. Neighborhood support was measured through the Neighborhood Support Scale, which included questions about the social features of neighborhoods. The results of the study indicated that for White Americans, neighborhood support had a positive association with birth weight, whereas neighborhood support was not associated with the birth weight of African American infants.

1.5. 'Quality of Life' as a comprehensive measurement of postpartum well-being:

Amongst the different existing approaches used to assess the impact of health interventions, and the consequences of social and environmental factors, on the well-being of individuals and their direction and intensity of preferences, "Quality of Life (QoL)" tools are being increasingly utilized. QoL instruments help assess health-related outcomes from an individual's perspective, based on the assumption that the individual's QoL is what he or she perceives it to be (Ferrans et al 2005; Berlim and Fleck 2003). QoL measurements are conceived to complement the traditional emphasis on objective clinical/biological tests in determining health-related outcomes.

While the latter provide important information on the pathology of a disease, they largely ignore individuals' preferences and perspectives and the social context of the disease (Giacaman et al 2006).

The QoL of an individual is multidimensional. Its measurement should include: physical, psychological, mental, emotional, social, environmental and spiritual factors and dimensions of well-being (Symon, Macdonald, Ruta 2002; Symon, McGreavey, and Picken 2003). QoL measurements are important because they provide researchers and policy makers with the opportunity to examine the well-being of the population as a whole, bypassing by this, the simple count of fatal and nonfatal outcomes of a disease (Giacaman et al 2006). QoL tools are designed to assess the life quality of either the general population – using generic QoL instruments (Ferrans et al 2005; Berlin and Fleck 2003) – or to reveal particularities of certain socio-demographic or disease groups – using specific QoL instruments (Symon , Macdonald, Ruta 2002; Symon, McGreavey, and Picken 2003; Hill et al 2006).

Due to the subjective and context-specific nature of life quality, various problems arise with the development and application of QoL instruments. Because of the specific nature of different social contexts, the generalizability and cross-cultural adaptation and validation of QoL tools can be daunting (Ferrans et al 2005). Validated tools could however be used as starting points to be amended to suit the context in which they would be applied (Giacaman et al 2006).

While a combination of factors play a role in determining life quality in general, few studies have focused on overall postpartum quality of life (Hill et al 2006; Symon,

McGreavey, and Picken 2003; Symon, MacDonald and Ruta 2002; Symon, MacKay, Ruta 2003). Because of the broad subjective view of quality of life tools, the use of quality of life methods to study the postpartum period may provide for additional insight into this period and can help generate policy recommendations to better enhance postpartum well-being.

This study will focus on generating additional information relevant to women in the post-natal period by utilizing the quality of life framework, adjusted to suit the Palestinian context. It is hoped that the findings of this study will help in understanding women's experiences of the postpartum period in their totality. The QoL approach aims to capture the psychosocial as well as physical aspects inherent to postpartum care in addition to the contextual factors that overlap and could negatively impact on well-being. The quality of life approach will help to understand the constraints and needs of women in their totality during this delicate period, as opposed to focusing on one framework alone. This spectrum may assist in formulating new ways of providing interventions to enhance well-being and reduce morbidity.

Chapter 2 METHODOLOGY

The study consisted of both qualitative and quantitative methods and was divided into two implementation phases.

2.1. Phase I- Focus Group Discussions and instrument development

Phase 1 of the study consisted of five focus group discussions. The focus group discussions were intended to understand women's needs and feelings during the postpartum period in order to modify the MAPP-QOL instrument to suit the Palestinian context and culture. The focus groups were conducted in urban, rural, semi-urban, and refugee camp locales. Two focus groups were conducted in the urban setting in order to include possible variations in socio-economic class. Due to accessibility concerns, all the focus groups took place in the Ramallah/al-Bireh district and were divided in the following manner: Ramallah (urban middle class); Al-Bireh (poor urban); Ni'leen (rural); Birzeit (semi-urban); Qalandia (refugee camp).

2.1.1 Study sample:

The focus group discussions were primarily organized through personal contacts in the target areas. The five focus group discussions were carried out between 11-6-2007 and 20-6-2007. A discussion guide based on the areas of postpartum quality of life (Hill et al 2006; Symon, MacKay, Ruta 2003) was used to guide the discussions. The discussion guide is summarized in the annexes. Most of the women that took part in the focus group discussions were women in reproductive age and whose youngest child was two years old or younger. However, there were some women whose youngest

children were older, typically between 3-10 years old. In one case (rural group), one woman past reproductive age whose youngest children were in adulthood, one young woman who was pregnant with her first child, and one unmarried woman in her early 20s who had been her mother's primary source of support[1] took part in the discussion.

Table 2-1: Description of Focus Groups

Location	Type of locality	Description	# Of participants	# Of children per mother	Mean years of education	Participants' age in Years
Nileen	Rural	Mostly low socioeconomic status women. Only one worked outside of the home. Most had low education levels.	7	4-12 (excluding 2 childless women)	9.25 (based on 4 participants)	19-44 (excludes one woman whose age is unknown)
Bireh	Urban	Maintenance and kitchen staff at the In'ash al-Usra society as well as unemployed women, low socioeconomic status and low education levels.	4	1-5	8.67 (based on 3)	32-37
Ramallah	Urban	Administrative and research staff-ICPH, middle and lower-middle class.	6	1-2	15.83	26-43
Qalandia	Camp	Very poor with low educational levels.	15	1-6	10(based on 7)	20-36
Birzeit	Semi-urban	Lower to middle-class women, one was employed outside of the home.	6	2-3	14	24-33
All	**All**	**Low to middle class**	**38**	**1-12**	**-**	**19-44**

2.1.2 Data Analysis:

The focus group discussions were transcribed manually at each session. The transcripts were then read repeatedly for familiarization. Themes and sub-themes were then identified. Responses were then coded into tables based on themes. The results were then analyzed based on the research objectives and the contents of the Postpartum Quality of Life questionnaire (Hill et al 2006). Following the initial analysis of the focus group discussions, the Postpartum Quality of Life questionnaire (Hill et al 2006)

[1] While these women did not fit the original selection criteria, they had come to the sessions and expressed interest in taking part in the discussion. The facilitators felt that denying them the ability to participate may have negative impact on the flow of the focus group discussion, so they took part in the discussion. Their presence actually provided some insight into intergenerational differences in the experience and cultural values of motherhood and the postpartum.

was revised to include additional questions deemed relevant to the local context based on the analysis of the focus group discussions. A draft of the questionnaire was then prepared for use in the training of fieldworkers.

Further content analysis of the focus group discussions was conducted. The findings were divided into two main areas: women's experiences of the postpartum; and support and care during the postpartum. For the findings on women's experiences, characteristic features of the postpartum were grouped by major themes. For the support domain, findings were grouped by predefined categories related to the types of support and then by women's perception of the impact of support on their quality of life and ability to take care of the child.

2.2. Phase II: Fieldwork and quantitative data analysis

2.2.1 Sampling frame, target population, and sample size:

The sampling frame for the study was based on the sampling frame used in the 2006 Pan Arab Project for Family Health (PAPFAM) survey. The target population of the PAPFAM survey consisted of all Palestinian households residing in the occupied Palestinian territory. A list of all Palestinian households was constructed from the updated frame in 2003. Stratified two-stage random sampling was then conducted by Enumeration Area (EA) and then by household. The final sample included a total of 13,238 households (PCBS 2007). The sample for this study comprised all women who

reported themselves as pregnant at the time of the 2006 PAPFAM survey[2], which included a total of 1159 women.

2.2.2 Data collection tool:

The Maternal Postpartum Quality of Life (MAPP-QOL) instrument is a validated instrument developed by Hill et al (2006). It includes questions asking the respondent to rate their satisfaction on a scale of 1 to 6 (1 being very dissatisfied and 6 very satisfied) on 40 items found to be of importance in the postpartum period (Hill et al 2006). The final instrument used for the purposes of this study included the items in the MAPP-QOL instrument; socio-demographic questions; satisfaction questions on items deemed important by women participating in the Phase I focus groups; and other non-scaled questions on women's preferences, pregnancy intentions, and care seeking behaviors.

The order of the MAPP-QOL items was maintained, with the exception of the item on satisfaction with sex life. This item was placed at the end of all the satisfaction questions because of the researchers' uncertainty about participants' willingness to answer this question. It was feared that it would bias the participants' responses to other questions in cases where the participants felt that this question was inappropriate or too personal. The response rate to this question was actually very high with a total response rate of 98.1%.

[2] The data collection phase of the PAPFAM survey conducted by PCBS started on November 1st, 2006 and finished by January 20th, 2007.

Four other questions on women's satisfaction with their husband's behavior in terms of jealousy, selfishness, violence and abandonment, added by the researchers, were removed from the analysis due to high non-response rates (non-response rates ranged from 36.1-47.9%).

2.2.3 Data collection:

The questionnaire was administered through an interview conducted by a female field worker. The Palestinian Central Bureau of Statistics (PCBS) and the primary researcher trained all field workers. West Bank field workers were trained at the PCBS office in Ramallah, while the Gaza Strip field workers were connected through videoconference due to movement restrictions between the two regions. Following the training, some adjustments to the questionnaire were made based on fieldworker suggestions.

The data collection took place between August 15th 2007 and September 1st 2007. Women gave their verbal informed consent to participate in the study. A total response rate of 88.3% resulted in a final sample of 1023 women. Three more women were then excluded from the analysis due to missing data that made it impossible to verify whether they met the conditions for selection into the sample or not.

2.2.4 Data Analysis:

Data analysis was conducted using SPSS version 15.0. Preliminary data analysis began with the examination of descriptive statistics. Postpartum quality of life scores were then scored based on Hill et al (2006). The quality of life domains were scored

according to the domains defined by Hill et al[3] with a possible range of scores between 0 and 30. The socioeconomic domain was scored twice; once based on the variables in Hill et al and again with the inclusion of the husband's employment variable. This decision was made because the majority of the women in the sample (over 90%) were not employed, and consequently the husband's employment is a better reflection of socioeconomic status than the women's employment status, which was one of the variables in the Hill model. Bi-variate analysis was conducted through chi-square tests, t-tests, and one-way ANOVA.

Linear regression was used to test differences in scores based on socio-demographic characteristics as well as scales developed from variables added on to the questionnaire. The variables that were significantly associated with quality of life scores in the bi-variate analysis were entered as independents in the regression analysis. The regression was conducted twice, once without the inclusion of the scales in the analysis and a second time including them. This was repeated for all the quality of life domains. It should be noted that for the regression, regional districts were included instead of a binary regional category (i.e. West Bank, Gaza) because there was indication of differences between the regions of the West Bank. The variable was recoded where once entered into the regression, each regional district would be compared to the North West Bank, which was set as the reference.

[3] It should be noted that the scoring for this study assumed equal weights for all the variables because questions on the importance of each item were not used in the adapted questionnaire.

2.2.5 Variable Explanations:

2.2.5.a Satisfaction Scales:

A total of eight satisfaction scales were developed based on questions added to the MAPP-QOL instrument. The numbers on each scale represent the number of items that the participant was dissatisfied with. Dissatisfaction was categorized as any response ranging from 1 to 3 (very dissatisfied to slightly dissatisfied). The eight scales are: Childcare Characteristics[4], Childcare Economic Characteristics[5], Husband Characteristics[6], Husband's Employment[7], Medical Support Characteristics[8], Information[9], Social Interventions & Choice[10], and a Support Scale[11].

The Childcare Characteristics scale deals with items pertaining to childcare and satisfaction with motherhood role acquisition; the Childcare Economic Characteristics scale deals with items pertaining to the mother's satisfaction with her ability to provide for her child; the Husband Characteristics Scale includes items on the husband's mood and support during the postpartum; the Husband's Employment scale pertains to more detailed questions about the husband's employment based on the focus group discussions; the Medical Support Characteristics pertains to the medical treatment the woman received during delivery and the postpartum; the Information scale includes women's satisfaction with the information they have on child and personal care; the Social Interventions & Choice scale pertains to items on interventions from the woman's social network as well as her ability to make choices pertaining to personal

[4] Includes responses to variables q45-q51
[5] includes responses to variables q52-q55
[6] Includes responses to variables q56-q59
[7] Includes responses to variables q63_1-q63_5
[8] Includes responses to variables q70-q75
[9] Includes responses to variables q76, q80-q83
[10] Includes responses to variables q84-q89
[11] Includes responses to variables q90-q95

and child care; the Support scale deals with items on the support and duration of support that the woman received during the postpartum.

Reliability testing was conducted on all the scales. The table 2-2 provides a summary of the Cronbach alpha for each scale.

Table 2-2 Summary of Scale Reliability Tests

Scale	Cronbach Alpha
Childcare Characteristics	0.761
Childcare Economic Characteristics	0.795
Husband Characteristics	0.736
Husband's Employment	0.88
Medical Support	0.759
Information	0.782
Social Interventions & Choice	0.752
Support	0.858

2.2.5.b Socio-economic factors:

Two factors were used as proxies for women's socio-economic status: an amenities index and a crowding ratio. The amenities index includes a list of 18 household amenities[12]. Yes responses were counted for all women. Descriptive analysis showed that the maximum score was 16. The variable was then recoded into four categories, based on an overview of the frequencies for the amenities. A crowding ratio was calculated by the number people living in the household divided by the number of

[12] The amenities were based on the responses by the same sample in the PAPFAM survey (variables h403a_1 – h403a_28). The crowding ratio was calculated by the number of rooms for household use (based no PAPFAM responses) and the number of people in the household (calculated by the sum of the number of males and females in the household based on the responses to the MAPPQOL survey.

rooms for household use. The variable was then divided into four categories based on the distribution of the sample.

Chapter 3 QUALITATIVE FINDINGS:

3.1. Characterization of the postpartum:

Women characterized the postpartum period in various ways. Regardless of how many children a woman had, each postpartum period had its' own share of joys and difficulties as well as a different process of adapting to the pressures and changes. Women's narratives of the postpartum period had four common elements: fatigue/exhaustion; new pressures; change in emotional state; and the concept of 'open body.'

These concepts were related to women's abilities to adapt and cope with the responsibilities associated with childcare; and their ability to balance between taking care of themselves and everyone else around them. Physical pain and exhaustion were underlying features of the postpartum that women had to overcome. Women's emotional states were seen mainly in response to the exhaustion and their ability to cope with family responsibilities. The concept of 'open body' was related to the traditional understanding of the postpartum period, sometimes referred to as '*nifas*' in Arabic. Women recognized their physical vulnerability during the postpartum, typically defined as the initial 40-day period. It was supposed to be a time of rest and recovery where the new mother was taken care of so she can adequately care for the newborn. Oftentimes, there was conflict between the expectation and the reality of the postpartum, which was overwhelming for many women.

3.1.1 Exhaustion:

Most women described the postpartum period as exhausting, difficult, or suffering. For most women, exhaustion referred to physical pain, fatigue, and the lack of sleep. Physical exhaustion was related to both the childbirth process (stitches, pain from delivery practices, CS) and elements of childcare (breastfeeding, lack of sleep due to staying up with the baby at night).

The childbirth process was viewed as an important determinant of postpartum wellbeing; it was a physically draining process that had overarching effects into the postpartum. At the very minimum it included pain resulting from delivery and stitches. For other women, sometimes questionable, interventions by physicians resulted in a greater degree of pain:

> *"I didn't have stitches but the doctor's intervention during delivery, entering his hand into my vagina to turn the baby's head was more difficult and lasted until after birth" (Urban middle-class woman).*

Women who had a caesarean delivery had a more difficult experience that resulted in a longer recovery period:

> *"My experience was difficult because it was a caesarean delivery. I stayed for a week until I was able to raise my back. Little by little the situation got better. After a month the matters were easier" (Urban lower-class woman).*

Various elements of childcare further exacerbated the amount of pain and fatigue a woman endured. Many women noted breastfeeding as being very difficult in the beginning. It often resulted in breast pain, the fissuring of the nipples, and in some cases infections. The irregularity of the baby's sleeping was another important source of fatigue. The infants' sleeping hours were irregular and often meant that women

would get little sleep during the night; this resulted in a reduction of the amount of energy they have during the day:

> *"After delivery breastfeeding was very difficult. Especially when I went back to work, my chest would get full of milk. After work I used to go home directly to feed the child and I had a rash on my breasts and my nipples were fissured and I wanted to try suction but it used to hurt a lot." (Urban middle-class woman)*

The pain and fatigue often limited women's ability to carry on with their daily routine and responsibilities. It limited the amount of energy they had to carry on other tasks and in cases of extreme pain kept them bedridden:

> *"For me, with my last son, my leg hurt me, it killed me for two months after birth, I had to stay sitting and I suffered a lot" (Rural woman);*

> *"I used to wash the dishes gradually. Wash a bit then sit, wash again, then sit and five times like this" (Urban lower class woman).*

A few women associated joy with the fatigue and exhaustion that they faced and characterized their experiences as both positive and negative. Women described the newborn as a source of joy and happiness. At the same time, the childcare demands and the physical pain women endured were daunting. Women's ability to carry on despite the pain and fatigue was a source of joy and accomplishment. Some indicated that it provided them with their first feelings of motherhood:

> *"You have strange feelings when you hold him and breastfeed him, and this child is part of you; feelings that are very beautiful. I don't know how to describe my feelings. And at the same time you are tired and despite that you have to change his diaper. There is a link between the fatigue and the beauty and you are in another world." (Urban middle class woman)*

A few women associated the postpartum period with rest or the lack of worries. For some of these women, the postpartum period signaled the beginning of relief from the worries of pregnancy. This was echoed by women that faced difficulties or great anxiety during their pregnancies:

> *"(The postpartum is) rest, rest from the exhaustion of pregnancy as if it's a mountain that was moved away from me, nine months of fear and worry: how is the child? What does he look like?" (Woman in semi-urban group).*

A few women categorized the postpartum period as normal and were not surprised by its reality; these women noted that they were constantly around children growing up and were aware of what was involved in the process.

Women in the rural and refugee camp groups were less likely to bring up the concept of exhaustion or mention the difficulties involved early on in the discussion. It usually took some time for them to talk about the difficulties they faced during the postpartum. Semi-urban and urban middle-class women were most vocal about this area. For the semi-urban group, about half of the group faced some hardship in the childbirth process and complained of medical malpractices. This may be associated with the amount of exhaustion and pain they went through during the postpartum period. For urban middle-class women, the pain and exhaustion was related primarily to the presence of stitches, the lack of sleep, and inflation or infections in their breasts. In general, stitches and the lack of sleep were the main causes of exhaustion. Most of the time, exhaustion lasted until the pain from the stitches subsided and the baby's sleeping pattern improved.

For the most part, time was a major ingredient in the reduction of exhaustion. Exhaustion generally decreased over time. The baby was an important part of women coping with the pain and exhaustion and sometimes also provided them with a feeling of joy or satisfaction that reduced their feelings of exhaustion and fatigue. This was mentioned by several women through statements like:

> *"It changes when you see the baby."*

3.1.2 New Pressures and Responsibilities:

"*(The postpartum is) the beginning of pressures" (rural woman)*

Most women described the postpartum period in terms of the new pressures and responsibilities that came with it. The new mothers were now responsible for a newborn and had to balance this role with their responsibilities to their spouse, other children and family, as well as household chores. Women also mentioned financial and social pressures particular to this period.

Women's reactions and ways of coping with the pressures and responsibilities varied; some described this as being more difficult than they had expected while others felt that the adjustment was smooth and 'normal'. Factors like birth order, experience, and available support were associated with the intensity of pressures faced. The first child was typically viewed as the most difficult because of women's inexperience. Support provided women with temporary relief during the postpartum. Women that did not have any support during the postpartum found it more difficult to cope with the pressures.

The most common pressure that women were faced with was the difficulty in finding a balance between infant care and other responsibilities. Although caring for the new infant was a daunting task, women typically had to make sure that other responsibilities were taken care of. These responsibilities included caring for other children, maintenance of the household, cooking, attending to their husbands, and attending to guests. The presence of support made this easier; while an unsupportive husband made it more difficult for women to balance between their various responsibilities.

> *"It is a difficult stage, you suffer, it's moving from one stage to another. Before, you can come and go and ride cars. After childbirth, there is a new child and you use up your time between breastfeeding, changing, and bathing. You actually feel*

> *like you are not being fair to everyone else and to your husband and then you experience internal pressures." (Urban lower class woman)*

> *"There is more than one thing I have to get done at the same time, I have to prepare food for my husband, and the baby is cranky and people are visiting with their children"* (refugee camp woman)

> *"For me the biggest problem was with the last baby because we hadn't planned for her and pregnancy occurred. And this affected me psychologically and on the pregnancy. I had her five years after her brother. She used to scream and my husband is hot-tempered and he used to get nervous from her screaming. And he wanted all of his requests ready and I would want to breastfeed at the same time." (Urban lower-class woman)*

In some cases, the pressures women faced were related to their lack of experience with childcare. Some women explained that the postpartum was most difficult after their first child. Some women mentioned that the postpartum period was actually more difficult than they had expected. Others described feeling anxious or fearful of taking care of the baby. In these cases, things usually got easier with time or with the presence of support.

