

Fall 2019

## Examining Women's Perceptions of Maternity Care in Public and Private Sectors of National Guard Hospitals in Saudi Arabia: A Qualitative Study

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EXAMINING WOMEN’S PERCEPTIONS OF MATERNITY CARE IN PUBLIC AND  
PRIVATE SECTORS OF NATIONAL GUARD HOSPITALS IN SAUDI ARABIA: A  
QUALITATIVE STUDY

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Submitted in Partial Fulfillment of the Requirements

For the Degree of Doctor of Philosophy in

Health Services Policy and Management

The Norman J. Arnold School of Public Health

University of South Carolina

2019

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## DEDICATION

I dedicate this work to two beautiful ladies. Zainab Shareef believed that I would be a doctor. Roqayah Ibraheem would be very proud of me for being one. Rest in peace, my grandmothers.

## ACKNOWLEDGEMENTS

This work would not be accomplished without the financial support of my beloved country, Saudi Arabia. This financial support helped me focus only on my study and not to have to worry about my living expenses.

I am grateful to have a great mentor and advisor, Dr. Melanie Cozad. She is a mentor that helped me from the very beginning of this work until the end. I am so thankful for her help and support. She showed me, by her example, what a great mentor should be. Furthermore, I am so thankful for having such great committee members, Dr. Jan Ostermann, Dr. Kelli Kenison, and Dr. Mark Macaуда, who provided me with professional guidance and supported my project.

Special thanks to Dr. Raneem Almahmoud, Dr. Hadeel Almahmoud, Dr. Taghreed Shams, Abeer Atabani, Anna Nourse and Alicia Oostdyk for helping me throughout this project.

Finally, but above all, my deepest thanks to my ultimate role model, my mother, Zain Basheer, and my dear father, Dr. Mahmoud Almahmoud. Without their support, prayers, and love, I couldn't pursue my dream. Special thanks to my beloved husband, Haitham Hijazi, for his unconditional love, support, and patience. No words can be enough to thank my three champions, Hussain, Eilan, and Marwan for their unlimited inspiration. Most importantly, unlimited thanks to Almighty for his guidance, help, support, and mercy, Thank you Allah for everything.

## ABSTRACT

Every second, a baby is born. The process of birth is a complex one – biologically, medically, and emotionally. In particular, women in labor need both physical and emotional care. They need to be heard, to be comforted, and to be safe.

Women’s satisfaction can be used as a legitimate way to measure the quality of maternity care. Moreover, when health systems practice patient-centered care and listen to women’s concerns and what they want out of their care, it can lead to improvements in their satisfaction. Hospitals in Saudi Arabia are considered to be among the best and most technologically advanced in the world. However, the quality of care in terms of how women are cared for is an issue, especially in the public sector. Therefore, to improve the quality of care, Saudi Arabia is planning to privatize the public sector, which comprises 60% of the services.

This study was designed to provide baseline information regarding how satisfied women are with their maternity care and garner their perspectives on how patient-centered care should be practiced. Specifically, it compares women’s satisfaction in the public and the private sectors in two of the National Guards hospitals in two cities (Jeddah and Riyadh) in Saudi Arabia. These hospitals are considered to be among the best in the kingdom. The quality of care in these governmental hospitals is high compared to other public hospitals. This dissertation also examined and compared women’s knowledge and willingness to contribute to patient-centered care during labor and delivery. This study shows that private

patients tend to be more satisfied with their care compared to public patients, especially regarding privacy and dealing with nurses. Moreover, private patients tend to know more about their health rights and contributed more into their care process with their health providers.

These findings serve as a baseline for health administrators, managers, and policymakers to consider as the transition to privatization begins. Stakeholders should focus on Key aspects to improve patients satisfaction. They should focus on improving patients' privacy, health providers' bedside manners, and women's health rights education within the public and the private sector. These improvements should take place while maintaining the doctors' and the hospitals' reputations for the high quality of services.

## PREFACE

My research will enhance Saudi understanding of maternity care and improve Saudi's perceptions of their health care. It will provide health systems a road map for being able to improve the delivery of care as they undertake privatization through Vision 2030. By improving the delivery of care, it will result in healthier and happier mothers.

This research is about women's satisfaction and patient centric care in public and private sectors in Saudi Arabia. In this research, we are comparing women perceptions of maternity care between the public and private sectors in two hospitals in Saudi Arabia. This research is focused on women's satisfaction, their understanding of patient-centered care, and their willingness to participate in their care.

As a Middle Eastern woman, my mission is to translate evidence from my study into structural and policy changes in Saudi Arabian hospitals, particularly in order to empower Saudi, Middle Eastern, and women around the world. My goal is to help women get to know their rights and to enable them to participate in their own health decision making. Women deserve to feel satisfied and included in their health decisions worldwide, because women's satisfaction matters.



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# CHAPTER 1

## INTRODUCTION

### 1. Background and Significance:

#### 1.1 Saudi Arabia's Health Care System and Health Expenditures:

The Kingdom of Saudi Arabia is located in the continent of Asia. It is the second largest Arabian Country. It has a population of 33 million individuals, 20 million of which are Saudi nationals, and 48 percent are female (Saudi Arabia Population, 2018). Saudi Arabia is one of the major economic forces in the world due to oil, “the black gold”, that was discovered under its sands in 1933 (Almalki, 2010). Saudi Arabia is a member of the G-20 members (countries) that their economies account for 90% of the gross world product (GWP) (G-20,2014). It is considered a high-income developing country with similar modern lifestyles as developed countries (Alhanawi,2018). The largest current financial resource in Saudi Arabia is the revenue from oil. However, economists forecast that this revenue will only last for approximately another 84 years (Alhanawi,2018 ). The drain on oil revenues comes from the current war in Yemen and decreasing prices of oil in the international market (Alharbi,2018). Another major economic issue is females' work restrictions. Although 60% of college students in Saudi Arabia are female, “women constitute a very slim minority of the labor force” (Perez, 2014). According to World Bank, only 22% of the females in Saudi Arabia are in the work force (2016). Women, before

2015,were allowed to work only in teaching and healthcare due to the custom of a conservative culture ( Burton,2018).

Saudi Arabia was ranked 141 out of 144 countries, the third place from the bottom, for gender equality in The Global Gender Gap 2016 Report, which was published in the World Economic Forum in 2016 ( World Economic Forum, 2016). The ranking improved to be the 135 out of 141 in 2018 perhaps due to the recently rights which women have earned in 2017 (World Economic Forum, 2016,2018). The Saudi government wants to empower women to rectify this issue, and in turn, by empowering women, hopes that they will continue to support gains in the economy through increased participation in the labor market. Since 2013, Saudi women have slowly gained back some of their rights, and in 2017 they have fully gained all of their rights inside the kingdom under the reign of King Salman (Burton,2018). These rights include attendance and participation in sports and entertainment events, and enable them to benefit from government services. In addition, these rights grant women their autonomy in regard to health care decisions (Burton, 2018) (2030 Vision,2018). In August the first 2019, the government gave women back their complete freedom and got rid of the Guardianship law. Women now are considered to be guardians for their children , just like the fathers. (Okath, 2019).

According to World Health Organization officials, the Saudi health-care system has hospitals that are on par with developing countries (WHO,2018). Yet, these hospitals face an increasing demand for services which will put pressure on their ability to continue delivering the same level of quality of care. This increase in demand comes from the fact that education and health services are rights for all Saudi, and the population is experiencing exponential growth. This growth comes from the rise in birth rates in Saudi

Arabia (23.7 per 1000 population), increasing life expectancy (72.5 years for men and 74.7 years for women), and decreasing mortality rates among infants and children (WHO,2018).