> *"There is a difference between the first child and the second. The first child is harder because you have to get used to the situation and to his cries and condition but the second one is easier because you would have had experience with the first." (Urban middle-class woman)*

> *"The first day after delivery, I am too afraid to hold the child especially bathing. I don't bathe the child. My eldest daughter, her grandmother bathed her. But after the first day, I don't want anyone else to touch them." (Urban lower-class woman)*

> *"More responsibility, with my first daughter I was afraid to hold her and bathe her, and then I said this means bringing someone to bathe the baby, and I used to get up after I removed the stitches when I wanted to sleep I used to call my mother, and she used to come and hold the girls and take care of them. But now oh the sadness, she's traveling and I tell her where did you go and leave me with the responsibility, the staying up, and the fatigue." (Semi-urban woman)*

Sometimes pressures were not limited to aspects of childcare and household duties but also included social pressures that varied from social visits to comments and interferences from people. Many women felt that the presence of these pressures made it more difficult for them to cope during the postpartum period. Some also felt that the

intrusions from people limited their ability to live their lives normally and sometimes hurt them emotionally:

> *"Intrusions hinder you from going out and living your life normally" (semi-urban woman).*

> *"When my child sees other people, he becomes 'nikid' (cranky). He isn't like that normally, but people don't understand. They start saying: 'he is nikid.' This bothers a mother and gives her the feeling that she must not go out of the house so that people won't say (her child is) nikid." (Semi-urban woman)*

Some women associated the postpartum period with increased financial pressures and demands. Infants required things that were not previously part of the household budget; which consequently meant that the household would incur more expenses. Women had different ways of coping with the added expenses. For poorer women, this was a more important issue because it meant that the household would have to find alternative ways of coping with the expenses. Sometimes this included borrowing money and at times things like clothes and baby furniture from family members or other people around them. Some women in the semi-urban group stated that the financial pressures associated with childcare were a major reason for their use of family planning; in order to make sure that they could adequately provide for their children.

> *"I suffered a lot until I adapted to the situation and there was an increase in expenses in the house. New things come up. You have a shortage with some things and you begin to decrease some things. If I worked we would have a second source of income. But what am I going to work, after high school all I have is a computer course, where am I going to work with it?" (Urban lower-class woman)*

> *"The economic situation the most important endowment is God's endowment, I only want to have two only because of money and exhaustion is the same, the thing that used to cost 2 shekels (NIS) is now 3 shekels when you buy a shirt for yourself that used to be for 100 shekels but now it is 150, school tuition and books." (Semi-urban woman)*

A few women, mainly in the refugee camp group, described the postpartum period as being normal ('*adi* in Arabic), easy, or as a joy. These women said that they didn't have

a hard time, or that the adjustment was normal. Others said that the prior experience they had with childcare made it easier for them:

> *"Normal, I knew how to deal with children; I didn't have a hard time." (Refugee camp woman)*

Some urban middle-class women also felt that the demands of childcare limited their ability to carry on with their regular routine. These women complained that the presence of a baby that was highly dependent on them limited their ability to take part in activities they enjoyed like going out. The presence of a baby meant that they would have to spend more time at home:

> *"You are forced to sit because the child is there and he wants you, but the father can go out"; "Breastfeeding ties you up, I could not go out of the house."*

For most women, regardless of class and locality, balancing responsibilities was the main source of pressures. Some women noted that it was made easier when someone was there to help or when their spouse helped create a supportive environment. Husbands with unrealistic demands often made it more difficult for their wives to cope with all the pressures. Working women with a post-secondary education were most vocal about the role the husband should play in the household and as a source of emotional support for the mother. Whereas other women mainly stressed emotional support from the husband as a factor that helped them cope with the pressures. Women with other children also felt that it was harder to cope because of other childrearing responsibilities.

The lack of experience was brought up by some of the women either in discussing their most recent experience or previous experiences with other children. Most multi-parous women discussed their first and latest experiences and often compared experiences with different children. The lack of experience was mostly discussed in terms of not

knowing how to bathe the baby, breastfeed, or not knowing how to identify the baby's needs. This was typically made easier over time and with some help from the female social network. Women who characterized the process as 'normal' or not difficult either had previous experience with childcare or help from their mothers in taking care of the baby.

In terms of social pressures, urban middle-class, refugee camp, and semi-urban women were the most vocal. The urban middle class and refugee group emphasized the pressures from people visiting. For urban middle-class women this was a burden primarily because they were in pain and trying to tackle tasks while being expected to serve their guests at the same time. For the refugee camp group, the pressure was associated with the chaos created in the household, which may partially be due to the lack of space and over-crowding that are characteristic of the camps.

Refugee camp and semi-urban women also stressed the issue of comments and interferences from people around them. These were seen to have a negative impact on the new mother; only one educated woman in the semi-urban group was vocal about the need to do what you feel is right and ignore social pressures. Urban lower-class women viewed social visits positively and said that it provided them with a change of atmosphere. Their primary source of social pressure was problems with the extended family or in-laws. Rural women briefly discussed the issue of conflicting advice but were more likely to follow the advice of women around them. Some also discussed the pressure to continue to have children until a boy was born. Mostly women who only had girls emphasized this topic more in this group and the refugee camp group.

Educated women in general were more likely to stress the need to find your own way of doing things.

3.1.3 Changes in the emotional state:

About a third of women described undergoing changes in their emotional states during the postpartum. At times women characterized the postpartum through these changes. Some women stated that they felt confused, while others felt more alert and anxious. A few also mentioned feeling depressed. Sometimes the emotional changes were associated with the perceived sensitivity of women during this period resulting from the changes occurring in their lives:

> *"A new mother is very sensitive and becomes depressed from any small word, even if it's not intended" (Urban middle-class woman)*

> *"When a mother delivers her whole life changes with her husband her child herself and a type of depression occurs, and from woman to woman the depression changes but its there for every woman after birth, but maybe she doesn't know how to express it meaning the mother begins to hit her children because there is something affecting her, meaning the period of forty days two months are hard to adapt to the situation because her life is not like before." (Rural woman)*

The emotional changes were typically believed to be caused by external factors like the lack of support; the inability to cope with the demands of childcare; unmet expectations during delivery; the loss of a child; and other external factors like the extended family or the political situation. The lack of support typically meant that women were left to meet simultaneous demands on their own. This was a source of both physical and emotional exhaustion. The lack of emotional support or having someone that empathizes with the new mother was also believed to be negatively associated with women's emotional status. At times, a negative experience during delivery was a source of anxiety during the postpartum. Typically this referred to a delivery that was much more difficult than expected, which left women unable to come to terms with

their experience. For others, a negative delivery experience was one where the desired mode of delivery was not achieved. At times this left women with a feeling that they somehow did something wrong because they ended up having a caesarean delivery; oftentimes it took women a while to come to terms with their birth experiences:

> *"When I began to think clearly and this was 10 months after delivery…because I had a caesarean delivery and also because of breastfeeding and the changes that happened for me." (Urban middle-class woman)*

The loss of a child was a source of anxiety during the postpartum stemming from feelings of loss and grief. For some, a previous negative experience of loss also had an impact on their mood in the consequent postpartum period. Previous loss resulted in constant fear and anxiety when dealing with the child that followed. One woman also mentioned that the news of what was going on in Gaza[13] at the time was the primary source of the anxiety and distress she experienced during the postpartum:

> *"When I was in the hospital 10/10 (quality of life score); when I went home zero from ten but the child was good and I was happy but it was because of the political news." (Refugee camp woman)*

The changes in women's emotional states were brought up more in the urban middle-class, rural, and semi-urban groups. Urban middle-class and semi-urban women were most likely to discuss their own experiences with depressive symptoms or distress whereas rural women were more likely to identify its occurrence in general but did not discuss their own experiences. For these women, the changes in their emotional states mainly stemmed from coping with the changes in their lives resulting from presence of a new child. Urban lower-class and refugee camp women were more likely to attribute depressive symptoms to external and family factors when it was brought up, although there were a few women in the refugee camp group that said they became more hot-tempered as a result of all the responsibilities they had to cope with. In general the

[13] This was at a time when the infighting in the Gaza Strip was on the rise resulting in many casualties.

emotional changes were seen as a temporary occurrence rather than indication of chronic or clinical depression.

3.1.4 'Open Body':

The postpartum was associated with the concept of 'open body' or 'open bones' by some women. In general the period that it covered was the first 40 days postpartum. It was a time when women needed to rest/ 'breathe'. It was believed that the woman's body was 'open' during the 40-day period making them more vulnerable to illness. Women's bones were also perceived to be weaker during this period and this was associated with more pain or a greater likelihood of osteoporosis if the woman did not rest. This also meant that women were not supposed to go out during the 40-day period, with emphasis on avoiding wind or cold air due to the vulnerability of the body. Women also stated that there was a belief that if you did go out and other people saw you doing regular chores like laundry during this period, then you were also vulnerable to the 'evil eye' and that people would 'jinx' (*bihsiduki* in Arabic) you:

> *"It means that the woman has to breathe, and if she is tired during this period she won't ever rest. And it is the period of bleeding" (Urban middle-class woman);*

> *"It's as if your body is open until the forty (days)" (Urban middle-class woman)*

Most women believed that it was necessary to rest during this period. However, it was not always possible considering their other responsibilities:

> *"The woman is more susceptible to osteoporosis than men because of childbirth and children and the lack of rest after childbirth has an impact, but its not in her hands not to get up and attend to her house and husband and children, I don't consider it a period of rest but a trial period." (Rural woman)*

Some of them also believed that it was unnecessary to stay in the house for the first forty days. For these women, it was more important that they find their own way of doing things and try to limit the impact of social pressure on their lives.

> *"The person, as long as they deal with the situation normally everything will become normal, if he is one week and you went out with him there is no law to prevent you or you could stay imprisoned in the house until the forty days… it is up to the woman to live her life normally who will be more afraid for her child than her." (Semi-urban woman)*

Rest during this period was also seen by some as an indicator of the woman's experience of motherhood and her ability to take care of her child. It was believed that if the woman was emotionally and physically rested she would be able to give more to the child. Some women tied this to breastfeeding. It was believed that if the woman did not rest properly or if her emotional state was poor, then this would affect her ability to breastfeed her child. If a woman was well rested and in a good emotional state, it was believed that her milk supply would increase. Some women warned of the milk of a sad mother:

> *'haleeb il za'al sam' (the milk of sadness is poison);*
>
> *"It's not good for the child to drink the milk of sadness."*

The concept of 'open body' was discussed in most groups. Most women identified the elements of physical vulnerability embedded in the concept in terms of 'open body' or 'open bones'. It was also typically associated with a 40-day duration. Women's opinions of the traditional expectation that they should not leave the house within the first forty days varied among the groups. Semi-urban and urban-middle class women expressed more opposition to this and stressed that women should do what they feel is right. Women in the urban middle-class group were more likely to attribute movement restrictions to the presence of the child rather than adherence to traditional norms. Rural women mentioned that it was expected but did not indicate whether they believed it should be adhered to or not. Urban lower-class women emphasized the necessity of rest during this period but did not discuss the issue of going out for the most part.

3.2. Support and Care:

The discussions of support centered on five areas: social support; emotional support; practical support (e.g. baby care and household chores); medical support (health advice, medical care, etc.); and financial support. Women were asked about each of these areas in terms of who provided the support; what it included; how long the support lasted (duration); and whether the support women received was enough or if there were areas they felt they needed more support in. Women were also asked about the effects of receiving support on their quality of life (in Arabic satisfaction with life was used) and their ability to care for the child.

3.2.1 Social Support:

The main providers of social support were husbands, mothers, mother in laws, and other relatives. Social support as defined here (in contrast to broader definition which includes all the various areas of support) refers to the presence of individuals alongside the new mother so that she does not feel alone or isolated. It should be noted that for many women, social support was often related to emotional and practical support. For most women, support was associated with presence of family members; oftentimes the mother or mother-in-law. Some women stated that their mother or mother-in-law would come and stay with them for a few days to a few weeks, while others noted that their mother or mother-in-law would come and check on them on a daily basis. They would help them with household chores, childcare, and provide them with emotional support.

Most women indicated receiving some sort of social support. Women characterized good social support through having everyone next to you, not feeling alone, and having a good relationship with the extended family. To some women social visits from

friends, family, and neighbors were also reflective of social support and provided them with a 'change of atmosphere.'

A few women viewed support as limited and temporary. Some women felt that the people around them didn't feel with them. One woman stated:

> *"No one feels with you. All of them say its natural, deal with it. When I used to enter the bathroom I used to cry and they would tell me it's natural and normal. I used to feel that only if someone held me and took the baby." (Urban middle-class woman)*

Other women stated that at the end of the day, you are alone and that no one is there the whole time. Support was seen as temporary where someone will stay with you for a few days and then you're left alone. Some women expressed the desire for a longer duration of support, while others felt that they just had to deal with it and cope. One woman who had given birth to her last child in the US expressed feeling alone and isolated because she was far from her family.

Some women also felt that the presence of people around them was not always a good thing. Of these women, some expressed feeling pressure from people visiting them right after they had given birth. They felt that entertaining guests was an added responsibility that they had to deal with while still being in pain and feeling fatigued. One woman from the refugee camp group said that people would visit and bring their children while the house was not clean and the water in the camp was cut off. She felt that it would have been better if they didn't come. Another woman from the semi-urban group had a bad experience with people visiting because of the comments that they would make about her son:

> *"The hair that was on my son fell off and I had him examined and everything was fine, but the way people used to come over and say why is your son like this, but I reached a conviction and reflected with myself that that's it I'm going to overcome*

> *this problem, because the comments cause an internal conflict and my emotional status was no longer good."*

Some women felt that support was relative and varied depending on the sex of the baby. A few women felt that there was more support when the baby is a boy. Some complained of people's comments when they gave birth to a girl. Although women who had more daughters than sons or women with only daughters were more likely to mention this, one woman who had given birth to her first daughter after having a son faced this problem:

> *"When I had my son, everyone around me made me happy. But when I had my daughter, they made me feel bad to the point where I began to hate my daughter" (Refugee camp woman).*

Other women, who didn't have any male children, felt pressured by their families and social networks to continue to have children until they gave birth to a boy.

> *"For me, if it was in my hands I would have had four children and stopped (tied tubes), but because I didn't have a boy and I wanted a boy they used to tell me go open (untie tubes), and go have more children, and I like having children but I give myself half/half (life quality) because it wears me out a lot"* (a woman in the rural focus group who was eventually had to have her tubes tied due to her physical condition after giving birth to six girls).

There were some variations between groups in the amount of support received. Most women in the urban middle-class, rural, and semi-urban groups indicated receiving adequate support during the postpartum period. There were a few exceptions in the urban middle-class and semi-urban groups who indicated not receiving adequate social support either because the duration was not long enough, the emotional component of support was missing, or because the mother was away from her family.

The refugee camp group was mixed with about half of the women indicating that they had adequate support; about a third wanting more support; and the rest preferring to do

things on their own. Most of the women in the urban lower-class group did not receive adequate social support. Most of the women indicated that it was because they did not live within close proximity of their families or because their families' situations don't permit, while one of these women also added that although her husband's family was close by everyone was on their own.

3.2.2 Emotional Support:

To mothers, being emotionally supported meant having someone to talk to and help them feel relaxed. Women expressed receiving this support from mothers, mother in laws, husbands, and sisters. It was important for women to feel that they had someone to talk and complain to. Having someone feel with them and show warm-heartedness towards them was also very important. Their mother, mother-in-law, or sister usually played this role. Mothers, mother in laws, and sisters were people the new mothers could turn to for emotional support. Women, who were far from their families at the time of childbirth and postpartum, found solace in the support of a friend or relied more on support from their husbands.

Women felt that it was important to feel emotionally supported by their husbands. Women felt supported by their husbands when they were calm and had a supportive attitude. Some women stated that their husbands provided them with emotional support when they accompanied them to doctor's visits or took part in family functions like birthday parties. Husbands that helped their wives with household chores or with picking stuff up for the baby were said to have improved their wives' emotional state because it gave them the opportunity to relax and worry less about things.

There was general consensus that the husband should be the primary source of emotional support, but many women noted that this was not always possible because the husband was at work and would come home tired himself. Others felt that their husbands didn't know how to provide the support that they needed. Some women also noted that their husbands were not supportive during this period. Unsupportive husbands were characterized as nervous, hot-tempered, or as having unrealistic expectations of their wives (i.e. expecting them to have everything done and food ready when they came home). Other women felt that their husbands were unsupportive when they would come home from work and just go to sleep; when he doesn't ask about his wife's wellbeing; when he is jealous; when he yells when the baby is crying; or when he sleeps in another room at night so that the baby's cries won't wake him. When asked about whether the support from her husband included help with household tasks, one woman from the urban lower-class group replied:

> *"If a cup was in front of him but placed crookedly, he used to call me from the other room so that I can move it. He doesn't do anything in the house at all. The important thing is that he provides me with emotional rest meaning that he is calm and does not become nervous. The worst thing is nervousness."*

3.2.3 Practical Support:

Practical support consisted of help with household chores, childcare, or with taking care of errands. Family members, mainly the mother and mother in law, usually provided it. Practical support was considered to be helpful because it relieved women of the burden of household and childcare responsibilities, and gave the new mother an opportunity to relax. In most cases, this type of support was not expected of the husband but rather of female family members. Educated working women were more likely to expect their husbands to provide them with practical support in household chores and childcare.

Some women tied the availability of practical support to their emotional state. These women felt that having someone help for longer periods of time makes you more relaxed. They also believed that when you have someone trustworthy (usually a close relative) watching your children you can relax and you're not as worried.

The majority of women reported receiving some sort of practical support with childcare or household chores. Very few women said that they had no support in this area. Urban lower class and refugee camp women were more likely to indicate not having any or little practical support. Not having support typically meant that women had to push themselves to manage everything on their own.

3.2.4 Medical Support:

Medical support refers to the support provided to women by health providers (skilled and unskilled). Many women did not talk about the nature of medical support they received in the postpartum without first discussing their childbirth experiences. These women typically had traumatizing childbirth experiences as a result of medical mistakes or negligence or a reality very different from their expectations.

Sometimes women compared different birthing experiences. One woman, for example, compared her earlier childbirth experiences at an NGO hospital with her last childbirth experience in a government hospital. She explained that at the government hospital she received very poor treatment:

> *"Imagine, after I finished delivering they told me go to the shower without doing anything for me (pointing to her lower body). I was walking as if I was a slaughtered animal with blood smearing behind me. Until now, I can not believe that they treated me this way." (Urban lower-class woman)*

Her last postpartum period was the most difficult, physically and emotionally, compared to her other two children. A woman in the semi-urban focus group also narrated her childbirth experience. She said that she was advised by her doctor to get pregnant right after her first born, so that her children will not be jealous of each other. She had problems in her pregnancy and her child was born with health problems that required her to be in an incubator.

> *"I moved my daughter to the (government) hospital, I went home to get the IUD put in and came back to see my daughter without an appointment and I told the supervisor I want to see my daughter, I went to see her and the oxygen that was supposed to stay on her all the time fell because I was so nervous as if it was the first time I had given birth and I felt like my milk filled the blanket so I went home. After three days I went back to the hospital and they told me that my daughter died even though they had all my numbers, my phone numbers were with them, its true that if she lived we would have had a hard time with her but I was very upset over her, she had difficulty in breathing (Deeyq nafas) but their behavior bothered me a lot."*

Other women narrated problems they faced during delivery. Oftentimes the impact of these experiences was tied to their emotional state in the postpartum and the way they interacted with their child. For some women it made them more worried and anxious around their child. One woman from the semi-urban group, who had a very painful birth experience, said she rejected her child when she first saw him because he was blue (in this case the doctor attempted to use vacuum suction 7 times during delivery):

> *"When I saw my son after birth, he was blue in color, full of blood. I told them I didn't want to see him."*

Another woman in the urban middle-class group explained how an unmet childbirth expectation impacted her emotional state in the postpartum. She was expecting to have a normal delivery, but her delivery was very difficult and she was forced to have a caesarean delivery.

> *"I didn't want to have a caesarean delivery because I had prepared myself completely for a normal delivery…I refused all extra help. I didn't begin to look at the positive sides that I refused (artificial help) until after 10 months. I tried to have the operation when I was awake so that I can feel everything and so that I*

> *would be able to breastfeed, but right when he started cutting my stomach, I was in a lot of pain. I went home stitched up and dissatisfied."*

Good medical support was generally characterized by adequate medical services; the provision of enough information; good midwifery care; going to doctors in a familiar place close to family; and a good nurse helping the woman deliver naturally. Women that took part in the focus group in the refugee camp stated that they had good access to care for themselves and their children through UNRWA and NGO clinics present in the camp. They said that the care was adequate and that their needs were met through the services provided. Women generally appreciated health professionals that took the time to explain things to them and ask them about how they were doing. Some women also said that they felt that the pediatricians were much more helpful than gynecologists, but that there was only so much in terms of their own personal care that they could ask them about.