Healthcare systems within Saudi Arabia are already facing challenges in their delivery of care. The Saudi healthcare system is ranked 26th among 191 countries around the globe when it comes to efficiency (Tandon, 2017). Yet, the public sector of care in Saudi Arabia suffers from inefficiency and low quality of care due to citizens demanding health services when they do not need them, and/or citizens demanding duplicate services from different hospitals. People do that because services and medications are free and available to all citizens. These people usually are seeking medications from different hospitals (Almalki,2010). This morally hazardous behavior increases annual health expenditures by placing a huge burden on the national government, which finances the Ministry of Health and other governmental bodies providing health services. For example, government health expenditures increased from 22.808.200 Saudi Riyals (\$6,082,186), which is 2.8% GDP, in 2007 to 62.342.539 Saudi Riyals (\$16,624,677), which is 6.2% GDP, in 2015 ( MOH,2016 ). The Saudi government will face serious financial problems if there is no urgent change in the current financing system and if the national health expenditures continue to grow at this pace (Alhanawi,2018). Since Saudi Arabia faces increasing demand for health services, and has finite revenues to pay to form them, the health care system must find a way to use its resources more efficiently and effectively. After departing, policy makers decided to privatize the health system to increase the quality of its services ( Hazazi & Chandeamohan, 2017).

In order to fully understand privatization efforts, it is important to understand the fundamental structure of the Saudi health care sector as it exists today. The Saudi health system has two parts: the Private and Public sectors (Figure 1.1).

The private sector plays a major role in providing high-quality health services, but at a high cost. Patients obtaining private sector services may pay out of pocket or be covered by private health insurance. Many hospitals prefer patients who pay cash (Alhanawi,2017).

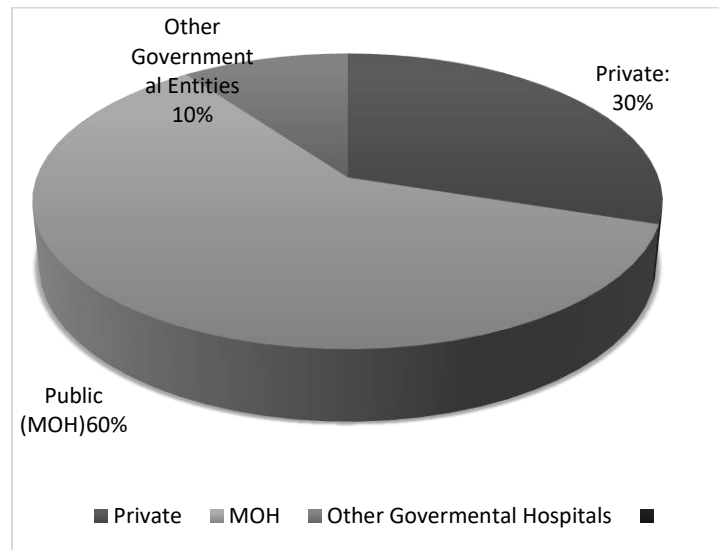


Figure 1.1 Current Saudi Health System.

In 1971 there were only 18 private hospitals, but this number had grown to 75 by 1996, accounting for approximately 21% of all hospital beds (MOH, 2005). Currently, there are 125 private hospitals in the major cities, with more than 11,833 beds and 2,218 dispensaries and clinics. Private hospital owners prefer to have their hospitals in crowded cities seeking revenues (Alkhamis,2017). As privatization takes place in the Kingdom, more private hospitals will be built to meet the increases in demand. With the growing

population, the current number of hospitals is not sufficient. The government is planning to support the construction of more private hospitals. A recent qualitative study asked people in a public hospital about their readiness to pay for insurance to have good health services. The study found that many Saudis are willing to pay for high quality services (Alhanawi,2018). However, some Saudis are not satisfied paying for health insurance after privatization. They believed that they should have free education and health services, as it is stated in the Saudi constitution as rights for all citizens. (Alkhamis,2017).

On the other hand, the public sector within the Kingdom is divided into the Ministry of Health (MOH) and a few other governmental agencies. Employees of the MOH and other governmental agencies gain their health care through the public sector. MOH is the major government provider and financer of healthcare services in Saudi Arabia with a total of 244 hospitals (33,277 beds) and 2,037 primary care centers (Alkhamis,2017). MOH is annually funded from the government budget and its services comprise 60% of the total health services in Saudi Arabia.

There are other government bodies that provide health services to their employees and their dependents in addition to MOH, such as “Ministry of National Guard Health Affairs, Ministry of High Education (teaching hospitals), Arabian American Oil Company (Saudi ARAMCO) hospitals, and Royal Commission Health Services” (Alkhamis,2017). The government finances every agency annually, and in turn, each agency is responsible for funding and providing health care services via its own health system. For example, the Ministry of National Guard manages and finances their own hospitals from the funds they receive from the government budget. These kinds of hospitals are the best in Saudi Arabia. They follow international quality guidelines and they are famous for their excellent



performance. These hospitals have gained international quality accreditation like accreditation from the Joint Commission International (JCI) (NGH,2016). The services in the majority of these hospitals are free but restricted to their employees and their dependents(Ministry of the National Guards,2016). For example, an individual working for the National Guard, and their dependents, receive free of cost health care services form National Guard hospitals. Other people can use such high-quality health services by accessing the private sections of each National Guard hospital. These people can use private health insurance or can pay out of pocket (NGH,2016).

Ministry of the National Guard believes that patients should have access to safe, effective, patient-centric , timely, efficient, and equitable health services (NGH,2016). National Guard hospitals care about their workers' and their dependents' health. They believe that healthy employees are dedicated, productive employees ( NQH,2016). When a National Guard hospital provides services to their employees, this is classified as occurring through a public channel. Other citizens who are not employees or dependents, who want to obtain high-quality services from National Guard hospitals, can. However, these citizens must pay out of pocket or have the cost covered by insurance companies. Thus, National Guard hospitals are unique because they currently provide services through a public and private channel. This study will focus on the provision of services within National Guard hospitals because this unique structure , with both public and private in the same facility, allows researchers to gain insights into the barriers and facilitators related to privatization of the health sector occurring within the Kingdom.

## 1.2 Privatization- A Potential Key Toward Improved Efficiency and Effectiveness:

To reduce the financial burden from the provision of health care, policymakers are planning to follow other developed countries by privatizing the provision of health care services. Through privatization, the kingdom hopes to improve the effectiveness and efficiency of health care delivery (Almalki,2011). The objective of privatization is to ensure access to high-quality health services for all people. Yet, introducing privatization is not an easy process and there will be challenges during the transition. The Kingdom has already privatized electricity, water, communication, and transportation services. The quality of their services has improved greatly in the last decade (Almalki,2011). The government is planning to privatize most of the Saudi health sector by the year 2030 to comply with the Vision of 2030, but the privatization process will not start until 2020.

One of the definitions of privatization is “the process by which a piece of property or business goes from being government owned to being privately owned” (Hargrave,2019). However, this definition does not adequately capture the privatization process that is about to occur in Saudi Arabia. The privatization of the health system will be partial, in which private entities will run and implement a government transformation program.” The Ministry of Health’s Vision Realization Office ( VRO) , has drawn a road map for this transformation in order to provide a value-based health care service in acknowledgement of economic and institutional requirements for strict control of health services expenditures” ( Health care transformation strategy, 2019). In the current system , the Ministry of Health is responsible for three main duties: financing , supervising, and running the health sectors. But after privatization these three roles will be distributed among two other entities, a holding company, and the National Insurance Center. The

holding company is a governmental company which will run five private health companies in the five regions of Saudi Arabia. Each private company will run a health cluster in each region in the kingdom. Under each health cluster, many hospitals and primary care centers will be combined. Each cluster will compete with each other's and hospitals under each cluster will compete with each other to provide high quality services seeking MOH incentives. Each cluster will offer complete medical and health services (primary, secondary, tertiary, and palliative) in which Saudis will be using their Saudi ID numbers for their electronic medical report numbers around the kingdom. Health providers will easily navigate patient's medical records , thus no duplicated services will occur, saving the government a lot of money . The third entity, NIC, will be the financier of the health system in which it will provide all citizen's health insurance. Thus, the MOH will supervise the new health system only (Figure1.2).

The transformation of the health sector's decision has been encouraged by the majority, if not all of the policy makers and the Saudi people. But the transformation, which was the strategy for privatization, was not an easy one for policymakers and the people of Saudi to agree on. A debate on how privatization would occur has been going on for years among policymakers, but this was amidst growing concern, expressed by the Saudi people, about what the implications from privatization would be. A review of published Saudi studies regarding the debate stated that the Saudi people did not favor privatization of over fears of rising prices in the health care sector. Also, private companies may not be interested in buying any old or rural governmental hospitals, and new hospitals may be located only in urban areas which would create disparities in access to care within the population. Furthermore, the primary care centers, which the government invested a lot in

, may be underutilized because patients may prefer to go to big hospitals that have more specialists instead (Hazazi & Chandeamohan, 2017).