Services were viewed as inadequate when women did not receive any empathy from doctors and midwives; when they were provided with limited instructions on how to care for the baby; when they were given short answers or treated as cases; or when they were not provided with adequate information. Many women felt that doctors were not really interested post-delivery. They complained of receiving inadequate information and with not being provided an adequate amount of time with the doctor. Some women stated that they would compare what the doctor told them with the information received by the friends so that they could fill in informational gaps.

Many women also mentioned not seeking medical care during the postpartum period. Some women said that they only sought care for their children but not for themselves.

Some believed that the focus is on the child during the postpartum and others expressed feeling worn out with going to health providers for baby's check-ups and immunizations that they didn't have the energy to seek care for themselves. Others said that they only sought medical care when they were having complications and felt that it was necessary. Some felt that a postpartum visit for preventive care purposes was unnecessary and did not expect to gain much from it.

Rural, camp, and lower middle-class women were more likely to be satisfied with the medical support that they received. Urban middle class and semi-urban women were more vocal about their dissatisfaction with the medical support they received than women in any other group. About half of the women in the semi-urban group had traumatic childbirth experiences as a result of doctors' mistakes; this may partially explain their general dissatisfaction with the medical care received. As for the urban middle-class group, many of them have experience within the health field or in health research. Because of their exposure and knowledge of this area, their expectations of the services may have been higher than other women.

3.2.4.a Information and advice:

Women were asked about where they sought information on personal and childcare. The most common sources of advice were doctors, mothers, and mother in laws. Other sources of information also included older women, daughters, husband (who was also a pediatrician), a midwife or nurse, books, a *daya* (traditional birth attendant), personal experience (with later children), and friends.

Many women received their information from more than one source. Some of these women discussed having to find their own way of doing things based on the information that they received:

> *"You have to be convinced and know that even if this does not benefit it won't harm. I used to bathe my daughter everyday and people kept telling me it was wrong but I didn't see that it was beneficial or that it was harmful but you go according to your way and you are satisfied with it personally. You adopt decisions based on what you know about these things and if it gives you ease of mind and if it achieves what you want it to." (Semi-urban woman)*

Some indicated a preference for information from a health professional, while others preferred advice from older women (including mother and mother-in-law) and would sometimes use information from health professionals to double check when they had doubts about something:

> *"I would take the advice from my mother-in-law but if it wasn't convincing I would try to convince the people around me and go to the doctor." (Refugee camp woman);*

> *"(I would go to) the older women like my mother-in-law and mother and if the child didn't get better I would go to the doctor." (Refugee camp woman)*

Some indicated using information from their mothers or traditional healers when the doctor's advice didn't work:

> *"I depend more on my mother and mother-in-law. Their experience is more important because they have beliefs that they know better than the doctor. For example, my daughter had a very high fever and we took her to the doctors a lot and they didn't know what was wrong with her. Then we took her to a woman, once she touched her she was better; she said that the girl was scared. How would the doctor know something like that?" (Urban lower class woman)*

Other women also indicated having to convince their spouse or mother-in-law when introducing or stopping practices based on doctors' advice:

> *"For me, my mother-in-law used to always tell me give your child this and do this for him and I used to be shy to say no, but in the end I convinced her" (semi-urban woman);*

> *"My nipples were fissured and it went on for a while and I tried all the medicines and I couldn't breastfeed; my husband and mother-in-law didn't want me to give him artificial milk but then my mother introduced me to a (traditional) medical recipe and she told me to give him artificial milk and he started drinking and my breasts got better." (Refugee camp woman)*

3.2.5 Financial Support:

Financial support refers to any financial or material assistance the new mother received. To women, adequate financial capacity was important for them to be able to care for their children. Many women felt that the economic situation in Palestine was generally very difficult. Some women mentioned that their financial capacities were limited due to husband's health and residency status[14]; the husband's limited income; and their inability to work because of childcare responsibilities and lack of education. Women had different ways of coping with the added expenses related to childbirth and childcare.

Some women received financial support from their families. One woman in the semi-urban group said that it was a family tradition that the woman's family provided their daughter with all the childcare necessities. Women in the refugee camp group also said that if they were short on cash or needed something; they were more likely to ask their side of the family for help rather than their husband's. One woman mentioned borrowing money from people through her church in order to cover hospital and childcare expenses.

Other women said that they resorted to using cheaper alternatives like breastfeeding for as long as possible to reduce the cost of formula; and delivering in a cheaper place like a government hospital. In the semi-urban group, some women said that they used

[14] A few women indicated that their husbands' work opportunities were limited because they did not have a Palestinian identity card and were not free to move about the West Bank.

family planning because the costs of raising children is so high and their financial capacity would not be enough to provide their children with a comfortable standard of living.

The urban middle-class group's outlook was a little different. Women mentioned the added expenses related to childcare, but none mentioned having to resort to seeking assistance from other people. It was generally believed that the expenses would be covered through some changes in the family budget or that they would just deal with them. Some women from this group also felt that it was important that their husbands provide them with what they ask for during this period. They mentioned that their husbands were less likely to refuse to purchase something or question the logic behind it; this was important for them. This group was mainly made up of middle class working women, so their financial situation is probably better than women in the other groups.

3.2.6 Effects of support on Quality of life:

Women were asked about whether they believed the presence of support had an impact on their quality of life or life satisfaction. Some women stated that they believed that the presence of support is directly related to their quality of life:

> *"It (support) improves your quality of life. If I don't keep my son with my mother I can't (cope) and this gives me peace of mind because I know he is in safe hands (woman in the urban middle-class group)."*

Others felt that it improves their emotional state because it allows them to feel safe, relaxed, assured, and satisfied. Others believed that feeling supported enhances their

emotional state. Others also felt that the presence of support provides them with a change in atmosphere and reduces feelings of isolation.

Others felt that the presence of support does not necessarily influence life quality or satisfaction. Some felt that having support is better than not having it, but that either way you have to cope and deal with the responsibilities in front of you. One woman felt that it wasn't all about support or satisfaction; that other things play a role as well:

> *"It's not all about satisfaction, satisfied or unsatisfied we just have to deal with it…life doesn't help, I want children and I gave birth to children and we love them, but the other things around us don't help like the financial, economic, and environmental situation." (Refugee camp woman)*

3.2.7 Other Factors affecting Quality of Life:

Women were asked about other factors that affected their quality of life during the postpartum. Responses included aspects of medical care, physical and emotional status of the mother and feelings of motherhood, the child's health, husband's mood, relationship with family, and financial situation.

Some women felt that their experience of childbirth and pregnancy had an influence on their quality of life. As discussed previously, women with traumatic experiences or unmet expectations were sometimes likely to been affected by their experience emotionally and at times physically.

The physical and emotional statuses of the mother were seen as important factors influencing quality of life in the postpartum. It was typically a direct relationship where women believed that being physically healthy and in a good emotional or psychological state lead to better quality of life. The feelings of motherhood or doing motherly things

were also aspects of the postpartum that women felt were important to their satisfaction in the postpartum. At times this led them to express the postpartum period as a paradox where they felt difficulty and pain, yet at the same time they found joy in their role as mothers. Others felt that doing motherly things and feeling like a mother were the most important sources of joy during the postpartum period.

The child's health and in some cases temperament were also seen as important factors related to postpartum well-being. A healthy child was an important indicator of the smoothness of the transition in the postpartum. Sick babies required more care and attention, which meant that the new mother would be more worn out. The child's temperament was also mentioned by women as having an affect on their experience in the postpartum. Moody and overly active children required more attention and were more draining to take care of than calm children. Also, the death of a child had a great impact on the mother's quality of life. It affected her emotional state and in some cases it had an impact on her experience with later children. Women, who had previously lost a child, expressed feeling more nervous and worried with their newborn. Others stated that finally giving birth to a healthy baby after several miscarriages brought them great joy; these women generally expressed their satisfaction with life during the postpartum as very high.

The husband's mood was also important to women in the postpartum. Women believed that having a supportive husband led to good quality of life or high satisfaction. Women stressed the importance of a calm, supportive, mild-tempered husband. Some women said that the husband's mood was sometimes reflected in the mood of the new mother, so it was important that the husband be supportive to the new mother.

The relationship with the family was also considered to be important to women. A good relationship with the family typically meant better support and emotional well-being. Problems with the family (nuclear and extended) were expected to have a negative impact on postpartum well-being.

The financial situation was also an important factor influencing life quality. A good financial situation meant that women would be more capable of providing for their children. It also meant that finances would not be a big worry or burden over their shoulders. It was important to their material state as well as their emotional well-being.

3.2.8 Effect of support on ability to care for the child:

Women were asked if they felt that the presence of support had an impact on their ability to care for the child. Many believed that there was a connection between the presence of support and their ability to care for the child. Two women believed that it did not make a difference and that either way you had to take care of the baby:

> *"It doesn't affect my care for my child if support is there or not." (Urban lower-class woman)*

Some women indicated that having support gives them more time with the baby. Having someone to take care of other responsibilities allowed women to rest and concentrate on the child. Some felt that feeling rested put them in a state where they can give more to the child. Some women felt that the alone time provided to them to rest was important and it put them in a state of mind where they can manage with everything. It was important that they didn't feel burned out during this period. One woman felt that having support in childcare enhances the relationship between mother and child because you love them more:

> *"You love him more, if someone took care of the child, you miss them more, because he's not in your lap the whole time. You start to give more and love him more." (Urban middle-class woman)*

One woman indicated feeling guilty because support from others existed:

> *"I used to keep my daughter with my mother and when I would come back from work I would go get her. When I wanted to go somewhere, I used to keep my daughter with her but I used to have a guilty conscience when I used to leave her because I am supposed to be the one taking care of her and not my mother." (Urban middle-class woman)*

Some women also tied the presence of support to their ability to breastfeed. It was believed that women that were supported and well rested were able to produce more milk. It was also believed that milk produced when the mother is upset is harmful to the baby:

> *"Anything that affects the woman has an affect on her milk and if she becomes tense then the child with become tense and cranky" (Rural woman);*

> *"When a woman is supported, her psychological state is better and she can produce more milk" (Urban middle-class woman).*

Women also discussed the effects of not having support. Some believed that not having support has a negative effect on the mother's state of mind. They believed that not having support makes you hot tempered and nervous. Others also felt that it makes you blame yourself and lose control, while others believed that it decreases the mother's capacity to give to the child.

> *"When there is no support, you become tense/hot tempered, and you begin saying why this and that and you blame yourself. You become nervous. You expect that someone will be near you, but no one is near you." (Urban middle-class woman)*

Three women admitted to questionable childrearing practices because they felt that they could not manage with the demands of childcare and household chores. One woman in the rural group said that she used to tie her children to the crib as soon as they began crawling so that she will be able to carry out household chores:

> *"I used to tie my children once they started crawling so that I can finish my work and my daughter, once she started crawling I used to tie her from her legs to the end of the bed from morning to sunset and she didn't used to talk and here she is Mashallah 'alaiha* (literally means what God has willed upon her, but its used with a sense of pride or when talking about something good in order to avoid the evil eye*)."*

Two other women said that the frustration that comes with not being supported enough by their spouse or people around them or not being able to manage with all the children makes them more irritable and likely to hit their children. Other women indicated that inadequate support was likely to reduce their ability to concentrate, which sometimes led to mistakes.

> *"My health is good thank God the thing I was least satisfied with is the pressure; from the pressure of schools and other children. One time from the pressure I (accidentally) gave my daughter acidic water, I took her straight to the hospital, and one time I fell asleep and forgot the milk bottles boiling on the stove and they melted and made a smell." (Semi-urban woman)*

Chapter 4 DISCUSSION OF QUALITATIVE FINDINGS:

4.1.Women's experiences of the postpartum:

As can be seen by women's characterizations, the postpartum is a period full of trials and tribulations coupled by a state of physical and sometimes emotional vulnerability. Physical pain, the lack of sleep, and coping with multiple simultaneous tasks were the primary sources of difficulty for women in the postpartum. The experiences of the women in this sample are similar to the findings of other studies on the experiences of postpartum women (Wilkins 2005; Liamputtong and Naksook 2003; DiMatteo, Kahn, Berry 1993; Wang et al 2007; Parvin et al 2004; Green, Broome, Mirabella 2006).

What appears to be different between the experiences of women in this study and the experiences of postpartum women in other studies is the absence of an internal conflict where the postpartum woman must find a way to define herself in light of her new role as a mother. Some studies have focused on what women have characterized as the 'loss of self' and autonomy (Wilkins 2005; Liamputtong & Naksook 2003; DiMatteo, Kahn, Berry 1993). This was largely missing from the discourse of these women; although there was some mention of losing control or being dictated by the child's pattern of behavior. The absence of this internal crisis in the discourse of the women that participated in this sample has to be understood within the larger framework of Palestinian culture and norms. Palestinian society, like Arab society to a greater extent, is a very family-centered society that values children and childrearing (Taraki 1997; Klaus et al 2007). The primarily Western discourse on finding one's 'self' or defining one's self in a very individualistic sense is largely absent from Palestinian discourse.

Rather, as Joseph has noted in Lebanon (1993) the self is seen largely in relation to others (primarily the extended family network). The parental role also plays an important part in one's identity, especially for women. Men and women are typically called as the father or mother of their eldest son as a sign of respect. It may be that the absence of a cultural view of an individualized independent self has made these women's transition into motherhood a more natural one where their sense of identity was not put into question, but rather validated (Joseph 1993; Taraki 1997).

Although there hasn't been much in the literature about traditional conceptions of the postpartum, some similarities exist between the traditional conception of the postpartum through the concept of 'open body' and other studies that have taken note of traditional rituals and beliefs some societies attribute to the postpartum. A few studies have discussed the traditional postpartum practices of Taiwanese, Chinese, Turkish, and Iranian women (Liamputtong and Naksook 2003; Ozsoy and Katabi 2006; Wang et al 2007) and have pointed to some practices and beliefs that are comparable with those discussed by women in this study. These include the beliefs that women are weak and susceptible to illness during the first month or 40-days postpartum; that postpartum women should avoid leaving the house during the first month postpartum; and the emphasis on warmth and avoiding cold water and wind. The practices and beliefs discussed in these studies also emphasize postpartum women's need for rest. Some have also noted that while women recognize the need for rest, it was not always a possibility, especially in cases where women are far from their traditional support system. This is also similar to what has been mentioned by women in this study.

Although much of the literature on women's emotional changes during the postpartum draws clear links to depression and depressive symptoms (Green, Broome, Mirabella 2006; Wang and Chen 2006; Rodrigues et al 2003; Parvin 2004), in this study, women's characterizations of the emotional changes they underwent were not referred to as depression or viewed as a chemical disorder. The emotional changes were rather seen in relation to all the changes that women underwent during this period as well as the exhaustion that they endured as a result of physical pain and multitasking. Support and an encouraging environment were important in determining how well women coped with the changes and in her emotional state. As women in this study noted, support from the husband was a crucial determinant of their emotional well-being. This has also been echoed in other studies where spousal support has been shown to be an important protective factor associated with a decreased likelihood of postpartum depression and distress as well as greater marital satisfaction (Rodrigues et al 2003; Khawaja and Habib 2007).

4.2. Support and Care:

The findings indicate that primarily female relatives provide postpartum support, with the mother and mother in law as the key players. The support provided by them is multifaceted and includes elements of practical, emotional, social, and sometimes medical support (mainly advice). Most of the women in the study reported receiving some support, although poorer women and women that lived away from their families were less likely to have adequate support during the postpartum.

Although the husband is not always present in the narratives of women as a provider of support, most women indicated that they preferred their husbands to play a more active

role in the postpartum although this was not always possible for various reasons. This is similar to other studies where women have indicated a desire for their husbands to be more active in providing them support during the postpartum (HDIP December 2002; Liamputtong and Naksook 2003).

Women in the study also recognized the importance and positive effects of support. Many women indicated that being supported allowed them to rest and give more time to the child, while the lack of support was more likely to make them tense and reduce their ability to cope with all their responsibilities. As mentioned previously, many studies have indicated the positive effects of support on both maternal and child wellbeing (Hung 2007; Wang and Chen 2006; Rodrigues et al 2003).

It is also clear from the findings that the dynamics of the support system are different when women are not within close proximity to their families. These women typically do not receive adequate support and are left to cope with the tribulations of the postpartum on their own. As young couples continue to leave their family homes in search for a better life in the city (Taraki 2006), the dynamics of support and the traditional structures that have helped women cope during the postpartum are likely to change as has been noted by studies on women who have experienced the postpartum away from their families and native homes (Parvin et al 2004; Liamputtong and Naksook 2003).

Women's narratives of the medical support that they received were very physician centered and often referred back to their childbirth experience. Despite the prominence of physicians in women's narratives of medical care and support, it is also clear the

women's female relatives (mainly the mother) play an advice-giving role in the postpartum. A study on the advice-giving role of women's support network during pregnancy (Dunn, Pirie, Hellerstedt 2003) also indicated those women's female friends and relatives (primarily found to be the mother) play a role in providing women with health advice during pregnancy. Although physician advice was seen as the most important, advice from this female network was viewed as second in importance. There was a similar trend in the narratives of women in this study, although at times women reported adhering to the advice of their mothers and mother in laws more often than the advice of physicians.

Most women did not focus much on the postpartum follow up or medical postpartum services. Medical care was typically sought when treatment was required. In fact, as other studies have shown (Lagro et al 2006; Chakraborty et al 2002) women did not stress the importance of the postpartum visit and indicated that they didn't believe that the postpartum visit was necessary or that they didn't have the time to go for preventive services. As the PAPFAM survey (PCBS 2007) has shown, most women did not go to a health professional for the postpartum follow-up. It was commonly believed that medical care was necessary for the child, but not always for the postpartum woman. This can possibly be related to women's perceptions of their primary role as caretakers, which is likely to lead them to understate their needs in order to meet those of their children.

What is striking about the narratives of the women is that importance attached to their delivery experience, especially for women that reported having a negative experience during childbirth. Women that received poor care or were given bad advice during

pregnancy and delivery were likely to hold on to that memory and often found it difficult to discuss their postpartum experience without alluding to their delivery. While not many studies have analyzed the effects of women's delivery experiences on their experience during the postpartum, DiMatteo et al (1993) have noted that the way that a woman is treated by health professionals may determine how she feels about her experience for the rest of her life. This was clear in the narratives of the women that reported a negative childbirth experience but needs to be studied further with a bigger sample.

Chapter 5 QUANTITATIVE RESULTS:

5.1.Sample Characteristics:

The final sample consisted of 1020 women who have given birth sometime between November 1st 2006 and September 15th 2007. The mean age of the sample was 28.05 years (median was 27.0), with a minimum age of 15 and a maximum age of 46). About 14.5% of the women in the sample were first-time mothers. The mean number of children for the sample was 4.05.

In terms of locality, 53.1% of women resided in an urban setting; 29.5% resided in a rural setting; and 17.4% resided in a refugee camp. About fifty-three percent (53.4%) of the women in the sample resided in the West Bank (22.3% in the North, 12.9% in the Center, and 18.2% in the South) and 46.6% in the Gaza Strip. 46.8% of the women in the sample identified themselves as refugees, with more refugees per population residing in the Gaza Strip than in the West Bank (68.8% of the Gaza Strip sample vs. 29% of the West Bank sample).

The majority of women in the sample did not complete their education beyond the preparatory level (60.8%). About a quarter of the women had a secondary education (24.5%) and 14.7% had an education beyond the secondary level. Most of the women in the sample were not employed at the time of the survey; 4.6% of women were employed outside of the home and about 1.6% of women stated that they were full-time students.

Most of the women reported having some form of health insurance (85.2%). Of the women that had health insurance, the al-Aqsa Intifada insurance was the most common form of health insurance (45.8%).

In terms of wanted-ness of the pregnancy, 62.6% reported wanting to be pregnant at the time that they found out they were pregnant. About a quarter of the women indicated wanting to be pregnant at a later time, and 12.0% indicated not wanting to be pregnant at all. About 27.6% of the participants indicated using some form of family planning at the time they found out they were pregnant. The prevalence of family planning use was highest for women that reported not wanting to be pregnant at all (63.9%) compared with 49.2% for women that wanted to be pregnant at a later time, and 12.1% for women that reported wanting to be pregnant at the time.

5.1.1 Amenities and Crowding Ratio (rooms/person):

Most women's households had three amenities or more with a median of 8 amenities per household. The maximum number of amenities per household was 16. The mean crowding ratio was 2.3 persons/rooms, with a minimum ratio of 0.31 and a maximum ratio of 13.00.

5.1.2 Overview of scale results:

The percentage of women dissatisfied with at least one scaled item ranged from 16.9% in the Childcare scale to 54.1% in the Husband's Employment scale. The following table provides an overview of the satisfaction and dissatisfaction rates for each scale.

Table 5-1: Overview of Scale Satisfaction & Dissatisfaction Rates

Scale	Satisfied with all Items (%)	Dissatisfied with at least 1 Item (%)
Childcare Characteristics	83.1	16.9
Childcare Economic	69.1	30.9
Husband Characteristics	48.5	51.5
Medical Care	64.4	35.6
Information	81.2	18.8
Social interventions & choice	58.1	41.9
Husband's Employment	45.9	54.1
Support	72.5	27.5

5.2. Postpartum Quality of life:

The quality of life scores range from 0-30. The mean quality of life score for the sample was 21.53. Domain means ranged from 19.74 for the revised socioeconomic domain to 23.12 for the relational spouse domain.