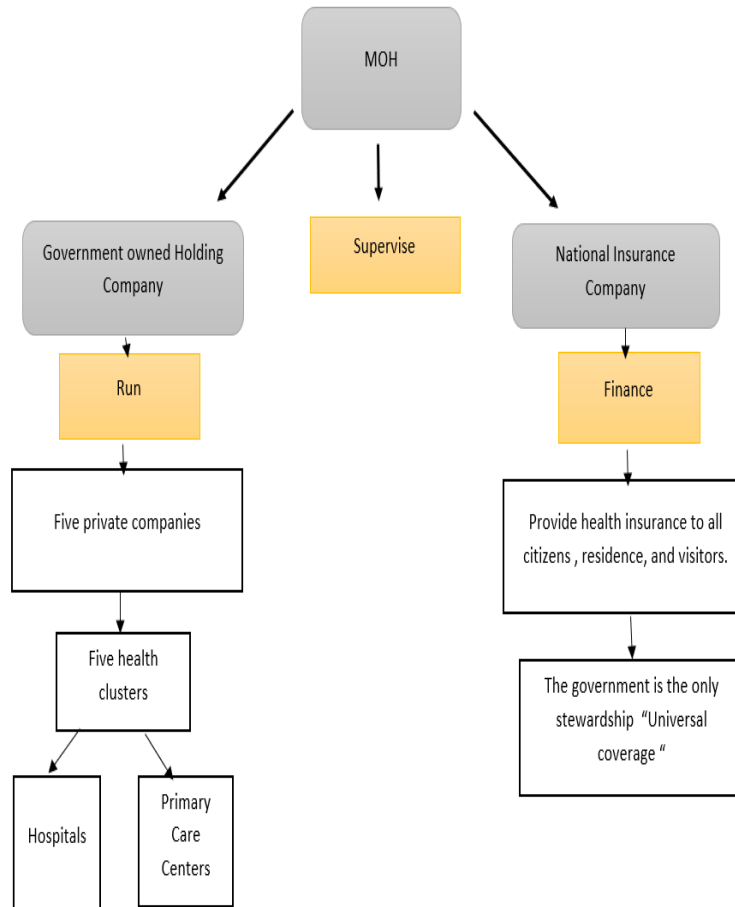


Figure 1.2 The Health System after privatization

### 1.3 Saudi women and the health care system:

In 2006, the Ministry of Health issued the Patient’s Bill of Rights (PBR) which states that health care is a right for all citizens for both genders. It was written in Article 27 and 31 of the Basic Rules (MOH,2011). Despite that, the law was not clear for health providers nor for society. Saudis believed that male guardians should decide all health decisions for women. This belief was/is based on a misinterpretation of an Islamic male

guardianship law. Based on Islamic scholars, approving any medical intervention for adult women would contrast with Islamic regulations and rules ( Alamoudi,2017).

Before 2017, women in Saudi Arabia could not participate in health decision making, sign their consent papers, or even sign their admission or discharge documents. Saudi Arabia lost many women's lives because these women could not make the decision regarding urgent cesarean section or breast cancer surgeries (Alamoudi,2017). An eye opening tragedy happened in 1981, when the husband of a women in labor refused, for more than 7 hours, to sign for a c-section, causing his wife and baby to die. This happened regardless of the fact that it is stated clearly in Article 60 of Hospital management and Medical by-Laws: " anesthesia or surgical procedures shall be obtained, and it should be noted that a woman is legally responsible for herself and shall be asked to give her own consent " ( Alamoudi, 2017). In other word, even though the women at that time (1981) had the legal right to request a c-section, her husband stopped her in an extra-legal way.

This happened due to a lack of understanding of women's rights among health providers, and a misunderstanding of the husband's rights ( Alamoudi,2017). In short, women could not approve any surgery for themselves nor for their loved ones due to the respect of Saudi Arabian custom, even though, in the case of the c-section, the woman had the legal right to request one. Unawareness of health rules and unclear laws is one of the most critical reasons for many female's morbidity and mortality rates (Alamoudi, 2017; MOH, 2012).

One barrier to privatization may be associated with how women access and obtain health care services. For the past few decades, women's voices in the Middle East have

been coerced into silence and their points of view have not been considered. “Evidence suggests that women in developing or low-income countries often have limited autonomy and control over their health decisions” (Osamor, Grady,2016).

Autonomy in health care is essential in the decision-making process ( Osamor, Grady, 2016). Having autonomy for women in health care decisions will lead to better health outcomes thereby resulting in more efficient and effective care ( Jahlan,2017). Women cannot be fully engaged in decision-making unless they have full autonomy. As of 2017, Saudi law supports the full autonomy of women in health decision-making; however, health providers, hospitals, and women themselves are not aware of this policy. It may be due to government oversight or because of a lack of knowledge regarding the policies. Most if not all hospitals still communicate with male guardians about making decisions for their wives, mothers, sisters, and daughters, even when the women are adults and mentally-well. Understanding the current state of women’s perspectives is important because it helps health care systems understand what is important to women, and empowers women to more actively engage in their care. Empowering patients to be more engaged in their care holds the potential to improve health outcomes leading to more effective delivery of health services. By having patients participate in their care process, the health system will be more efficient and effective. (Dohan,2005).

Since Saudi women live in a society where men often make decisions on their behalf, it is important to explore what women know about their health rights to make their own medical decisions, how comfortable they feel about making decisions, and what else they need to feel more supported and confident to engage in their health care. A deeper

understanding of women's needs and satisfaction with health care services will support the National Guard Hospital transition to Saudi Vision of 2030.

#### 1.4 2030 Vision and Saudi Women's Rights:

The Vision of 2030 supports the autonomy of women. Since 2017, women have gained back many rights that were taken from them for decades. King Salman , in the Saudi constitution law number 33322 ( April, 21, 2017), has ordered all governmental agencies to treat women equally to men. "Women are their own guardians and they have full rights to make decisions regarding themselves inside the kingdom" (Albeker, 2017). Before that, in 2011, "Saudi Arabia has ratified the Convention [Article 10] on the Elimination of All Forms of Discrimination against Women (CEDAW);" before ratification, Article 10 required States Parties to "take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men" (Aldemini, 2011). Women now can vote, drive, and even work in high-level jobs in the government. Women are allowed to access all governmental, educational, and medical facilities without the need for any consent from guardians.

The 2030 Saudi Vision is based on three objectives: "vibrant society, a prosperous economy and an ambitious homeland" (Alqahafis,2018 ). The Saudi government will not achieve these objectives unless women gain back their rights and contribute to achievement alongside their male counterparts. The Saudi government believes in equal roles for both males and females in building a better society (Saudi Vision,2018 ). To enable women to fully participate in their health decisions, a necessary first step is to assess what is currently important to women regarding their satisfaction with health services and desire to

participate in their care. To date, not enough literature takes the approach of assessing what is important in the eyes of women as patients in either the public or private sector of the health system within the Kingdom. Current efforts by the MOH focus on changing provider's behaviors, because provider ignorance about women's health rights remains problematic (Alamoudi,2018). For example, at King Abdelaziz University Hospital, evidence from a retrospective chart review shows a lack of knowledge on the part of providers regarding who should sign the consent forms in breast cancer surgeries. Forty percent of the providers were under the impression that male guardians were supposed to sign the forms, and this lack of knowledge continues to keep women from exercising their health care rights. The study concluded that there is an urgent need to change health provider behavior, but women also need education regarding their rights (Alamoudi, 2018). To further emphasize the need for women's education, another study found that even well-educated female medical students believed that female patients needed a male guardian's approval in order to receive a medication or get a surgery (Alamoudi, alharbi, 2017). In order to effectively craft education strategies aimed at women, an important first step is to assess the baseline level of Saudi women's satisfaction with their care.