5.2.1 Factors associated with variation in QoL scores:

5.2.1.a Region:

Table 5.2 provides a summary of the QoL results by region. The Gaza Strip had lower scores for all domains. The differences between the West Bank and Gaza Strip were significant for the total QoL score, the Psychological Baby domain, and the Relational Spouse domain.

The region category was divided further into four categories: North West Bank, Central West Bank, South West Bank, and the Gaza Strip. The variations were significant for all domains except the socioeconomic domains and the health and functioning domain. Typically, the North West Bank had the highest mean while the Central West Bank and

the Gaza Strip (typically the Central West Bank had slightly lower scores) had the lowest means (table 5-3).

Table 5-2: T-Test Summary of QoL Scores by region

QoL Domain Mean	All Sample	West Bank	Gaza Strip	95% CI of difference	t	Sig.
QoL Standard	21.53	21.78	21.25	0.077 - 0.973	2.290	**0.022**
Psychological Baby	22.22	22.61	21.77	0.279- 1.39	2.949	**0.003**
Relational Spouse	23.12	23.69	22.47	0.69 - 1.75	4.482	**<0.001**
Relational Family and Friends	22.57	22.75	22.38	-0.098 - 0.83	1.549	0.122
Health and Functioning	21.16	21.33	20.97	-0.21 - 0.94	1.232	0.218
Socio-economic	19.89	20.03	19.73	-0.37 - 0.96	0.866	0.387
Socio-economic revised	19.74	19.87	19.58	-0.38 - 0.96	0.854	0.393

Table 5-3: Regional Districts ANOVA Summary Table

QoL Domain	North West Bank	Central West Bank	South West Bank	Gaza Strip	p-value
QoL Standard 95% CI of mean:	22.37 21.86 - 22.89	21.02 20.34- 21.70	21.58 21.11- 22.05	21.25 20.93 - 21.57	**0.001**
Psychological Baby 95% CI of mean:	23.36 22.70 - 24.02	21.5073 20.68 - 22.34	22.47 21.91 -23.03	21.77 21.39 - 22.16	**<0.001**
Relational Spouse 95% CI of mean:	24.76 24.15 - 25.37	22.44 21.65 - 23.23	23.26 22.72 - 23.81	22.47 22.010 - 22.85	**<0.001**
Relational Family and Friends 95% CI of mean:	23.82 23.33 - 24.30	21.28 20.51 - 22.04	22.48 22.02 - 22.95	22.38 22.05 - 22.71	**<0.001**
Health and Functioning 95% CI of mean:	21.30 20.59 - 22.01	20.88 20.10 -21.66	21.70 21.06 - 22.34	20.97 20.56 - 21.37	0.270
Socio-economic 95% CI of mean:	20.40 19.62 - 21.18	20.16 19.23 - 21.09	19.48 18.83 - 20.13	19.73 19.24 - 20.23	0.280
Socio-economic revised 95% CI of mean:	20.22 19.43 - 21.01	20.00 19.07 -20.93	19.36 18.71 -20.02	19.58 19.09 - 20.08	0.342

5.2.1.b Type of Locality:

The type of locality was significant for the Relational Spouse and the Relational Family domains. Camp women had the lowest scores for these domains, while rural women had the highest scores (table 5-4).

Table 5-4 Locality Type ANOVA Summary table:

QoL Domain Mean	Urban	Rural	Camp	p-value
QoL Standard 95% CI of mean:	21.65 21.34 - 21.95	21.61 21.19 – 22.03	21.04 20.48-21.59	0.140
Psychological Baby 95% CI of mean:	22.29 21.92 – 22.66	22.45 21.92-22.99	21.60 20.94	0.120
Relational Spouse 95% CI of mean:	23.02 22.67-23.39	23.67 23.16-24.18	22.47 21.84-23.10	**0.011**
Relational Family and Friends 95% CI of mean:	22.53 22.22-22.84	22.95 22.51-23.29	22.06 21.46-22.66	**0.042**
Health and Functioning 95% CI of mean:	21.47 21.09-21.86	20.94 20.38-21.50	20.61 19.95-21.27	0.062
Socio-economic 95% CI of mean:	20.14 19.70-20.59	19.58 18.96-20.21	19.68 18.80-20.46	0.276
Socio-economic revised 95% CI of mean:	19.98 19.53-20.43	19.46 18.83-20.09	19.48 18.66-20.31	0.328

5.2.1.c Refugee Status:

Refugee status was significant for all domains except the revised socioeconomic domain. Refugees (registered and non-registered) had lower scores than non-refugees (table 5-5).

Table 5-5 Refugee Status T-Test Summary table

QoL Domain Mean	Refugee	Non-refugee	95% CI of difference	t	Sig.
QoL Standard	21.12	21.89	-1.20 - -0.32	-3.346	**0.001**
Psychological Baby	21.70	22.68	-1.37 - -0.30	-3.496	**<0.001**
Relational Spouse	22.68	23.51	-1.54 - -0.43	-3.050	**0.002**
Relational Family and Friends	22.24	22.87	-1.09 - -0.16	-2.641	**0.008**
Health and Functioning	20.75	21.53	-1.36 - -0.21	-2.688	**0.007**
Socio-economic	19.52	20.22	-1.36 - -0.34	-2.063	**0.039**
Socio-economic revised	19.39	20.04	-1.32 - -0.02	-1.898	0.058

5.2.1.d Education:

Education was significant for five of seven domains, except the health and functioning domain and the relational family domain. Higher education status was associated with a positive change in quality of life scores. Table 5-6 provides a summary of the quality of life scores in relation to educational status.

Table 5-6 Educational Status ANOVA Summary table:

QoL Domain Mean	Primary & below	Preparatory & Secondary	Post-Secondary	p-value
QoL Standard 95% CI of mean:	20.94 20.46 – 21.41	21.67 21.39 – 21.96	21.91 21.35 – 22.46	**0.011**
Psychological Baby 95% CI of mean:	21.59 21.00 – 22.17	22.35 21.99 – 22.70	22.72 22.06 – 23.38	**0.027**
Relational Spouse 95% CI of mean:	22.54 22.01 – 23.07	23.19 22.84 – 23.54	23.78 23.08 – 24.47	**0.019**
Relational Family and Friends 95% CI of mean:	22.65 22.21 – 23.08	22.63 22.33 – 22.92	22.24 21.53 – 22.94	0.498
Health and Functioning 95% CI of mean:	20.85 20.25 – 21.46	21.31 20.95 – 21.68	21.06 20.34 – 12.78	0.406
Socio-economic 95% CI of mean:	18.59 17.85 – 19.32	20.15 19.73 – 20.56	20.96 20.18 – 21.75	**<0.001**
Socio-economic revised 95% CI of mean:	18.34 17.62 – 19.07	19.99 19.58 – 20.42	20.94 20.16 – 21.71	**<0.001**

5.2.1.e Age:

Age was significant for five of seven domains except for the health and functioning and the relational family domain. There was an inverse relation between age and quality of life score, as can be seen in table 5-7.

Table 5-7Age ANOVA Summary Table:

QoL Domain Mean	15-19	20-24	25-29	30-34	35-39	40-44	45-49	p-value
QoL Standard 95% CI of mean:	23.05 22.27 – 23.82	21.71 21.26 – 22.16	21.53 21.16 – 21.91	21.28 20.78 – 21.79	20.90 20.20 – 21.61	20.92 19.67 – 22.18	19.77 15.94 – 23.60	**0.003**
Psychological Baby 95% CI of mean:	23.80 22.87 – 24.73	22.09 21.54 – 22.64	22.45 21.99 – 22.90	21.96 21.31 – 22.61	21.81 20.97 – 22.64	21.10 19.17 – 23.03	20.25 6.82 – 23.69	**0.021**
Relational Spouse 95% CI of mean:	24.68 23.62 – 25.73	23.06 22.50 – 23.61	23.48 23.04 – 23.92	22.84 22.23 – 23.46	22.20 21.42 – 22.98	22.50 21.12 – 23.88	20.50 16.20 – 24.80	**0.003**
Relational Family and Friends 95% CI of mean:	23.82 23.08 – 24.56	22.74 22.29 – 23.19	22.32 21.93 – 22.72	22.39 21.82 – 22.97	22.35 21.62 – 23.07	22.82 21.75 – 23.89	21.56 18.11 – 25.00	0.082
Health and Functioning 95% CI of mean:	22.14 20.96 – 23.31	21.60 21.05 – 22.15	21.23 20.71 – 21.74	20.89 20.28 – 21.49	20.36 19.51 – 21.21	20.04 18.27 – 21.81	21.50 14.96 – 28.04	0.052
Socio-economic 95% CI of mean:	22.05 21.00 – 23.10	20.24 19.57 – 20.90	19.72 19.11 – 20.32	19.66 18.96 – 20.35	18.97 17.93 – 20.01	19.32 17.58 – 21.07	16.89 13.06 – 20.71	**0.004**
Socio-economic revised 95% CI of mean:	21.87 20.81 – 22.94	20.07 19.40 – 20.74	19.61 19.00 – 20.22	19.46 18.76 – 20.16	18.85 17.80 – 19.90	19.18 17.41 – 20.94	16.13 14.62 – 17.65	**0.005**

5.2.1.f Parity:

Parity was significant for all domains. There was an inverse relation between parity and quality of life. Women with a greater number of children typically had lower quality of life scores in all domains. The change seems to be gradual, with no clear peak in difference between categories (table 5-8).

Table 5-8 Parity ANOVA Summary table:

QoL Domain	1 child	2-3 children	4-6 children	6-8 children	9+ children	p-value
QoL Standard 95% CI of mean:	22.34 21.79-22.88	22.00 21.62 – 22.38	21.25 20.81 – 21.68	20.83 20.31 – 21.36	20.72 19.66 – 21.77	**<0.001**
Psychological Baby 95% CI of mean:	23.06 22.40 – 23.73	22.57 22.10 – 23.04	22.01 21.48 – 22.54	21.54 20.86 – 22.22	21.48 20.24 – 22.72	**0.008**
Relational Spouse 95% CI of mean:	23.87 23.11 – 24.62	23.65 23.19 – 24.10	23.06 22.57 – 23.56	22.28 21.66 – 22.89	21.51 20.34 – 22.68	**<0.001**
Relational Family and Friends 95% CI of mean:	23.22 22.65 – 23.79	22.97 22.59 – 23.36	22.01 21.52 – 22.56	22.24 21.73 – 22.76	22.58 21.64 – 23.52	**0.003**
Health and Functioning 95% CI of mean:	21.60 20.83 – 22.37	21.80 21.31 – 22.29	20.89 20.36 – 21.42	20.39 19.71 – 21.08	20.52 19.27 – 21.76	**0.005**
Socio-economic 95% CI of mean:	21.27 20.49 – 22.06	20.30 19.72 – 20.87	19.67 19.03 – 20.31	18.90 18.23 – 19.76	18.49 16.96 – 20.01	**<0.001**
Socio-economic revised 95% CI of mean:	21.09 20.30 – 21.87	20.19 19.62 – 20.77	19.54 18.90 – 20.18	18.77 17.99 – 19.56	18.33 16.83-19.83	**<0.001**

5.2.1.g Duration of the Postpartum:

The duration of the postpartum was calculated by the difference between the child's date of birth and the date of the interview. The number of weeks ranged from 0 (less than 7 days postpartum) to 41 weeks, with a mean duration of 20.88 weeks. Postpartum duration was not significant for any of the quality of life domains.

5.2.1.h Wanted-ness of Pregnancy:

Wanted-ness of pregnancy was significant for all domains. Women who wanted to be pregnant at the time had the highest quality of life scores for all domains, while women that did not want to be pregnant at all had the lowest scores (table 5-9).

Table 5-9 Wanted-ness of Pregnancy ANOVA Summary table:

QoL Domain Mean	Wanted at time	At later time	Not at all	p-value
QoL Standard 95% CI of mean:	22.05 21.78 – 22.33	20.93 20.47 – 21.38	20.16 19.50 – 20.81	**<0.001**
Psychological Baby 95% CI of mean:	22.82 22.50 – 23.15	21.55 20.97 – 22.12	20.58 19.66 – 21.49	**<0.001**
Relational Spouse 95% CI of mean:	23.55 23.22 – 23.88	22.64 22.09 – 23.20	21.99 21.22 – 22.76	**<0.001**
Relational Family and Friends 95% CI of mean:	22.93 22.64 – 23.22	22.10 21.62 – 22.57	21.73 21.03 – 22.43	**<0.001**
Health and Functioning 95% CI of mean:	21.77 21.42 – 22.11	20.59 19.99 – 21.19	19.30 18.39 – 20.20	**<0.001**
Socio-economic 95% CI of mean:	20.46 20.05 – 20.88	19.12 18.44 – 19.80	18.59 17.68 – 19.49	**<0.001**
Socio-economic revised 95% CI of mean:	20.32 19.90 – 20.74	18.97 18.29 – 19.65	18.41 17.51 – 19.31	**<0.001**

5.2.1.i Use of Family Planning:

Family planning use was significantly associated with all domains except the relational spouse domain. Women who reported using some form of family planning when they found out they were pregnant had significantly lower scores than women who did not report using any form of family planning at the time they found out they were pregnant (table 5-10).

Table 5-10 Family Planning Use T-Test Summary table

QoL Domain Mean	Yes	No	95% CI of difference	t	Sig.
QoL Standard	20.90	21.77	-1.37 - -0.37	-3.414	**0.001**
Psychological Baby	21.56	22.47	-1.53 - -0.30	-2.904	**0.004**
Relational Spouse	22.77	23.25	-1.08 - 0.13	-1.553	0.121
Relational Family and Friends	22.11	22.75	-1.16 - -0.12	-2.416	**0.016**
Health and Functioning	20.37	21.47	-1.74 - -0.47	-3.396	**0.001**
Socio-economic	19.16	20.17	-1.75 - -0.27	-2.685	**0.007**
Socio-economic revised	18.99	20.02	-1.78 - -0.28	-2.712	**0.007**

5.2.1.j Health Insurance:

Having health insurance was significantly associated with all domains except the health and functioning and the relational family domains. Having health insurance was inversely related to quality of life scores. Women who reported not having insurance had significantly higher quality of life scores than women that reported having health insurance for all domains except the health and functioning domain and the relational family domain.

Table 5-11 Health Insurance T-Test Summary table

QoL Domain Mean	Yes	No	95% CI of difference	t	Sig.
QoL Standard	21.42	22.14	-1.36 - -0.081	-2.211	**0.027**
Psychological Baby	22.09	22.95	-1.65 - -0.076	-2.151	**0.032**
Relational Spouse	22.99	23.82	-1.60 - -0.070	-2.142	**0.032**
Relational Family and Friends	22.52	22.85	-0.99 - 0.33	-0.974	0.330
Health and Functioning	21.08	21.67	-1.40 - 0.28	-1.413	0.158
Socio-economic	19.72	20.87	-2.087 - -0.201	-2.381	**0.017**
Socio-economic revised	19.58	20.63	-1.99 - -0.096	-2.160	**0.031**

5.2.1.k Loss of a relative due to occupation:

The loss of a relative due to occupation was significant for all domains except the relational spouse and relational family domains. Women who reported losing a relative due to the Israeli occupation generally had lower scores than women who did not report the loss of a relative due to occupation.

Table 5-12 Loss of a Relative due to Occupation T-Test Summary table

QoL Domain Mean	Yes	No	95% CI of difference	t	Sig.
QoL Standard	20.82	21.69	-1.45 – -0.29	-2.963	**0.003**
Psychological Baby	21.36	22.42	-2.14 - -0.436	-2.925	**0.004**
Relational Spouse	22.80	23.19	-1.09 – 0.39	-1.123	0.262
Relational Family and Friends	22.09	22.69	-1.89 - -1.27	-1.962	**0.050***
Health and Functioning	20.46	21.32	-1.60 - -0.12	-2.290	**0.022**
Socio-economic	18.84	20.13	-2.14 - -0.36	-2.967	**0.003**
Socio-economic revised	18.75	19.96	-2.07 - -0.36	-2.782	**0.005**

* 0.057 with equal variances not assumed

5.2.1.lEmployment:

Women were categorized as currently employed or not employed. Employment status was significantly related to the relational spouse domain, but was not significant for any other domain. Women who were employed at the time of the survey had significantly higher scores for this domain.

Table 5-13 Employment Status T-Test Summary Table

QoL Domain Mean	Currently employed	Not employed	95% CI of difference	t	Sig.
QoL Standard	22.13	21.50	-0.44 - 1.70	1.149	0.251
Psychological Baby	22.49	22.21	-1.04 - 1.61	0.420	0.674
Relational Spouse	24.35	23.06	0.01 - 2.57	1.981	**0.048**
Relational Family and Friends	22.25	22.59	-1.45 - 0.77	-0.606	0.545
Health and Functioning	21.81	21.13	-0.69 - 2.05	0.973	0.331
Socio-economic	21.14	19.83	-0.27 - 2.90	1.629	0.104
Socio-economic revised	21.16	19.67	-0.10 - 3.09	1.838	0.066

5.2.1.m Amenities Index:

The amenities index variable was significant for the socioeconomic domains, relational spouse domain, and the standard quality of life domain. The differences were not significant for the Relational Family and Friends domain or the Health and Functioning domain. In general, there was a positive association between the number of amenities and the scores for the domains.

Table 5-14 Amenities Scale ANOVA Summary Table

QoL Domain	1-5*	6-8*	9-11*	12-16*	p-value
QoL Standard 95% CI of mean:	20.22 19.58 - 20.85	21.24 20.88 - 21.59	22.02 21.65 - 22.39	22.60 22.00 - 23.20	**<0.001**
Psychological Baby 95% CI of mean:	21.26 20.49 - 22.03	21.86 21.42 - 22.30	22.66 22.19 - 23.13	23.32 22.64 - 24.01	**<0.001**
Relational Spouse 95% CI of mean:	21.73 20.95 - 22.50	22.83 22.42 - 23.25	23.63 23.19 - 24.08	24.17 23.39 - 24.96	**<0.001**
Relational Family and Friends 95% CI of mean:	22.34 21.73 - 22.96	22.65 22.28 - 23.01	22.64 22.25 - 23.03	22.37 21.63 - 23.12	**0.790**
Health and Functioning 95% CI of mean:	20.38 19.51 - 21.25	21.19 20.75 - 21.64	21.35 20.87 - 21.84	21.32 20.54 - 22.10	**0.254**
Socio-economic 95% CI of mean:	16.99 15.99 - 17.99	19.13 18.62 - 19.65	20.95 20.45 - 21.45	22.70 21.88 - 23.51	**<0.001**
Socio-economic revised 95% CI of mean:	16.80 15.78 - 17.81	18.92 18.40 - 19.44	20.87 20.37 - 21.37	22.63 21.82 - 23.44	**<0.001**

* Number indicates number of amenities

5.2.1.n Crowding Ratio:

The crowding ratio was negatively associated with quality of life scores. In general, women with a lower crowding ratio had higher scores in all the quality of life domains.

Table 5-15 Crowding ANOVA Summary Table

QoL Domain	≤1	1-2	2-3	3-4	≥4	p-value
QoL Standard 95% CI of mean:	22.72 22.20 - 23.23	21.90 21.56 - 22.24	20.86 20.42 - 21.29	20.63 19.79 - 21.47	20.35 19.46 - 21.23	**<0.001**
Psychological Baby 95% CI of mean:	23.34 22.73 - 23.94	22.55 22.12 - 22.98	21.63 21.09 - 22.17	21.25 20.17 - 22.34	21.25 20.21 - 22.28	**<0.001**
Relational Spouse 95% CI of mean:	24.30 23.65 - 24.95	23.56 23.15 - 23.97	22.36 21.84 - 22.87	22.38 21.54 - 23.21	21.55 20.45 - 22.65	**<0.001**
Relational Family and Friends 95% CI of mean:	23.37 22.83 - 23.92	22.69 22.32 - 23.05	22.26 21.81 - 22.72	22.02 21.18 - 22.86	22.01 21.14 - 22.89	**0.013**
Health and Functioning 95% CI of mean:	21.95 21.23 - 22.67	21.38 20.95 - 21.82	20.49 19.92 - 21.06	20.83 19.76 - 21.89	21.13 20.16 - 22.11	**0.020**
Socio-economic 95% CI of mean:	21.83 21.13 - 22.53	20.59 20.10 - 21.09	18.81 18.17 - 19.45	18.15 16.97 - 19.34	17.42 15.96 - 18.88	**<0.001**
Socio-economic revised 95% CI of mean:	21.69 21.00 - 22.39	20.43 19.93 - 20.93	18.70 18.06 - 19.35	18.07 16.87 - 19.27	17.04 15.59 - 18.50	**<0.001**

*number represents the crowding ratio

5.2.1.o Scales:

ANOVA tests were used to analyze the relationship between the scale scores and the domain scores. The variations were significant in all the quality of life domains for all

eight scales described previously. There was an inverse association between each respective scale score and the quality of life mean for each domain. In other words, women with higher dissatisfaction scores in these eight areas had lower quality of life scores in all domains. Tables 5.16 – 5.23 provide an overview of the ANOVA analysis for each of the scales.