#### 1.5 Patient satisfaction:

Since understanding women's satisfaction with their care is important to advancing Vision 2030, it is important to understand the multiple components that encompass and can be used to define satisfaction. These components are: care experience, patient perception, preferences for care, and patient engagement in the treatment process(Khodyakov,2016). Understanding the various components is important because defining and assessing patient satisfaction is often associated with numerous challenges due to lack of specificity in the



definitions and differences measures and assessment found within the literature (Kluwer,2012). One definition of patient satisfaction is “a measure of the extent to which a patient is content with the health care which they received from their health care provider” (Farley, 2014). More specifically, it helps providers customize treatment for patients and engage them in their care process. When providers and patients are working together toward more personalized patient-centric care, this, in turn, helps hospitals to achieve higher benchmarks for their performance. In order to assess the satisfaction of women seeking maternity care, we should measure both physical and psychological care. Low women’s satisfaction in maternity care affects utilization and health outcomes. Unsatisfied women will cause the hospital to lose their customers in the long run and that will decrease their revenues. Also, maternity studies have proven that unsatisfied women are more likely to suffer from postpartum depression(Kluwer,2012 ).

To assess baseline levels of women’s satisfaction with their maternity care in this study, we focused on understanding how women feel about the quality of care provided by doctors, nurses and support staff in hospitals, and the amount of privacy they have during their hospital stay. Based on the literature review of women's satisfaction in Middle East (chapter two of this dissertation), those two factors that matter the most for women’s satisfaction in labor were provider-patient relationship and privacy. Satisfaction was defined using this metric because systematic review of the literature demonstrates that the existing research in Saudi Arabia focuses on improving the process of giving birth in order to improve clinical outcomes (Jahlan, 2016). At this time, there is no comparative study that examines how women feel about the care they receive as they interact with their providers during their stay, such as their interactions with doctors, nurses, support staff.

Understanding satisfaction in relationships with providers is imperative toward garnering baseline levels of women's understanding of their current health care rights. Therefore, this study fills the gap within the Saudi health literature by assessing women's satisfaction in terms of their relationship with providers while giving birth and receiving care in the public and private sector of the National Guard hospital. In this study, both the public and private sectors will be included.

By including both sectors, we will better understand which groups of women are more satisfied with their relationship with health providers. When women are comfortable with dealing with their health providers, they are more likely to actively participate in their own health care. By analyzing women's relationships with health care providers, the data this study collects about women's satisfaction will aid in a transition toward more patient-centric care and women's engagement in their own care, helping the National Guard Hospitals achieve the Vision's 2030 objectives.

#### 1.6 Patient-centered care:

There are six domains of health care quality: safety, efficacy, timely, efficient, equitable, and patient-centric care (Agency for Healthcare Research & Quality, 2015). Patient centric-care is defined by The National Academy of Medicine as "the care that is respectful of and responsive to patients' preferences, needs, and values and ensures that patients' values guide all clinical decisions (Wilkerson,2010). This study will consider many of Pickers' eight components of PCC: Respect of patients preference, coordination, and integration of care, information and education, physical comfort, emotional support,

the involvement of family and friends, continuity and transition, and access to care (oneview.2015).

Furthermore, there is a recent focus on family-centric care in maternity care in Western literature (Aaron, 2016). In Western countries, policymakers are trying to involve fathers in the care plan so they can decide with the mothers what the best options are for their child during the birth process. In Saudi Arabia, given its cultural history and respect for male authority, we want to explore what conditions exist in order to implement policies that allow women to participate more actively with their babies' fathers regarding what the best birth options are for their child. Health care providers should be interested in these findings because it has been shown that patient and family-centric care can lead to better outcomes for mothers and babies (Gooding, 2011).

Furthermore, patient-centric care should focus on patients but should be structured for the convenience of providers (Freeman, 2006). Studies have proven that provider-centric care may leave patients confused and isolated. On the other hand, patient-centric care may improve patients' outcomes (Betancourt,2002). Such patients may have delays in their treatment plans or even complications. But in a patient-centric care delivery system patients should have emotional support, physical comfort, and coordination of care. It is built up in a way that helps the continuity of care between patients and health providers (Stone,2006). In patient-centric care, patients' values, preferences, and needs are all considered and valued. "It provides patients with education and support that help them to make their health-related decisions and to participate in their care" (Dohan,2005 ). Thus, PCC improves patient satisfaction as studies have proven (Siddiqui,2011). A study found

that involving women in the decision-making process, in intrapartum and antenatal stages, increases women's satisfaction (Chen,2018).