Table 5-16 Support Scale ANOVA Summary Table

QoL Domain	0	1	2	3	4+	p-value
QoL Standard 95% CI of mean:	22.55 22.33 – 22.77	19.83 19.32 – 20.34	18.31 17.23 – 19.39	18.53 17.25 – 19.81	17.06 16.01 - 18.10	**<0.001**
Psychological Baby 95% CI of mean:	23.28 23.01 – 23.55	20.94 20.29 – 21.59	18.23 16.71 – 19.75	19.65 17.88 – 21.42	17.07 15.66 - 18.48	**<0.001**
Relational Spouse 95% CI of mean:	24.05 23.78 – 24.32	21.71 21.01 – 22.40	19.84 18.50 – 21.17	20.76 18.79 – 22.73	18.54 17.20 - 19.88	**<0.001**
Relational Family and Friends 95% CI of mean:	23.37 23.13 – 23.61	21.28 20.68 – 21.87	20.29 19.27 – 21.31	20.38 18.84 – 21.91	18.82 17.70 - 19.95	**<0.001**
Health and Functioning 95% CI of mean:	22.04 21.73 – 22.34	19.68 18.92 – 20.45	18.33 16.75 – 19.92	17.42 15.58 – 19.26	18.18 16.80 - 19.55	**<0.001**
Socio-economic 95% CI of mean:	21.20 20.85 – 21.54	17.32 16.46 – 18.18	16.26 14.71 – 17.81	16.04 14.26 – 17.83	14.26 12.85 - 15.67	**<0.001**
Socio-economic revised 95% CI of mean:	21.08 20.74 – 21.42	17.05 16.19 – 17.91	15.98 14.45 – 17.52	16.01 14.13 – 17.88	14.03 12.63 - 15.43	**<0.001**

*Number indicates number of times unsatisfied, women who had a scale of 4 or more (maximum= 6) were grouped together due to small numbers.

Table 5-17 Medical Care Scale ANOVA Summary Table

QoL Domain	0	1	2	3	4+	p-value
QoL Standard 95% CI of mean:	22.46 22.20 – 22.71	20.50 20.08 – 20.92	19.20 18.20 – 20.20	18.38 17.05 – 19.72	18.29 17.06 - 19.52	**<0.001**
Psychological Baby 95% CI of mean:	23.24 22.94 – 23.53	20.86 20.23 – 21.48	20.10 18.87 – 21.34	19.30 17.48 – 21.12	18.57 16.87 -20.27	**<0.001**
Relational Spouse 95% CI of mean:	23.72 23.40 – 24.13	22.61 22.06 – 23.16	21.06 19.69 – 22.44	21.38 19.86 – 22.90	20.87 19.55 - 22.19	**<0.001**
Relational Family and Friends 95% CI of mean:	23.22 22.95 – 23.49	21.89 21.43 – 22.35	20.91 21.43 – 22.35	20.40 18.94 – 21.86	20.34 19.10 -21.57	**<0.001**
Health and Functioning 95% CI of mean:	22.26 21.95 – 22.57	19.67 19.04 – 20.30	18.66 17.22 – 20.09	17.94 16.27 – 19.60	18.26 16.73 - 19.80	**<0.001**
Socio-economic 95% CI of mean:	20.98 20.60 – 21.36	18.97 18.31 – 19.62	16.94 15.38 – 18.50	15.31 13.42 – 17.20	15.41 13.64 - 17.19	**<0.001**
Socio-economic revised 95% CI of mean:	20.84 20.46 – 21.23	18.82 18.16 – 19.49	16.70 15.11 – 18.30	14.98 13.11 – 18.45	15.26 13.49 - 17.03	**<0.001**

*Number indicates number of times unsatisfied, women who had a scale of 4 or more (maximum= 6) were grouped together due to small numbers.

Table 5-18 Information Scale ANOVA Summary Table

QoL Domain	0	1	2	3+	p-value
QoL Standard 95% CI of mean:	22.07 21.84 – 22.31	19.27 18.60 – 19.93	19.27 17.94 – 20.59	18.84 17.46 - 20.21	**<0.001**
Psychological Baby 95% CI of mean:	22.75 22.47 – 23./4	19.97 19.06 – 20.89	20.06 18.27 – 21.84	19.57 17.69 - 21.45	**<0.001**
Relational Spouse 95% CI of mean:	23.56 23.27 – 23.85	21.40 20.56 – 22.25	21.14 19.43 – 22.84	20.44 18.79 - 22.09	**<0.001**
Relational Family and Friends 95% CI of mean:	23.05 22.80 – 23.29	21.05 20.38 – 21.72	19.54 17.92 – 21.16	19.83 18.14 - 21.51	**<0.001**
Health and Functioning 95% CI of mean:	21.76 21.46 – 22.05	18.52 17.57 – 19.46	19.03 17.15 – 20.91	18.79 17.04 - 20.54	**<0.001**
Socio-economic 95% CI of mean:	20.47 20.12 – 20.82	17.12 16.02 – 18.22	18.19 16.26 – 20.11	17.05 15.06 - 19.03	**<0.001**
Socio-economic revised 95% CI of mean:	20.35 19.99 – 20.70	16.88 15.78 – 17.99	17.87 15.95 – 19.95	16.82 14.81 - 18.83	**<0.001**

*Number indicates number of times unsatisfied, women who had a scale of 3 or more (maximum= 5) were grouped together due to small numbers.

Table 5-19 Childcare Characteristics Scale ANOVA Summary Table

QoL Domain	0	1	2+	p-value
QoL Standard 95% CI of mean:	21.98 21.74 - 22.21	19.45 18.78 - 20.11	19.17 18.28 - 20.06	**<0.001**
Psychological Baby 95% CI of mean:	22.73 22.45 - 23.02	20.03 19.08 - 20.98	19.20 17.96 - 20.44	**<0.001**
Relational Spouse 95% CI of mean:	23.44 23.15 - 23.72	21.42 20.56 - 22.28	21.74 20.61 - 22.87	**<0.001**
Relational Family and Friends 95% CI of mean:	23.0208 22.78 - 23.26	20.55 19.72 - 21.38	20.11 19.09 - 21.14	**<0.001**
Health and Functioning 95% CI of mean:	21.62 21.32 - 21.93	19.00 18.01 - 19.99	18.75 17.62 - 19.88	**<0.001**
Socio-economic 95% CI of mean:	20.31 19.95 - 20.67	17.87 16.82 - 18.92	17.76 16.40 - 19.11	**<0.001**
Socio-economic revised 95% CI of mean:	20.17 19.81 - 20.53	17.64 16.59 - 18.69	17.61 16.26 - 18.95	**<0.001**

*Any scores above two were grouped together due to a low number of cases in these groups.

Table 5-20 Childcare Economic Characteristics Scale ANOVA Summary Table

QoL Domain	0	1	2	3	4	p-value
QoL Standard 95% CI of mean:	22.59 22.35 - 22.83	19.91 19.42 - 20.41	19.20 18.49 - 19.91	18.25 17.29 -19.21	17.08 15.85 - 18.31	**<0.001**
Psychological Baby 95% CI of mean:	23.12 22.81 - 23.43	20.98 20.29 - 21.66	20.31 19.37 - 21.25	19.25 17.93 - 20.57	17.96 16.02 - 19.90	**<0.001**
Relational Spouse 95% CI of mean:	24.07 23.77 -24.36	21.29 20.55 - 22.04	21.30 20.43 - 22.17	21.02 19.85 - 22.19	18.89 17.45 - 20.34	**<0.001**
Relational Family and Friends 95% CI of mean:	23.34 23.08 - 23.59	21.29 20.69 - 21.89	20.64 19.59 - 21.70	20.38 19.36 - 21.41	20.22 18.88 - 21.55	**<0.001**
Health and Functioning 95% CI of mean:	22.00 21.68 - 22.31	19.88 19.14 - 20.63	19.42 18.29 - 20.55	17.95 16.61 - 19.30	18.45 16.56 - 20.34	**<0.001**
Socio-economic 95% CI of mean:	21.55 21.20 - 21.90	17.46 16.76 - 18.17	16.37 15.37 - 17.36	14.92 13.37 - 16.46	11.87 9.88 - 13.86	**<0.001**
Socio-economic revised 95% CI of mean:	21.40 21.05 - 21.75	17.41 16.70 - 18.12	16.03 15.02 - 17.03	14.67 13.13 - 16.22	11.73 9.74 - 13.73	**<0.001**

Table 5-21 Husband Characteristics Scale ANOVA Summary Table

QoL Domain	0	1	2	3	4	p-value
QoL Standard 95% CI of mean:	23.01 22.74 - 23.28	21.19 20.71 - 21.68	20.38 19.86 - 20.90	19.30 18.64 - 19.96	16.97 16.04 - 17.90	**<0.001**
Psychological Baby 95% CI of mean:	23.64 23.31 - 23.96	22.00 21.39 - 22.61	21.13 20.43 - 21.83	20.27 19.33 - 21.21	17.17 15.83 - 18.50	**<0.001**
Relational Spouse 95% CI of mean:	24.64 24.34 - 24.95	23.04 22.47 - 23.61	21.83 21.18 - 22.48	21.02 20.14 - 21.89	17.55 16.09 - 19.00	**<0.001**
Relational Family and Friends 95% CI of mean:	23.74 23.46 - 24.02	22.16 21.62 - 22.70	22.15 21.67 - 22.64	20.55 19.69 - 21.41	18.29 17.06 - 19.52	**<0.001**
Health and Functioning 95% CI of mean:	22.47 22.12 - 22.82	20.59 19.93 - 21.26	20.20 19.49 - 20.92	19.28 18.29 - 20.28	17.76 16.38 - 19.15	**<0.001**
Socio-economic 95% CI of mean:	21.75 21.34 - 22.16	19.65 18.95 - 20.35	18.00 17.19 - 18.81	17.15 15.94 - 18.36	14.95 13.63 - 16.27	**<0.001**
Socio-economic revised 95% CI of mean:	21.66 21.26 - 22.07	19.47 18.76 - 20.17	17.82 17.02 - 18.63	16.79 15.56 - 18.02	14.76 13.45 - 16.07	**<0.001**

Table 5-22 Social Interventions & Choice Scale ANOVA Summary Table

QoL Domain	0	1	2	3	4+	p-value
QoL Standard 95% CI of mean:	22.41 22.14 - 22.68	21.05 20.48 - 21.62	20.86 20.41 - 21.31	18.40 17.22 - 19.58	16.70 15.35 - 18.06	**<0.001**
Psychological Baby 95% CI of mean:	23.05 22.71 – 23.39	22.00 21.32 - 22.67	21.67 21.08 - 22.25	18.96 17.39 - 20.53	16.65 14.81 - 18.48	**<0.001**
Relational Spouse 95% CI of mean:	23.98 23.67 - 24.29	22.54 21.81 - 23.27	22.60 22.00 - 23.19	19.60 17.95 - 21.25	18.72 16.96 - 20.47	**<0.001**
Relational Family and Friends 95% CI of mean:	23.29 23.01 - 23.57	21.93 21.33 - 22.53	22.37 21.88 - 22.86	19.40 18.03 - 20.76	18.68 17.23 - 20.13	**<0.001**
Health and Functioning 95% CI of mean:	21.99 21.64 - 22.35	20.40 19.62 - 21.18	20.69 20.10 - 21.28	18.67 17.18 - 20.16	16.54 14.85 - 18.24	**<0.001**
Socio-economic 95% CI of mean:	21.00 20.59 - 21.41	19.57 18.68 - 20.45	18.49 17.78 - 19.20	16.68 14.94 - 18.42	14.56 12.58 - 16.54	**<0.001**
Socio-economic revised 95% CI of mean:	20.82 20.41 - 21.23	19.45 18.55 - 20.35	18.42 17.71 - 19.13	16.46 14.73 -18.19	14.34 12.37 - 16.30	**<0.001**

*Any scores above four were grouped together due to a low number of cases in these groups.

Table 5-23 Husband's Employment Scale ANOVA Summary Table

QoL Domain	0	1	2	3	4	5	p-value
QoL Standard 95% CI of mean:	22.86 22.57 - 23.16	21.90 21.35 - 22.45	20.63 20.03 - 21.23	20.59 19.77 - 21.40	19.67 18.67 - 20.67	18.96 18.41 - 19.51	**<0.001**
Psychological Baby 95% CI of mean:	23.41 23.04 - 23.77	22.53 21.82 - 23.24	21.39 20.61 - 22.18	21.27 20.14 - 22.41	20.79 19.58 - 21.99	19.93 19.17 - 20.69	**<0.001**
Relational Spouse 95% CI of mean:	24.05 23.68 - 24.41	23.60 22.89 - 24.31	22.32 21.53 - 23.11	23.60 22.71 - 24.49	21.32 20.21 - 22.42	20.85 20.11 - 21.59	**<0.001**
Relational Family and Friends 95% CI of mean:	23.37 23.07 - 23.67	22.54 21.93 - 23.15	21.46 20.72 - 22.20	22.83 21.98 - 23.68	21.63 20.37 - 22.90	21.23 20.58 - 21.89	**<0.001**
Health and Functioning 95% CI of mean:	22.28 21.89 - 22.66	20.89 20.09 - 21.69	20.28 19.40 - 21.15	20.31 19.15 - 21.47	19.72 18.34 -21.10	19.68 18.96 - 20.40	**<0.001**
Socio-economic 95% CI of mean:	21.91 21.48 - 22.34	20.89 20.16 - 21.62	18.97 18.08 - 19.87	17.50 16.30 - 18.71	16.92 15.30 - 18.53	15.75 14.95 - 16.54	**<0.001**
Socio-economic revised 95% CI of mean:	21.96 21.53 - 22.38	20.30 - 21.71	18.91 18.08 - 19.75	17.14 15.97 - 18.31	16.45 14.88- 18.01	14.91 14.13 - 15.68	**<0.001**

5.2.2 Multi-variate Analysis:

Regression analysis was conducted for each quality of life domain with a combination of the factors mentioned previously as independent variables. Tables 5.24 – 5.29 summarize the results of the regression analysis for each of the domains. The regression was run twice for each domain, once without the inclusion of scales and a second time including them.

For the standard or general domain, an unwanted pregnancy[15]; a higher crowding ratio; residence in the South, Central, and Gaza Strip (compared to North West Bank); the loss of a relative due to occupation; being a refugee; and a lower number of household amenities had a negative impact on the general quality of life score in the regression analysis without the inclusion of the scales (R^2= 0.126). In the regression analysis including the scales, the significance of residence in the South West Bank; refugee status; and higher crowding were reduced to the $p<0.10$ levels (previously $p<0.05$). The

[15] An unwanted pregnancy refers to a pregnancy that was either untimely or not wanted at all.

impact of higher scores for all scales was significant for this domain. The R^2 for the model including the scales rose to 0.502.

For the socio-economic domains (original and revised), refugee status; the loss of a relative due to occupation; a higher crowding ratio; a lower number of amenities; and an unwanted pregnancy had a negative impact on the domain scores in the regression analysis without the inclusion of the scales. The R^2 scores for the standard and revised socioeconomic domains were 0.152 and 0.156 respectively.

Following the regression analysis with the inclusion of the scales; higher scores on the support, childcare economic, husband characteristics, social interventions & choice, husband's employment, and medical support scales; a higher crowding ratio[16]; and the loss of a relative due to occupation inversely impacted the domain score. An increase in the number of amenities positively impacted the scores for these domains. The R^2 scores for the standard and revised socioeconomic domains under this model were 0.464 and 0.500 respectively.

[16] The crowding ratio was significant to the $p< 0.10$ level.

Table 5-24 Standard and Socio-Economic Domains Regression

Independent Variables	Domain								
	Standard QoL			Socio-Economic			Socio-Economic Revised		
	β	SE	Sig.	β	SE	Sig.	β	SE	Sig.
Constant	21.600	1.840	**<0.001**	15.704	2.679	**<0.001**	15.610	2.689	**<0.001**
Age	-0.039	0.027	0.150	-0.037	0.040	0.346	-0.034	0.040	0.391
Years of Schooling	-0.019	0.040	0.629	0.007	0.058	0.898	0.015	0.058	0.795
Number of Children	0.022	0.078	0.780	-0.001	0.114	0.990	-0.010	0.114	0.933
Refugee Status	0.615	0.250	**0.014**	0.747	0.364	**0.040**	0.699	0.365	**0.056**
North/Center	-1.663	0.384	**<0.001**	-0.668	0.559	0.232	-0.681	0.561	0.225
North/South	-0.751	0.351	**0.033**	-0.616	0.512	0.229	-0.510	0.514	0.321
North/Gaza Strip	-0.957	0.334	**0.004**	-0.221	0.486	0.649	-0.169	0.488	0.729
Urban/Rural	-0.027	0.283	0.925	-0.328	0.412	0.427	-0.256	0.414	0.535
Urban/Camp	-0.180	0.316	0.570	0.043	0.460	0.925	0.036	0.462	0.938
Loss of a Relative due to occupation	0.760	0.283	**0.007**	1.043	0.412	**0.012**	0.983	0.414	**0.018**
Number of Household Amenities	0.232	0.046	**<0.001**	0.545	0.066	**<0.001**	0.565	0.067	**<0.001**
Crowding Ratio	-0.273	0.090	**0.003**	-0.516	0.131	**<0.001**	-0.530	0.132	**<0.001**
Health Insurance	0.101	0.325	0.757	0.705	0.474	0.137	0.618	0.475	0.194
Family planning use	0.345	0.280	0.218	0.267	0.407	0.513	0.275	0.409	0.501
Wanted-ness of pregnancy	-1.128	0.261	**<0.001**	-0.938	0.380	**0.014**	-0.926	0.381	**0.015**
Employment	-0.422	0.549	0.442	-0.434	0.799	0.587	-0.504	0.802	0.530
R^2	**0.126**			**0.152**			**0.156**		

Table 5-25 : Standard and Socio-Economic Domains Regression with Scales

Independent Variables	Domain								
	Standard QoL			Socio-Economic			Socio-Economic Revised		
	β	SE	Sig.	β	SE	Sig.	β	SE	Sig.
Constant	23.962	1.401	**<0.001**	19.440	2.148	**<0.001**	19.614	2.089	**<0.001**
Age	-0.033	0.021	0.110	-0.024	0.032	0.458	-0.021	0.031	0.504
Years of Schooling	-0.028	0.030	0.353	-0.018	0.046	0.701	-0.012	0.045	0.796
Number of Children	0.031	0.059	0.607	0.019	0.091	0.839	0.015	0.089	0.864
Refugee Status	0.331	0.190	**0.082**	0.392	0.292	0.180	0.360	0.284	0.205
North/Center	-1.403	0.294	**<0.001**	-0.470	0.450	0.297	-0.485	0.438	0.268
North/South	-0.527	0.270	**0.051**	-0.319	0.413	0.440	-0.205	0.402	0.610
North/Gaza Strip	-0.691	0.255	**0.007**	0.105	0.391	0.787	0.158	0.380	0.678
Urban/Rural	-0.036	0.215	0.866	-0.276	0.329	0.402	-0.198	0.320	0.537
Urban/Camp	0.115	0.240	0.633	0.425	0.368	0.249	0.414	0.358	0.248
Loss of a Relative due to occupation	0.549	0.215	**0.011**	0.751	0.330	**0.023**	0.683	0.321	**0.034**
Number of Household Amenities	0.118	0.035	**0.001**	0.356	0.054	**<0.001**	0.360	0.052	**<0.001**
Crowding Ratio	-0.129	0.069	**0.062**	-0.357	0.106	**0.001**	-0.363	0.103	**<0.001**
Health Insurance	0.049	0.248	0.842	0.577	0.379	0.128	0.489	0.369	0.185
Family planning use	0.112	0.213	0.597	-0.057	0.326	0.861	-0.087	0.317	0.783
Wanted-ness of pregnancy	-0.590	0.200	**0.003**	-0.306	0.306	0.318	-0.284	0.298	0.341
Employment	0.079	0.417	0.850	0.213	0.639	0.739	0.199	0.622	0.749
Childcare Characteristics	-0.457	0.130	**<0.001**	-0.188	0.200	0.348	-0.203	0.195	0.297
Medical Care Scale Score	-0.386	0.080	**<0.001**	-0.501	0.122	**<0.001**	-0.509	0.119	**<0.001**
Information Scale Score	-0.211	0.105	**0.045**	0.108	0.161	0.501	0.085	0.157	0.587
Support Scale Score	-0.523	0.078	**<0.001**	-0.525	0.120	**<0.001**	-0.504	0.116	**<0.001**
Social interventions & choices Scale Score	-0.332	0.075	**<0.001**	-0.411	0.115	**<0.001**	-0.356	0.112	**0.002**
Husband Characteristics Scale Score	-0.597	0.076	**<0.001**	-0.587	0.116	**<0.001**	-0.592	0.113	**<0.001**
Husband Employment Scale Score	-0.331	0.048	**<0.001**	-0.645	0.074	**<0.001**	-0.829	0.072	**<0.001**
Childcare Economic Characteristics Score	-0.648	0.087	**<0.001**	-1.332	0.134	**<0.001**	-1.281	0.130	**<0.001**
R^2	**0.502**			**0.464**			**0.500**		

In the regression analysis without the inclusion of the scales, the Psychological Baby domain was negatively impacted by refugee status; residence in the South West Bank, Central West Bank, and the Gaza Strip; the loss of a relative due to occupation; a higher crowding ratio; a lower number of household amenities; and an unwanted pregnancy. The R^2 for the model was 0.101.

The Psychological Baby score was negatively associated with an unwanted pregnancy; a higher score on the support, childcare characteristics, childcare economic, husband characteristics, social interventions & choice, husband's employment, and medical support scales; and residence in the Central West Bank, the Gaza Strip, and the South West Bank; and refugee status[17] in the regression analysis including the scales. There was a significant positive association between the number of amenities in the household and the score for this domain. The R^2 for the model including the scales was 0.352.

The Health and Functioning score was negatively associated with age, refugee status, the loss of a relative due to occupation[18], and an unwanted pregnancy in the regression analysis without the inclusion of the scales. The R^2 for the model was 0.057.

In the regression analysis with the inclusion of the scales, the Health and Functioning score was inversely associated with age, years of schooling, an unwanted pregnancy, the loss of a relative due to occupation[19], and higher scores on all scales. It was positively associated with residence in a rural setting (with urban as reference). The R^2 for the model was 0.236.

[17] Refugee status and residence in the South West Bank (with North West Bank as comparison) were significant at p= 0.063.
[18] $p< 0.06$
[19] $p< 0.10$

Table 5-26 : Psychological Baby and Health & Functioning Regression

	Psychological Baby			Health & Functioning		
Independents	**β**	**SE**	**Sig.**	**β**	**SE**	**Sig.**
Constant	20.906	2.302	**<0.001**	24.028	2.437	**<0.001**
Age	-0.036	0.034	0.293	-0.075	0.036	**0.037**
Years of Schooling	0.035	0.050	0.485	-0.024	0.053	0.651
Number of Children	0.060	0.098	0.541	0.079	0.104	0.444
Refugee Status	0.738	0.313	**0.018**	0.689	0.331	**0.038**
North/Center	-2.170	0.480	**<0.001**	-0.692	0.508	0.173
North/South	-0.902	0.440	**0.040**	0.107	0.465	0.819
North/Gaza Strip	-1.472	0.418	**<0.001**	-0.658	0.443	0.138
Urban/Rural	0.062	0.354	0.860	-0.561	0.375	0.135
Urban/Camp	-0.175	0.396	0.659	-0.412	0.419	0.326
Loss of a Relative due to occupation	0.999	0.354	**0.005**	0.712	0.375	**0.058**
Number of Household Amenities	0.190	0.057	**0.001**	0.059	0.060	0.333
Crowding Ratio	-0.233	0.113	**0.039**	-0.040	0.119	0.739
Health Insurance	0.053	0.407	0.897	-0.007	0.431	0.987
Family planning use	0.399	0.350	0.255	0.504	0.371	0.174
Wanted-ness of pregnancy	-1.476	0.326	**<0.001**	-1.332	0.345	**<0.001**
Employment	0.063	0.687	0.927	-1.020	0.727	0.161
R^2	**0.101**			**0.057**		

Table 5-27 : Psychological Baby and Health & Functioning Regression with Scales

Independent Variables	Domain					
	Psychological Baby			Health & Functioning		
	β	SE	Sig.	β	SE	Sig.
Constant	22.956	1.971	**<0.001**	25.958	2.213	**<0.001**
Age	-0.030	0.029	0.298	-0.071	0.033	**0.029**
Years of Schooling	0.029	0.043	0.503	-0.022	0.048	0.651
Number of Children	0.061	0.084	0.469	0.071	0.094	0.448
Refugee Status	0.469	0.268	**0.080**	0.435	0.300	0.148
North/Center	-1.798	0.413	**<0.001**	-0.530	0.464	0.253
North/South	-0.698	0.379	**0.066**	0.180	0.426	0.672
North/Gaza Strip	-1.241	0.358	**0.001**	-0.462	0.402	0.251
Urban/Rural	0.038	0.302	0.900	-0.591	0.339	**0.081**
Urban/Camp	0.149	0.338	0.659	-0.159	0.379	0.675
Loss of a Relative due to occupation	0.801	0.303	**0.008**	0.571	0.340	**0.093**
Number of Household Amenities	0.096	0.049	**0.052**	-0.025	0.056	0.659
Crowding Ratio	-0.077	0.097	0.425	0.092	0.109	0.398
Health Insurance	0.022	0.348	0.949	-0.077	0.391	0.844
Family planning use	0.171	0.299	0.569	0.308	0.336	0.359
Wanted-ness of pregnancy	-0.901	0.281	**0.001**	-0.854	0.315	**0.007**
Employment	0.513	0.587	0.382	-0.623	0.659	0.345
Childcare Characteristics Scale	-0.695	0.184	**<0.001**	-0.541	0.206	**0.009**
Medical Care Scale Score	-0.414	0.112	**<0.001**	-0.562	0.126	**<0.001**
Information Scale Score	-0.168	0.148	0.257	-0.458	0.166	**0.006**
Support Scale Score	-0.763	0.110	**<0.001**	-0.338	0.123	**0.006**
Social interventions & choices Scale Score	-0.331	0.106	**0.002**	-0.339	0.119	**0.004**
Husband Characteristics Scale Score	-0.565	0.107	**<0.001**	-0.485	0.120	**<0.001**
Husband Employment Scale Score	-0.231	0.068	**0.001**	-0.169	0.076	**0.027**
Childcare Economic Characteristics Score	-0.420	0.123	**0.001**	-0.445	0.138	**0.001**
R^2	**0.352**			**0.236**		

The Relational Family & Friends score was inversely associated with years of schooling; residence in the South West Bank, Central West Bank, or Gaza Strip; an

unwanted pregnancy; a higher crowding ratio; and the loss of a relative due to occupation.[20] The R^2 for the model was 0.086.

In the analysis with the inclusion of the scales, the loss of a relative due to occupation was no longer significant and the significance of an unwanted pregnancy was reduced to p=0.066 (compared to p=0.001). Higher scores on the support, childcare, childcare economic, husband characteristics, social interventions & choice, information, and medical support scales resulted in significantly lower scores in this domain. The R^2 for the model was 0.313.

The Relational Spouse score was negatively associated with a lower number of amenities, higher crowding an unwanted pregnancy and residence in the Central West Bank, the South West Bank, and the Gaza Strip in the regression analysis excluding the scales. The R^2 for the model was 0.121.

In the analysis including the scales, the domain score was negatively impacted by an unwanted pregnancy; lower number of amenities in the household; a higher crowding ratio; higher scores on the support, childcare economic, husband characteristics, social interventions & choice, and husband's employment scales; and residence in the South West Bank, the Central West Bank, or the Gaza Strip. The R^2 for the model was 0.330.

[20] p = 0.053

Table 5-28 : Relational Spouse and Relational Family & Friends Regression

Independent Variables	Domain					
	Relational Spouse			Relational Family & Friends		
	β	SE	Sig.	β	SE	Sig.
Constant	26.195	2.205	**<0.001**	24.778	1.947	**<0.001**
Age	-0.036	0.033	0.268	-0.013	0.029	0.661
Years of Schooling	-0.011	0.048	0.815	-0.108	0.042	**0.011**
Number of Children	-0.045	0.094	0.629	-0.019	0.083	0.823
Refugee Status	0.363	0.299	0.226	0.424	0.264	0.109
North/Center	-2.632	0.460	**<0.001**	-2.700	0.406	**<0.001**
North/South	-1.299	0.421	**0.002**	-1.342	0.372	**<0.001**
North/Gaza Strip	-1.920	0.400	**<0.001**	-1.231	0.354	**0.001**
Urban/Rural	0.349	0.339	0.304	0.416	0.300	0.166
Urban/Camp	-0.195	0.379	0.607	-0.205	0.335	0.540
Loss of a Relative due to occupation	0.361	0.339	0.288	0.581	0.300	**0.053**
Number of Household Amenities	0.241	0.055	**<0.001**	0.039	0.048	0.426
Crowding Ratio	-0.311	0.108	**0.004**	-0.212	0.095	**0.026**
Health Insurance	0.053	0.390	0.892	-0.281	0.344	0.415
Family planning use	0.098	0.335	0.770	0.340	0.296	0.252
Wanted-ness of pregnancy	-0.996	0.312	**0.001**	-0.928	0.276	**0.001**
Employment	-0.888	0.658	0.177	-0.053	0.581	0.927
R^2	**0.121**			**0.086**		

Table 5-29 : Relational Spouse and Relational Family & Friends Regression with Scales

Independent Variables	Domain					
	Relational Spouse			Relational Family & Friends		
	β	SE	Sig.	β	SE	Sig.
Constant	27.928	1.942	**<0.001**	26.203	1.702	**<0.001**
Age	-0.033	0.029	0.250	-0.011	0.025	0.671
Years of Schooling	-0.022	0.042	0.606	-0.108	0.037	**0.003**
Number of Children	-0.018	0.082	0.830	-0.015	0.072	0.834
Refugee Status	0.084	0.264	0.752	0.157	0.231	0.498
North/Center	-2.319	0.407	**<0.001**	-2.418	0.357	**<0.001**
North/South	-0.919	0.374	**0.014**	-1.136	0.328	**0.001**
North/Gaza Strip	-1.544	0.353	**<0.001**	-0.994	0.310	**0.001**
Urban/Rural	0.301	0.298	0.312	0.378	0.261	0.148
Urban/Camp	0.056	0.333	0.867	0.024	0.292	0.933
Loss of a Relative due to occupation	0.150	0.298	0.616	0.396	0.262	0.131
Number of Household Amenities	0.149	0.049	**0.002**	-0.029	0.043	0.503
Crowding Ratio	-0.197	0.095	**0.039**	-0.080	0.084	0.337
Health Insurance	0.110	0.343	0.748	-0.302	0.301	0.316
Family planning use	-0.078	0.295	0.791	0.199	0.258	0.441
Wanted-ness of pregnancy	-0.549	0.277	**0.047**	-0.446	0.243	**0.066**
Employment	-0.385	0.578	0.505	0.355	0.507	0.483
Childcare Characteristics	-0.070	0.181	0.698	-0.621	0.159	**<0.001**
Medical Care Scale Score	-0.066	0.111	0.552	-0.217	0.097	**0.025**
Information Scale Score	-0.205	0.146	0.159	-0.375	0.128	**0.003**
Support Scale Score	-0.539	0.108	**<0.001**	-0.478	0.095	**<0.001**
Social interventions & choices Scale Score	-0.388	0.104	**<0.001**	-0.250	0.091	**0.006**
Husband Characteristics Scale Score	-0.860	0.105	**<0.001**	-0.610	0.092	**<0.001**
Husband Employment Scale Score	-0.152	0.067	**0.023**	-0.063	0.059	0.280
Childcare Economic Characteristics Score	-0.480	0.121	**<0.001**	-0.427	0.106	**<0.001**
R^2	**0.330**			**0.313**		

5.3. Support Preferences:

5.3.1 Support type:

Participants were asked to rank the importance of each type of support (medical, financial, social, emotional, and practical) during the postpartum. About 44% of women stated that emotional support was most important; 20.8% stated that medical support was most important; 20.3% emphasized financial support; while 9.7% and 5.1% stated that social and practical support were most important, respectively. There were some variations in responses by the type of locality, education, parity, regional district, standard of living (by crowding ratio and number of amenities), and age. The variations were significant at the $p<0.010$ level.

Women in rural areas were more likely to emphasize financial support than urban and camp women. Camp women were almost two times more likely to give preference to medical support over financial support. For urban women, financial and medical support were preferred at more similar percentages (with medical support slightly higher). Emotional support was the most common response for all women.

Women with higher levels of education were more likely to stress emotional support. The percentage of women in the lowest education category that chose financial support as the most important was about two times more than women in the highest education category. Women with more children were more likely to emphasize financial support than women with fewer children.

Women in the North West Bank had the highest preference for emotional support than other women. Women in the South West Bank stressed financial support more than

other women. Women in the Gaza Strip had the highest preference for medical support. Women with a lower standard of living were more likely to emphasize financial support. As standard of living improved, emphasis on financial support decreased and emphasis of emotional support increased.

Older women were more likely to emphasize the importance of financial support than younger women. Also, the significance of medical support began to decline in the 25-29 age group and increased again with the 40 and over age group.

5.3.2 Preferred Providers of Support:

Women were asked about whom their preferred providers of each type of support in the postpartum are. For social, emotional, and financial support, an overwhelming percentage of women preferred their husband as their source of support for these areas (68.5% for social support, 74.9% for emotional support, and 88.7% for financial support). For practical support, 27.1% of women indicated preference for their husbands as the source of support, while 53.1% preferred practical support from a female family member. In terms of medical support, 84.9% indicated preference for a physician, 5.7% for a nurse, 2.0% for a midwife, and 5.1% for their mother or mother-in-law.

5.3.2.a Variations in Provider Preferences:

The general trends in women's preferences remained pretty consistent when analyzed in reference to various factors. There were some variations in each support-type category.

In the medical support category, rural women had a significantly lower physician preference and more nurse preference than women in urban and camp locales. There were some variations by regional district where women in the North West Bank had the lowest physician preference while the South West Bank had the highest physician preference. In the Gaza Strip, preference for midwives was almost non-existent (0.2%). Physician preference was also significantly higher as women's ages increased.

For the emotional support category, there were some variations associated with education and regional districts. Women with higher education had significantly higher preference for their husbands and friends than women with lower levels of education. Women in the Central West Bank had the lowest percentages for husband preference and the highest for mother preference than women in any other regional district in this category.

There were some variations in practical support provider preferences based on education, employment status, the number of children, and regional district. Women with higher education were more likely to prefer practical support from their husbands than other women. This was also true for women that were currently employed. There was a negative association between the number of children and preference for practical support from the husband or mother. Women in the Central West Bank had the lowest percentage for husband preference in this category. In the Gaza Strip, women expressed less preference for practical support from their mothers and sisters than other regions.

In the social support category, there were some variations associated with parity, region, and age. As parity and age increased, there was less preference for mothers and mothers-in-law. Again, in the Central West Bank, there was less stated preference for the husband than any other area. There was also higher preference for mothers and mothers-in-law as providers of social support than in any other region.

In terms of the preferred providers for financial support category, there was some variation based on employment, region, and crowding ratio. Women that were currently employed, women in the Central West Bank, and women with a lower crowding ratio were more likely to indicate preference for depending on themselves for financial support than other women. The general trend that overwhelmingly gave preference to the husband as the provider of financial support did not change to a great extent among these groups.

Chapter 6 DISCUSSION:

6.1.Variations in Quality of Life Scores:

The results indicate that the main factors that affect the quality of life scores are: regional district, refugee status, the loss of a relative due to occupation, crowding and the number of amenities in the household, the wanted-ness of the pregnancy, and the scale scores.

The crowding ratio and the number of household amenities were used in the analysis of this study as proxies for socioeconomic status. Women's postpartum quality of life was positively associated with better socioeconomic status. This is comparable with the international literature (Pinquart, Sorensen 2000; Penson et al 2001), which has indicated that socioeconomic status is related to health status, access, wellbeing, and life satisfaction. In this sample, women with better socioeconomic status were also less likely to have an unwanted or untimely pregnancy, which has been negatively correlated with maternal wellbeing in other studies (Santelli et al 2003; Trussell, Vaughan, Stanford 1999; Sable, Wilkinson 2000; Giacaman et al 2008) and quality of life in this study.

Pregnancy intention and wanted-ness have been the issue of much debate in the literature (Santelli et al 2003; Trussell, Vaughan, Stanford 1999; Sable and Wilkinson 2000; Giacaman et al 2008). Recent literature has made the distinction between an unintended pregnancy and an unwanted one (Santelli et al 2003; Trussell et al 1999); where an unintended pregnancy is a pregnancy that occurs despite family planning use while an unwanted pregnancy occurs when the pregnancy has been characterized as

unwanted at the time or not wanted at all. Previous studies (Santelli et al 2003; Trussell et al 1999; Sable MR and Wilkinson DS 2000; Giacaman et al 2008) have associated unwanted pregnancies with poor infant and maternal outcomes, the occurrence of negative behaviors during pregnancy, and increased stress during pregnancy and after delivery. Similarly, the results of this study indicate that an unwanted pregnancy is negatively associated with perceived quality of life. An unintended pregnancy was negatively associated with most domains in the bi-variate analysis, but was not significant in the regression analysis. This may indicate that wanted-ness rather than intention is a more important indicator of postpartum well-being.

Similar to the findings of an analysis of the DHS 2004 survey (Giacaman et al 2008), the data indicates that there is an inverse relation between pregnancy wanted-ness and the age of the woman and the number of children she has. Younger women with fewer children were more likely to have wanted to be pregnant at the time than older women with a greater number of children. Also, the association between wanted-ness and a poorer perception of socioeconomic components of life quality and childcare (based on socioeconomic domain scores and scores for the Childcare Socioeconomic scale) indicates that there may be an association between pregnancy wanted-ness and women's perceptions of the household's ability to cope with the costs associated with childrearing. This was also consistent with Giacaman et al's (2008) study.

It is also interesting to note that over half of women that reported not wanting to be pregnant at the time or not wanting to be pregnant at all (about 37% of the sample) were using some form of family planning. Over half of the women that had a mistimed or unwanted pregnancy and were using some form of family planning reported using

modern contraception methods. For these women, the need for contraception was technically met, but was not effective in preventing pregnancy. This calls for further inquiry into the quality of family planning services that are being offered to these women; family planning use patterns; information provided to women on family planning; as well as a deeper analysis of pregnancy intention and wanted-ness that goes beyond unmet need for contraception (Giacaman et al 2008).

Women who reported having lost a relative due to occupation had significantly lower scores on most of the quality of life domains. The nature of this association may be multi-faceted. The international literature has indicated that grief resulting from the loss of a loved one is a stressful life-event that can have an adverse affect on emotional well-being, can induce greater stress, and has been associated with restlessness in children (Lavee, McCubbin, Olson 1987; Broman, Riba, Trahan 1996; Goodyer, Wright, Altham 1998). Further analysis of the data also indicates that smaller percentages of women who have lost a relative due to occupation resided in the least crowded households, while they were more likely to be in the lowest household amenities category. They also had higher dissatisfaction scores on the childcare economic scale. This may indicate that there is an economic component associated with the loss of a relative. We do not have any information from this sample to conclude whether it is that women who have lost a relative due to occupation are more likely to be in the low socioeconomic segments of the population as a result of that loss or whether low socioeconomic status makes them more vulnerable to the loss of a relative.

The association between refugee status and perceived quality of life also seems to be mediated by various factors. The international literature has shown that refugees are

generally at a disadvantage and tend to live under poorer conditions and have poorer health status (Taraki 1997). This is comparable with the results of this study. Further analysis, however, indicates that there may be other dimensions to this association. About 67% of the refugees in the study sample reside in the Gaza Strip (66.9% of the Gaza Strip sample are also refugees). The Gaza Strip has been characterized by spiraling deterioration in economic, humanitarian, and political conditions as well as closure and more stringent restrictions on movement than the West Bank (Amnesty International et al 2008). A comparison of the means of the quality of life scores of refugee and non-refugee women in the Gaza Strip using T-tests indicates that there is no significant difference in the quality of life scores. The same does not hold true when a similar analysis is conducted for the West Bank population. In the West Bank population, refugees were significantly more disadvantaged in terms of quality of life scores. So, on one level it seems that refugees are more likely to have lower quality of life scores because of their concentration in the Gaza Strip and their living conditions there, given that their scores were similar to non-refugees, and on another it seems that the refugees in the West Bank are more likely to have lower quality of life scores than their non-refugee counterparts. The concentration of refugees in the Gaza strip, as has been noted in previous studies (Taraki 1997), seems to have resulted in a smoother assimilation of refugees in Gazan society and in the reduction of inequalities between the refugee and non-refugee populations. The same does not hold true in the West Bank, where refugees seem to be more disadvantaged in relation to the non-refugee population of the West Bank. There is some indication of this in the relative differences in the unemployment rates among refugees and non-refugees in the West Bank and the Gaza Strip; where the differences between refugees and non-refugees in the West Bank is greater than in the Gaza Strip (Egset 2003).

Various studies have pointed to differences among the regions of the West Bank and Gaza Strip (Johnson 2006; Taraki 1997), and some have also noted more striking variations within the West Bank (Johnson 2006; Taraki and Giacaman 2006). Johnson (2006) notes that the variations in practices and preferences were stronger among households living in the different regions of the West Bank and Gaza Strip than they were among households living in different types of localities or with varying degrees of wealth, supporting the notion that it is life in Gaza that may be determinant of quality of life scores among refugees, compared to life on the West Bank.

The peculiarity of the results of this study is not that variations exist between these regions, but rather the nature of these variations in terms of life quality; particularly the ranking of the Central West Bank as the worst in terms of life quality and the North West Bank as the best. The relatively high ranking of the North West Bank seems to be quite puzzling, considering the construction of the Separation Wall, and the military closures affecting those living in the North of the West Bank in serious ways, and leading to the North's isolation from the central districts, and the worsening economic conditions because of the high levels of unemployment there (PCBS 2005). By contrast, the Central West Bank has the best socioeconomic conditions in comparison to other Palestinian regions; and it has also been affected by closures and military incursions, and isolation, but to a lesser extent than the North (World Bank 2007; OCHA 2008). What makes this more striking is that the Gaza Strip respondents reported better life quality indicators than the Central West Bank, while the fieldwork for this study was conducted at a time of high levels of factional violence, dwindling economic conditions, and increased closure in the Gaza Strip.

A general overview of the characteristics of the women in each of these regions may help in the further interpretation of the findings. The data indicates that women in the Center had, on average, fewer children (followed by the North West Bank, the Gaza Strip, and the South West Bank). The Center had the lowest crowding levels (followed by the North West Bank, the South West Bank and the Gaza Strip) as well as the highest average years of education (followed by North WB, Gaza Strip, and South WB) and the highest number amenities (followed by North WB, Gaza Strip, and South WB). Women in the Gaza Strip were the most likely to have wanted to be pregnant at the time that they found out they were pregnant (followed by Central WB, South WB, and the North WB).

This overview provides us a possible clue as to why the North ranks better than the South West Bank and the Gaza Strip, given that the North ranks better in living conditions, education, and a lower number of children. What remains to be understood is the unexpectedly low ranking of the Central West Bank.

Quality of life instruments, like this one, are highly dependent on individuals' stated satisfaction and perception of well-being. Satisfaction is a highly subjective concept and is often measured in relation to people's expectations, preferences, desires, capabilities, and their actual living conditions. The point of reference that people use to determine their degree of satisfaction is relative and may not necessarily reflect actual conditions (Sen 1999). The literature has shown that what people consider to be satisfactory varies, and can be determined by ethnicity, education, socio-economic status, etc (Lazarus 1994; Sen 1999, Mataria et al 2006). Lazarus (1994) has shown that class and education play a role in determining what women want and expect in their

experience of medical care during pregnancy and childbirth. Women with better socioeconomic status and higher levels of education had expectations that constituted higher levels of control, choice, and a more elaborate conception of quality medical care, reflecting higher exposure to choices; while poorer women's preferences required less of the health provider, given limited choices and exposure to the notion of choice. So, if women in the lower socioeconomic class group were provided with care that met their stated preferences, we would expect them to be satisfied. Whereas if the same care was provided to women in the higher socioeconomic group, which had higher expectations, their degree of satisfaction would be lower than that of the former because it would not be up to par with their desires and expectations. The health provider would be expected to provide the women with better socioeconomic status and higher levels of education with more in terms of quality care for them to reach similar levels of satisfaction.

If we broaden this framework and include it in the analysis of regional variations in perceived life-quality, the reasons for what seems to be an illogical finding may be better elucidated. The regions of the occupied Palestinian territory can be very different in terms of the behaviors and preferences of their residents (Johnson 2006). They are also very different in terms of their exposure to the outside world and consequently other modes of living (Taraki and Giacaman 2006). In their study of the populations of three main West Bank towns, Taraki and Giacaman (2006) have noted that the populations of these towns differ in their acceptance of 'the given-ness of things' and their perceptions of the possibilities available. The three West Bank towns in question are Ramallah, Hebron, and Nablus. Ramallah has become of central importance to the Palestinian Authority controlled West Bank, especially after the implementation of

stricter restrictions that have denied most West Bank residents access to Jerusalem (Ramallah and Jerusalem residents actually constitute slightly over 86% of the Central West Bank study sample). Hebron is the largest town in the West Bank and the main urban setting in the South West Bank (about 80% of the South West Bank population in this study reside in the Hebron district), while Nablus is the largest city and cultural center in the North West Bank. While the study sample is not restricted to these three cities, their characteristics can help provide a partial explanation for the variations between the North, Central, and South West Bank in terms of perceived life quality. Also, some characteristics of Ramallah may be similar to Jerusalem with respect to exposure and the level of 'modernity', although variations between the two cities do exist.

The study indicated that Ramallah represents a more 'modern' urbanity in terms of mode of production, average age at first marriage, family size, women's employment outside the home, and the degree of freedom allowed to its residents. Hebron stands as the least 'modern', while Nablus is somewhere in between. Ramallah has also been the most influenced by exposure to the non-Arab world, emigration, and more 'modern' lifestyles. Residents of Ramallah tend to be better educated; emphasize education more for their children; and have a stronger history of emigration to and higher education in non-Arab countries, particularly the US. This has meant that residents of Ramallah are generally more exposed to different lifestyle patterns, whereas Nablus and Hebron are more similar in terms of exposure. So in Ramallah, although living conditions are generally better, people's preferences are different and often compared to non-local conditions. So it may be that Ramallawis' inability to translate what they see and desire, as a result of exposure, into reality on the ground has resulted in a less positive

perception of their own life quality. This may also be true for the residents of Jerusalem who are more exposed to the lives of Israeli Jews, who tend to live more comfortable lives and have been shown to be at an advantage in terms of livelihood, opportunity, life quality, and health status when compared to their Palestinian counterparts residing in Jerusalem and Israel proper (Baron-Epel et al 2005; Kaminker 1997; Zureik 1998; Mataria et al 2008).

In a study of quality of life in Palestine (Giacaman et al 2007), the authors noted that a participant of a focus group discussion in the West Bank had a positive view of his quality of life because he was using the conditions in the Gaza Strip as a point of reference. But if the point of reference was Tel Aviv or the US, his perception of his quality of life is likely to be different, although his actual living conditions are the same. As Amartya Sen has noted:

> *"A hopeless destitute with much poverty, or a downtrodden laborer living under exploitative economic arrangements, or a subjugated housewife in a society with entrenched gender inequality, or a tyrannized citizen under brutal authoritarianism, may come to terms with her deprivation. She may take whatever pleasure she can from small achievements, and adjust her desires to take note of feasibility (thereby helping the fulfillment of her adjusted desires). But her success in such adjustment would not make her deprivation go away. The metric of pleasure or desire may sometimes be quite inadequate in reflecting the extent of a person's substantive deprivation."* (Sen 1999, p.358)

This may provide a possible explanation for why life satisfaction in the Gaza Strip is not as low as would be expected given a situation characterized by extreme deprivation, spiraling poverty and unemployment, chronic political violence, a deteriorating humanitarian situation, and almost complete isolation (Amnesty International et al 2008). While the living conditions in the Gaza Strip have been consistently worse than the West Bank, a Palestinian study of life quality conducted at the end of 2005 (Mataria et al 2008) indicated that Gaza Strip residents had higher quality of life scores. In the

case of Gaza, it may be that under impoverishment conditions, women in the Gaza Strip have adapted their expectations and consequently, their ability to 'desire' and express their satisfaction in an adequate manner is limited (Sen 1999; Mataria et al 2006). It may also be that motherhood has mediated the effects of conflict and deprivation by providing women with a source of 'joy' (Kamal 2006; also reported by women in the qualitative portion of this study) and validation in a culture that values children and often defines women in terms of their role as mothers and wives (Khawaja 2000; Fargues 2000; Oweis, Abushaikha 2004; and Joseph 1993). Further study is required to understand the regional variations in preferences and quality of life scores.

6.1.1 Scale Scores:

The scales are based on questions added to the questionnaire following the analysis of the focus group discussions and were found to be consistent with the literature (Hill, Aldag 2007; Ruchala, James 1997; Moran et al 1997; Wilkins 2005; Gjerdingen, Center 2003; DiMatteo, Kahn, Berry 1993) in terms of the needs of postpartum women as well as the strains that affect women during the postpartum. The questions were related to economic, childcare, medical, spousal, as well as social dimensions of the postpartum. The scale scores represent the number of items on each scale that a woman reported being dissatisfied with. The scores range from a minimum of 0 to a maximum of 4-6 (depending on the number of items on each scale). The scales that women reported the highest rates of satisfaction on were the Childcare Characteristics scale (83.1% satisfied) and the Information scale (81.2% satisfied). The scales with the highest rates of dissatisfaction were the Husband Employment Scale (54.1% dissatisfied with at least one item) and the Husband Characteristics scale (51.5% dissatisfied with at least one item). For the purpose of the statistical analyses, the scale scores were entered as

determinants of postpartum life quality. In the bi-variate analysis, the scale scores were found to be significant for all domains. In the regression analysis, all the scale scores were found to be significant for at least some of the quality of life domains and all were significant for the overall life quality domain. The entry of the scale scores into the regression analysis had a dramatic effect on the R^2 value; for example for the overall quality of life domain the R^2 value jumped from 0.126 prior to the addition of the scale scores to 0.502 after their inclusion. Aside from the obvious impact the scale scores have on postpartum quality of life scores, the dramatic increase in the R^2 value raise some questions on whether the variables in the scales should continue to be treated as independent determinants of postpartum quality of life or whether they would fit as part of a more culturally specific postpartum quality of life tool. Further research and analysis needs to be conducted in order to determine where these variables best fit.

6.2. Support Preferences:

The support preferences reported by the women in this sample seem to be fairly consistent with the qualitative findings of this study as well as some findings from the literature. In the focus group discussions, many women mentioned emotional support as an important and often unmet need during the postpartum period (it is important to note here that emotional support was often referred to as social support). The literature has shown that women value emotional support and encouragement in the postpartum period and transition to motherhood (Wilkins 2006; Warren PL 2005). Various studies have also shown that women who were not supported emotionally were more likely to exhibit signs of postpartum depression and distress (Rodrigues et al 2003; Hung and Chung 2001).

Medical and financial support followed in perceived importance. This is understandable since they symbolize more practical dimensions of physical wellbeing, the provision of sustenance, and the ability to cope with the physical and material demands of childcare. Social support, which was defined as not being alone in the questionnaire, followed. The greater preference of emotional support compared to social support seems to indicate that women are more concerned with the quality and intimacy of the support provided rather than the mere presence and quantity of people around them. Perhaps social support, as elaborated in the focus group discussion, is perceived as overburdening for women during the sensitive postpartum period, in contrast to emotional support, which implies intimacy within family and care.

Unlike previous studies (Zadorozynj 2006) that found home-based practical support to be among women's more important support needs and have included it as a component in postpartum care packages; women in this study have indicated a relatively low preference for practical support. This was also similar to the qualitative findings where women were more likely to stress emotional wellbeing, adequate finances, and access to medical support when needed. Also, practical support was typically available, especially in the early postpartum period, so it may be that it was often not something left to be desired.

In terms of the non-medical support aspects, women indicated an overwhelming preference for the husband to be the primary support provider (to a lesser extent with practical support). The mother and other female relatives typically followed the husband in preference. This is also fairly consistent with the qualitative findings where women expressed preference for their husbands as the primary support providers; often

because, as they noted, “he is the one that stays.” This was also echoed in the HDIP study (December 2002), which also indicated that women wanted their husbands to play a bigger role in the postpartum period. The preference for husband support was least in the practical support category in both the qualitative and quantitative findings. Typically women focused more on emotional support from the husband and were less likely to expect their husbands to provide them with practical support. This may be due to the traditional perception that household work and childcare is something that is a female responsibility.

It should also be noted that the preference for the husband to be the primary provider of support is not necessarily indicative of the husband’s supportiveness. In the qualitative phase of this study, women often noted that while they preferred that their husbands be their primary source of support, the mother or mother in law usually played this role. Women noted that their husbands often didn’t know what to do; were not always available because of other obligations; or were unsupportive for other reasons. The relatively high rates of dissatisfaction on the Husband Characteristics scale may indicate a similar trend among women in this sample. This also seems to consistent with the literature concerning women from non-Western backgrounds where the findings have been indicative of an increasing, and often unmet, desire for husbands to play a bigger role in what has traditionally been viewed as a women’s domain (Khawaja and Habib 2007). Other studies have also noted the positive effects of spousal support on women’s psychosocial health (Rodrigues et al 2003; Liamputtong and Naksook 2003).

The overwhelming preference for physicians as providers of medical support is consistent with the increasing medicalization of the childbirth process in the developing world (Kabakian-Khasholian, Jurdi, and El-Kak 2006). It is also consistent with the utilization patterns of the women in this study where 90.4% of women that reported seeking care from a health professional during the postpartum reported going to a physician.

The low prevalence of midwife preference is similar to the qualitative findings where women rarely mentioned seeking care from a midwife. This raises concerns pertaining to maternal health provision and policy. In various parts of the world, midwives have proven to be important providers of effective quality maternal health care provision in normal maternity cases (Rana et al 2003; Mejia et al 1998). A physician-led maternal health care program may be in line with women's preferences, but if adopted would imply higher costs in return for questionable effectiveness. The low utilization and low preference for midwife-led care may be a result of low exposure; the belief, resulting from the medicalization of society, that physicians are more competent providers of maternal healthcare (Kabakian-Khasholian, Jurdi, and El-Kak 2006); or may be related to the poor working conditions that midwives are under in Palestine. Hassan's assessment (2006) of a government hospital in the West Bank revealed that midwives typically work under poor conditions, with very limited resources, and often spend their time carrying out tasks that should be completed by orderlies and medical secretaries. This has impeded on their ability to carry out their work in a proper manner and has reduced the quality of midwifery care. Women's low preference for midwives may be due their exposure to midwifery care under substandard conditions. Any attempt at

reorientation of women's preferences and service provision will have to take into account the systemic impediments that pose obstacles to quality care.

Chapter 7 CONCLUSIONS:

This study has utilized both qualitative and quantitative methods in order to gain deeper insight into how women experience the postpartum in the oPt. The women in this study are similar to other women in their experiences during the postpartum, especially in the challenges of childcare and the physical stress associated with the postpartum.

It is evident from the experiences of these women that women's social networks play a prominent role in the postpartum period, particularly mothers and mother in laws. Most of the women in the study indicated receiving some support, although there were some disparities between poorer women and women living away from their families. Younger couples' continued moving away from their families may change the dynamics of the social support network further; this change may require greater input and restructuring of the health system in order to cover the support gap in such cases. Or it may increase the need for husbands to play a bigger role in supporting their wives during the postpartum. The preference for husbands as the primary (non-medical) support providers has also been echoed in the quantitative results. Programs and interventions focused on enhancing the role of husbands in postpartum care and support may be worthwhile to look into as a way to enhance women's postpartum well-being.

The long-term effects of women's delivery experiences also call for a reevaluation of the maternity health system. Although the qualitative sample is not representative, the experiences reported by some women call for further investigations of the care provided to Palestinian women during childbirth. Further research is also needed in understanding the low preference and utilization of midwife provided care.

The quantitative results have also highlighted the important role of district and pregnancy wanted-ness in postpartum quality of life, calling for more in depth research to understand the true nature of the variations by district. The role of pregnancy wanted-ness in determining quality of life scores indicates that further research is also required to understand the nature of pregnancy wanted-ness in the oPt in order to institute more effective family planning services that better serve the needs of Palestinian women.

The dramatic change in the percentage of variance explained in the regression analysis with the addition of the scale scores indicates that while the MAPP-QOL instrument may be a good starting point for assessing postpartum life quality; further analysis is required to determine the comprehensiveness of the instrument and the fit of the added questions in a more culturally relevant instrument. Further inquiry is required to determine whether the variables included in the scales should be part of the construct or if they should remain as determinants of quality of life during the postpartum period.

Chapter 8 LIMITATIONS OF THE STUDY:

Several limitations need to be taken into account in this study. Similar to other cross-sectional studies, this study can only draw on associations. The results of this study should not be used to induce causation. There are two main sources of potential bias in the sample. The sampling frame for this study is based on a 2003 update of the 1997 Palestinian census sampling frame. It is likely that geographic distribution of the population has changed, although the extent of this change is unknown. There is also a potential non-response bias, although it is important to note that the non-respondents are similar to the participants in this study in terms of geographic distribution and demographic characteristics and the response rate for this study is relatively high at about 88%.

Another important limitation of this study is the lack of information available on the participants' mode of delivery; the child's health; and whether they went through any complications during delivery and the postpartum. These factors might be important in explaining some of the variation in quality of life scores. Finally, in this study, equal weights were given to all of the postpartum quality of life items. This limits our ability to fully assess each individual's perception of her life quality during the postpartum.

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Chapter 10 ANNEXES:

10.1.Focus Group Guide:

مجموعات نقاش مصغرة حول موضوع: الرضى عن الحياة عند النساء في مرحلة ما بعد الولادة
أسئلة للتعمق في النقاش

تعريف على فريق المعهد وهدف اللقاء:
إحنا ..... من معهد الصحة العامة والمجتمعية التابع لجامعة بيرزيت، عمّالنا بنعمل دراسة عن رضى الأمهات عن حياتهم في مرحلة ما بعد الولادة وطبيعة الدعم/المساندة إلّي بتحصل عليها الأم في هذه المرحلة. وعشان نقدر نقوم بهذه الدراسة ونختار أسئلة مناسبة حابين نسمع منكم عن تجاربكم في هذه المرحلة ونتعلم من خبرتكم.

إحنا عمّالنا بنجتمع مع مجموعات نسائية ثانية كمان في ..... عشان نتعرف على وجهات نظر مختلفة ونقارنها مع بعض.
راح نقضي حوالي ساعة ونصف لساعتين معاكم.

التعرف على المشاركات

- الاسم
- العمر
- العمر عند الزواج
- عاملة (طبيعة العمل) أم ربة منزل
- المستوى التعليمي
- عدد وعمر وجنس الأطفال

الاتفاق على قوانين عامة

الطلب من المشاركات وضع قوانين جلسة أو اقتراح بعض القوانين عليهم مثل:
- احترام آراء بعضنا البعض – لا يوجد إجابة صحيحة أو خاطئة
- إعطاء المجال للجميع بالتحدث ولكن دون إجبار أحد على التحدث
- احترام سرية المعلومات والمجموعة
- إغلاق الهواتف النقالة

جزء 1: تعريف مرحلة ما بعد الولادة

1. ما هو المصطلح الذي تستخدموه لوصف المرحلة بعد ولادة الأم؟ (قد يقولوا نفاس، نفسة،..... وندخل بالموضوع انطلاقاً من المصطلح الذي يستخدموه)
2. ما هي برأيكم مرحلة ما بعد الولادة؟ وصف لها؟
3. كم من الوقت تستمر هذه المرحلة؟
4. لماذا تعتقدون أن هذه الفترة مهمة؟

جزء 2: الرضى عن الحياة:

1. كيف كان رضاكم عن حياتكم في مرحلة ما بعد الولادة؟
2. لو بدكم تعطوا لنفسكم علامة من صفر – 10، عن رضاكم عن حياتكم في هذه الفترة، ما هي العلامة التي تعطوها لنفسكم؟

3. لماذا أعطيتم نفسكم هذه العلامة؟ ما هي الأمور التي جعلتك تعطي نفسك هذه العلامة؟

جزء 3: توقع مرحلة ما بعد الولادة والحقيقة:

1. كيف كنت تتوقعين مرحلة ما بعد الولادة وماذا حصل في الواقع؟

جزء 4: أكبر مشكلة واجهتكم

1. ما هي أكبر مشكلة واجهتكم في مرحلة ما بعد الولادة؟
2. لماذا حصلت؟
3. كيف تم حلها؟
4. إن لم تحل، لماذا لم تحل؟
5. ما نتيجة عدم حلها؟
6. في أي شهر من هذه المرحلة حصلت هذه المشكلة؟
7. أي فترة من هذه المرحلة هي الأصعب؟

جزء 5: التجربة الشخصية لكمية وطبيعة الدعم/المساندة في مرحلة ما بعد الولادة

1. هل شعرتم بعد فترة الولادة أنكم حصلتم على الدعم/المساندة الكافية؟ هل كنتم راضيين عن المساندة التي تلقيتموها؟
2. ما هو هذا الدعم/المساندة؟

بشكل عام ولماذا (الاستفسار بتعمق هنا والسؤال عن النواحي التالية إن لم تُذكر)

1. ما هو هذا الدعم/المساندة من ناحية **اجتماعية؟**
2. ما هو هذا الدعم/المساندة من ناحية **نفسية؟**
3. ما هو هذا الدعم/المساندة من ناحية **طبية ؟**
4. ما هو هذا الدعم/المساندة من ناحية **مادية؟ هل كان في أكل وشرب ولبس كافي؟**
5. إن كانت الإجابة لا، لماذا لم تحصلوا على الدعم/المساندة؟
6. ما هو أهم دعم/مساندة باعتقادكم للمرأة في مرحلة ما بعد الولادة؟

جزء 6: أفضل ناس يقدمون الدعم/المساندة ولماذا؟

1. من باعتقادك أفضل ناس يمكنهم تقديم هذا الدعم/المساندة؟ **بشكل عام ولماذا؟**
2. من باعتقادك أفضل ناس يمكنهم تقديم هذا الدعم/المساندة من ناحية **اجتماعية ونفسية وطبية ومادية؟ ولماذا؟**
3. من تمنيتم أن يكون بجانبكم أكثر شيء في هذه المرحلة؟ **ولماذا؟**

جزء 7: توفر الدعم/المساندة وارتباطه بالقدرة على رعاية الطفل

1. كيف تؤثر المساندة على قدرتك على رعاية طفلك (ديرة بال)؟
2. ما هي الأمور الأخرى غير "المساندة" التي تؤثر على قدرتك في رعاية طفلك؟ كيف تؤثر عليك إيجابياً وسلبياً؟

جزء 8: الرضى عن أكثر وأقل أمر في مرحلة ما بعد الولادة: (جولة دائرية للختام)

1. ما هو أكثر شيء كنتم راضيين عنه في مرحلة ما بعد الولادة؟
2. ما هو أقل شيء كنتم راضيين عنه في مرحلة ما بعد الولادة؟

نهاية وختام

- الشكر والاستفادة
- إبقاء الأبواب مفتوحة لاجتماعات قادمة ممكنة
- تقييم

10.2.MAPP-QOL Questionnaire:

Palestinian National Authority
Palestinian Central Bureau of Statistics

MAPPQoL Survey 2007

Birzeit University
Institute of Community and Public Health.

All information in this questionnaire is intended for pure statistical purposes and will not be used for any other purpose. All information included in this questionnaire is considered confidential and is protected by the Statistics Law for the year 2000.					
IDH00 – Serial questionnaire number in the sample: ☐☐☐☐			**IDH01** – District: ☐☐		
IDH02 – Agglomeration:_____ ☐☐☐☐☐☐			**IDH03 –** Enumeration area number in the agglomeration: ☐☐☐		
IDH04 – Questionnaire number in EA:_____ ☐☐			**IDH05 –** Building Address:_____		
IDH06 – Name of Head of Household: _____					
IDH07- date of interview (day, month, year)			**Day** ☐☐ **Month** ☐☐ **Year** ☐☐☐☐		
Interview register:					
- Visits schedule **IR01**			**Day**	**Month**	
					First visit
					Second visit
					Third visit
IR02 – total visits number:					
IR03 – Interview result: ☐			1	Completed	
			3	Household in travel	
			4	No body home	
			5	Refused to cooperate	
			6	No information is available	
			7	Woman Incapable of cooperating	
			96	Others (specify): _____	
IR04	number of males in the family	☐☐	**IR05**	Number of females in the family	☐☐
IR06	number of males (18yrs+) in the family	☐☐	**IR05**	Number of females (18yrs +) in the family	☐☐
IR08	**Fieldworker: .....** ☐☐☐☐		**IR09**	**Supervisor: .....** ☐☐☐☐	
IR10	**Name of auditor: .....** ☐☐☐☐		**IR11**	**Name of data entry person: .....** ☐☐☐☐	
IR12	**Coding: ……..** ☐☐☐☐		**IR 13**	**Date of Entry: ……** ☐☐☐☐	

HR02 **Name:** _____

HR01 Interviewee number: To the fieldworker (this number is from the attached document on the sample) ☐☐

WH000 Result of interview 1. Completed 2. Partially completed 3. Refused to participate 4.Other/specify: …….. ☐☐

WH01 What is your date of birth (Day/Month/Year)? **Day Month Year** ☐☐/☐☐/☐☐☐☐

WH02 To the fieldworker: calculate the age from the date of birth in H3 and register the answer in number of complete years. In case the date of birth is unknown, ask about the age and register it. Register (98) for "I do not know". ☐☐

WH03 What is the number of schooling years that you completed with success? To the fieldworker: Register (00) if the number of schooling years is less than 1 year; register (98) for "I do not know". ☐☐

WH04 What is your education status? ☐☐

01 Illiterate
02 Alphabetic
03 Primary school
04 Preparatory school
05 Secondary school
06 Diploma
07 Bachelor
08 High diploma
09 Masters
10 Ph.D.
99 I do not know

WH05 How many times have you been pregnant (including abortions)? *To the fieldworker: write down the number of pregnancies including the latest newborn.* Write down 99 if the newborn is the first child ☐☐

Record the age and sex of all living children born from oldest to youngest.

WH06 For the fieldworker: Record all children born living, in the case of a dead child, record age at death. For children younger than one year write 00

Birth Order	**Age in years completed**		**Sex 1. male 2.female**
WH061	**Name**	**WH062**	**WH063**
1.		☐☐	☐
2.		☐☐	☐
3.		☐☐	☐
4.		☐☐	☐
5.		☐☐	☐
6.		☐☐	☐
7.		☐☐	☐
8.		☐☐	☐
9.		☐☐	☐
10.		☐☐	☐
11.		☐☐	☐
12.		☐☐	☐
13.		☐☐	☐
14.		☐☐	☐
15.		☐☐	☐

WH064 What is date of birth of your last child: *To the field worker: record the date of birth in days, month, and year* **Day Month Year** ☐☐/☐☐/☐☐☐☐

WH07 Who is the primary breadwinner in the 1. Male → proceed to WH09 ☐☐

	family?	2. Female 3. Male and female have a share in family income 99. Don't know/unanswered →proceed to WH09
WH08	Are you the primary breadwinner in the family?	1. Yes 2. No 99. Don't know/unanswered ☐☐
WH09	Relationship to the workforce in general:	01 Working from 1-14 hours 02 Working 15 hours and more 03 Absent from work (looking for work but has not been able to find work) 04 Unemployed 05 Full-time student 06 Full-time housewife 07 Incapacitated, cannot work 08 Do not work and do not seek to work 09 Do not work and do not seek to work due to feeling hopeless from finding a work 10 Others/specify…….. (if the answers is 5-10, go to WH14) ☐☐
WH10	What type of work did you do, in details?	Main job: _____ Code: ☐☐☐
WH11	Have you returned to your work after delivery?	1. Yes 2. no 99. Don't know/unanswered →proceed to WH14 ☐☐
WH12	How many weeks after birth?	☐☐☐
WH13	If you have returned to work after birth, have you worked during the last week?	1. Yes 2. no 99. Don't know/unanswered ☐☐
WH14	Refugee status:	1. Registered refugee 2. Unregistered refugee 3. Non-refugee ☐
WH15	Do you have a health insurance?	1. Yes 2. no 99. Don't know/unanswered→ proceed to WH18 ☐
WH16	What is the insurance that you use the most?	1. MoH insurance 2. Military insurance 3. UNRWA insurance 4. Social Affaire/Elderly ins. 5. Intifada Al-Aqsa insurance 6. Private insurance 7. Israeli insurance 8. Outside the country insurance 99. Don't know/unanswered ☐☐
WH17	Is all your family covered by the insurance?	1. Yes 2. No 99. Don't know/unanswered ☐☐
WH18	Do you need to cross one or more Israeli checkpoint (to go to work, school, etc.)?	1. A lot 2. Sometimes 3. Rarely 4. Never 99. Don't know/unanswered ☐☐
WH19	Do you live close to the "Separation Wall"? (for WB residents only)	*To the field worker: for Gaza residents enter 88* 1. Yes, within 2. Yes, outside of the Wall 3. No (go to WH21) ☐☐
WH20	Specify distance in meters: _____	*To the field worker: for Gaza residents enter 88* ☐☐☐☐
WH21	Does the "Separation Wall" have a negative direct impact on you?	1. Yes 2. No 99. Don't know/unanswered ☐☐
WH22	Do you live close to an Israeli settlement?	1. Yes 2. No 99. Don't know/unanswered ☐☐

WH23	Does the Israeli Settlement have a negative direct impact on you?	1. Yes 2. no 99. Don't know/unanswered	☐☐
WH24	Did you loose (martyred, imprisoned, etc.) a relative (father, mother, brother, sister, husband, wife, son, daughter, uncle, aunt) due to the occupation?	1. Yes 2. No	☐
WH25	When you found out you were pregnant, did you:	1. Wanted to be pregnant at the time 2. Wanted to be pregnant at a later time (wanted to wait) 3. Didn't want to get pregnant at all 99. Don't know/unanswered	☐☐
WH26	Were you using any method of family planning when you found out you were pregnant?	1. Yes 2. No→ proceed to WH28	

WH27	What types of family planning methods were you using: 1. Yes 2. No 8. Don't know the method	1. Pills	☐☐
		2. IUD	☐☐
		3. Injections	☐☐
		4. Implants/norplants	☐☐
		5. Male condoms	☐☐
		6. Female condoms	☐☐
		7. Female diaphragm	☐☐
		8. Spermicide cream	☐☐
		9. Tying tubes	☐☐
		10. Vasectomy	☐☐
		11. Breastfeeding	☐☐
		12. Tracking menstrual cycle/ovulation	☐☐
		13. Vibration	☐☐
		14. Other/specify: ……	☐☐

WH28	Why didn't you use these methods? 1. Yes 2.No	1. I wanted to become pregnant	☐☐
		2.My husband wanted me to get pregnant	☐☐
		3.The family wanted me to get pregnant	☐☐
		4.My husband didn't want me to use or didn't want to use family planning methods	☐☐
		5.Could not access them due to distance of service providers	☐☐
		6.Could not access them due to checkpoints/closures/curfews	☐☐
		7.Could not access them due to cost	☐☐
		8.Other: specify: …….	☐☐

For the following questions, please select the choice that best describes your level of satisfaction with various areas of your life during your last postpartum period.
Please choose from the following:

1. Very Dissatisfied 2. Moderately Dissatisfied 3. Slightly Dissatisfied 4. Slightly Satisfied 5.Moderately Satisfied 6.Very Satisfied 88.Not Applicable

Part 1:
The following questions ask about your satisfaction with your physical status in general in the last postpartum period. How satisfied are you with:

Q01	Your health?	☐☐
Q02	The amount of pain that you have?	☐☐
Q03	Amount of energy for everyday activities?	☐☐
Q04	Amount of control you have over your life?	☐☐
Q05	Your ability to take care of yourself without help?	☐☐
Q06	Your physical appearance?	☐☐
Q07	Your breasts?	☐☐
Q08	Your surgical incision or episiotomy (stitches)?	☐☐
Q09	Your peace of mind (psychological wellbeing)?	☐☐
Q10	Your happiness in general?	☐☐
Q11	Your life in general?	☐☐
Q12	The amount of worries you have?	☐☐

Part 2:
The following questions ask about your satisfaction with your home, husband, and other children during the postpartum period. How satisfied are you with:

Q13	The emotional support you get from:	☐☐
	1. Your husband?	☐☐
	2. Your extended family?	☐☐
	3. Your friends or other people?	☐☐
Q14	Your relationship with your husband/partner?	☐☐
Q15	Your ability to meet family responsibilities?	☐☐
Q16	Your baby's health?	☐☐
Q17	The assistance with baby care and other children?	☐☐
Q18	Time for children?	☐☐
Q19	Time for maintaining the household?	☐☐
Q20	Time for friends/relatives?	☐☐
Q21	Time for husband?	☐☐
Q22	Time for yourself?	☐☐
Q23	Your ability to feed your new baby?	☐☐
Q24	Your husband's health?	☐☐
Q25	Your daily life routine?	☐☐
Q26	Your home/place you live in?	☐☐
Q27	Your neighborhood?	☐☐
Q28	Your (household's) financial independence?	☐☐
Q29	Your ability to meet financial obligations?	☐☐
Q30	Your access to medical care?	☐☐
Q31	Your access to transportation?	☐☐
Q32	Your living conditions in your home?	☐☐
	1. Your materialistic possessions?	☐☐
	2. Your economic or financial capacity?	☐☐
	3. Your overall (home) environment/surroundings? (no yelling, fights, squabbles)	☐☐
Q33	Your husband's employment?	☐☐
Q34	Your employment (regardless of whether in the home or for pay)	☐☐

Part 2
The following questions ask about your satisfaction with various areas in your life. Some of the questions may be repeated because we would like to obtain some additional information and answers to all the questions. How satisfied are you with:

1. Very Dissatisfied 2. Moderately Dissatisfied 3. Slightly Dissatisfied 4. Slightly Satisfied 5.Moderately Satisfied 6.Very Satisfied 88.Not Applicable

Q35	Your ability to move within your house?	☐☐
Q36	Your ability to go out of the house?	
	1. As a result of your physical health	☐☐
	2. As a result of the political situation	☐☐
Q37	Your ability to concentrate/think clearly?	☐☐
Q38	Your psychological well-being?	☐☐

The following questions concern your satisfaction with various areas related to your family and child. How satisfied are you with:

Q39	Your relationship with:	
	1. Your family?	☐☐
	2. Your in-laws?	☐☐
	3. Your other children?	☐☐
Q40	The sex distribution of your children?	☐☐
Q41	The spacing between your children?	☐☐
Q42	Your baby's temperament? *(to the fieldworker: ask about the last child, if he/she is dead record 88)*	☐☐
Q43	Your baby's growth? *(to the fieldworker: ask about the last child, if he/she is dead record 88)*	☐☐
Q44	The sex of your baby? *(to the fieldworker: ask about the last child, if he/she is dead record 88)*	☐☐
Q45	Your ability to breastfeed?	☐☐
Q46	Your capacity to breastfeed given other family responsibilities?	☐☐
Q47	Your ability to care for the child?	☐☐
Q48	Your ability to identify the child's needs/cries?	☐☐
Q49	Your ability to adapt to motherhood?	☐☐
Q50	Your experience of motherhood?	☐☐
Q51	The extent of your emotional bond with your child?	☐☐
Q52	Ability to provide for the child?	☐☐
Q53	Ability to give the child an education in the future?	☐☐
Q54	Your child's prospects for the future?	☐☐
Q55	The environment in which your child will be raised?	☐☐

The following questions ask about your satisfaction with areas that have to do with your husband. How satisfied are you with:

Q56	The amount of help you received from your husband with childcare?	☐☐
Q57	The amount of help you received from your husband with household chores?	☐☐
Q58	Your husband's psychological status?	☐☐
Q59	Your husband's temper?	☐☐
Q60	Your husband's behavior?	

1. Jealousy (in relation to the newborn) ☐☐
2. Violence ☐☐
3. Selfishness ☐☐
4. Leaving you alone ☐☐
5. Other, specify: ☐☐

The following questions concern your satisfaction with factors related to your home.

Q61 The amount of space in your home? ☐☐

Q62 The environment surrounding your home? ☐☐

The following questions are related to you and your husband's work. How satisfied are you with:

1. Very Dissatisfied 2. Moderately Dissatisfied 3. Slightly Dissatisfied 4. Slightly Satisfied 5.Moderately Satisfied 6.Very Satisfied 88.Not Applicable

Q63 Husband's Employment/work:

1. The stability of your husband's employment? ☐☐
2. Your husband's work hours? ☐☐
3. Your husband's pay? ☐☐
4. The timeliness of pay? ☐☐
5. Your husband's type of work? ☐☐

Q64 Your Employment/work:

1. The stability of your employment? ☐☐
2. Your work hours? ☐☐
3. Your pay? ☐☐
4. The timeliness of pay? ☐☐
5. Your type of work? ☐☐
6. Your ability to accommodate the baby with work? ☐☐
7. The amount of support you received in the workplace as a new mother? ☐☐

The following Questions ask about your satisfaction with your last childbirth experience. How satisfied are your with:

Q70 Your childbirth experience? ☐☐

Q71 The quality of medical care you received during childbirth? ☐☐

Q72 The quality of medical care you received in the postnatal period? ☐☐

Q73 The quality of medical care your child received in the postnatal period? ☐☐

Q74 The medical assistance provided to your child during the postnatal period? ☐☐

Q75 The medical assistance provided to you during the postnatal period? ☐☐

Q76 The information you had in general during the postpartum period on: pregnancy, your health, the health of your baby, regardless of the source of information. ☐☐

Q77 The amount of time your medical provider spent with you in the immediate postnatal period?

1. Doctor ☐☐
2. Midwife ☐☐
3. Nurse ☐☐

Q78 The amount of time your medical provider spent with you throughout the course of the postpartum period: ☐☐

1. Doctor

2. Midwife
3. Nurse

Q79 The way you were treated by the medical provider in the postnatal period?
1. Doctor
2. Midwife
3. Nurse

Q80 The information you have on childrearing?

Q81 The information you have on child development (movement, talking, etc)?

Q82 The information you have on child growth and nutrition?

Q83 The information you have on your own personal care?

Q84 Interventions from people around you?

Q85 Comments from people around you?

Q86 The amount of visits from people?

Q87 Your ability to make decisions regarding childcare?

Q88 Your ability to make decisions regarding your personal care?

Q89 Your ability to choose your medical provider?

The following questions ask about your satisfaction with the support that you received during the postpartum period. How satisfied are you with:

Q90 The amount of support you received in general?

Q91 The duration of support you received in general?

Q92 The social support you received?

Q93 The practical support you received?

Q94 The financial support you received?

Q95 The psychological/emotional support you received?

The following questions ask about your satisfaction with the support you received from certain people in your life during the last postpartum period. How satisfied are you with:

Q96 The emotional support you received from:
1. Husband
2. Your mother?
3. Your mother in law?
4. Your sister(s)?
5. Other family members?
6. Your friends or other people around you?

Q97 The social support you received from:
1. Husband
2. Your mother?
3. Your mother in law?
4. Your sister(s)?
5. Other family members?
6. Your friends or other people around you?

Q98 The practical support you received from:
1. Husband
2. Your mother?

3. Your mother in law? ☐☐
4. Your sister(s)? ☐☐
5. Other family members? ☐☐
6. Your friends or other people around you? ☐☐

Q100	Did you see a doctor during your last pregnancy?	1. Yes 2. No	☐☐
Q101	Did you see a midwife during your last pregnancy?	1. Yes 2. No	☐☐
Q102	Did you see a nurse during your last pregnancy?	1. Yes 2. No	☐☐
Q103	Did you see a doctor for your personal health during your last postpartum period?	1. Yes 2. No	☐☐
Q104	Did you see a midwife for your personal health during your last postpartum period?	1. Yes 2. No	☐☐
Q105	Did you see a nurse for your personal health during your last postpartum period?	1. Yes 2. No	☐☐
Q106	Did you see a doctor for your child's health during your last postpartum period?	1. Yes 2. No	☐☐
Q107	Did you see a midwife for your child's health during your last postpartum period?	1. Yes 2. No	☐☐
Q108	Did you see a nurse for your child's health during your last postpartum period?	1. Yes 2. No	☐☐

Q109 Which of the following individuals would you prefer to provide you with the difference types of support?

1. social support (feeling that you're not alone)	1. Mother 2. Mother in law 3. Husband 4.Sister 5. Sister in law 6. Friends 7. Other/specify_____	☐
2. medical support	1. Physician 2. Nurse 3. Midwife 4. Mother 5. Mother in law 6. Older women 7.Other/specify_____	☐
3. material/financial support	1. Husband 2.Myself 3.My family 4. Husband's family 5. No one 6. Other/specify_____	☐
4. emotional/psychological support	1. Mother 2. Mother in law 3. husband 4.Sister 5. Sister in law 6. Friends 7. Other/specify_____	☐
5. practical support (in the household, childcare (last and other children)	1. Mother 2. Mother in law 3. Husband 4.Sister 5. Sister in law 6. Friends 7. Other/specify_____	☐

Q110 Give a number from 1-5 for each type of support based on the following
1=most important/5=least important
Put in order according to importance

1. Social support ☐
2. Medical support ☐
3. Material/financial support ☐
4. Emotional/psychological support ☐
5. Practical support ☐

Q111	What is the most difficult period during the postpartum?	1. First week 2. First month 3. First 3 months 4. First 6 months 5. First year 6. No difficulty 88. not applicable	☐☐
Q112	How satisfied are you with your sex life?	1=very dissatisfied, 2=moderately dissatisfied, 3=slightly dissatisfied, 4=slightly satisfied, 5=moderately satisfied, 6=very satisfied 99. don't want to answer	☐☐

The following questions concern the individuaks that provide advice during the last postpartum period and your satisfaction with the advice you received from them.

(you can choose more than one answer for questions: Q200 + Q201 to indicate the person providing the advice (from a-i) and writing down the appropriate number between 1-6 in the box underneath the name of the individual to indicate the extent of your satisfaction with that advice)

1. Very dissatisfied 2. Moderately Dissatisfied 3. Slightly dissatisfied 4. Slightly Satisfied 5.Moderately satisfied 6. Very satisfied 88.not applicable

		a.Doctor	*b.Midwife*	*c.Nurse*	*d.Mother*	*e.Mother in law*	*f.Sister*	*g.Friend*	*h.Book*	*i.Other /specify*
Q200	Who do you go to for advice on personal care in the postpartum?	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
Q201	Who do you go to for advice on child care in the postpartum?	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐

Choose 3 individuals that you prefer to provide you with advice and write down a number from 1-3(where 1=most preferred and 3=least preferred) underneath the name of the individual

		a.Doctor	*b.Midwife*	*c.Nurse*	*d.Mother*	*e.Mother in law*	*f.Sister*	*g.Friend*	*h.Book*	*i.Other /specify*
Q202	Who do you prefer to go to for advice on personal care in the postpartum?	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐
Q203	Who do you prefer to go to for advice on child care in the postpartum?	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐	☐☐