One of the main goals of the 2030 Vision is to improve the health sector (Saudi Vision,2018). Although Saudi public hospitals have advanced types of equipment and well-trained doctors, they suffer from inadequate quality in their health services, which leads to unsatisfied patients, institutional waste, and resource misuse (Alqarni, 2018). Studies have suggested that the Saudi Health System needs an independent body to monitor health services, increase efficiency, and improve quality of care. Such studies led the Saudi government to the decision of privatizing the health sector by the year 2030 (Aljuaid,2015). Therefore, in 2016, Saudi Arabia assigned a private company to implement the foundation of patient-centered developmental program in 30 crowded Ministry of Health (MOH) hospitals in the Kingdom (Rasooldeen, 2016). The main mission of this private program is to provide satisfying patient-centric health services to the increasing number of patients. By training staff to provide more patient-centric care, an improvement in the performance will lead to universally accepted health practices to all Saudis(Aljuaid,2015). This continuous training, as well, will help with the implementation of the PCC program within all MOH hospitals. However, the terminology of the PCC is used by MOH as "Patient first"(Rasooldeenn, 2016).

In the same year, the Ministry of National Guard adopted the "best care" system in all its hospitals around the kingdom. "Best care" is a health information system that has two main missions: record patient's medical record and invite patients to participate in their health process and the decision making (NGH,2016). Implementing such software was considered as the first step toward PCC. Since pregnancy and deliveries are considered to

be around a year of hospital visits and checkups, this software plays a critical role in helping women to participate effectively in their care

In addition to filling a knowledge gap within the literature surrounding patient satisfaction, this also will be the first study to explore women's perceptions related to patient-centric care and the extent to which women want to be engaged in medical decision making. This study will assess what women know about patient-centered care and how willing and empowered they feel about participating in making their own treatment decisions.

One of the barriers in the execution of the 2030 Vision is changing the beliefs, attitudes, and the current culture regarding how women participate in their health care. Since the Saudi culture is a conservative one, it is not easy to change decades of beliefs and thoughts (Saudi Vision, 2018 ). Having baseline evidence on women's attitudes and beliefs about PCC and engagement in their care will help shape education and policy strategies for women. This data will enable health systems such as the National Guard hospitals to reach the 2030 Vision.

The government supports the implementation of women empowerment through educational units developed within health care organizations. The first education unit was founded in 2016 at the King Abdul Aziz University by a group of OB/GYN female doctors. The main goal of this unit is to educate women, physicians, and medical students about women's rights in hospitals (Al-Almoudi, 2012).

## 2. Specific Research Aims:

To support filling the articulated knowledge gaps, the specific research aims of this study are:

### 2.1 Specific Aim 1:

Identify the state of Middle Eastern Literature regarding women's satisfaction with their maternity care ,including elucidating the most common factors that other researchers have found to affect women's satisfaction. The study that addresses this specific aim is presented in Chapter 2 of the dissertation.

### 2.2 Specific Aim 2:

Evaluate and compare the satisfaction of mothers in terms of their interaction with providers and privacy while giving birth in private versus public sections in two National Guard hospitals. The study that addresses this specific aim is presented in Chapter 3 of the dissertation.

### 2.3 Specific Aim 3:

a- Evaluate and compare the baseline levels of knowledge and perceptions of women regarding what constitutes patient-centric care in public and private sectors of National Guard Hospitals.

b- Understand the roles and desire of the mothers to participate and engage in patient-centric care by being involved in decisions related to their delivery and follow- up care. Additionally, to examine how mothers' goals, values, and priorities for care can be integrated to improve the quality of care.

The study that addresses these specific aims is presented in Chapter 4 of the dissertation.

Chapter 5 of this dissertation presents overarching conclusions and implications of the future.

## CHAPTER 2

### A SYSTEMATIC REVIEW AND META-ANALYSIS OF FACTORS THAT AFFECT MIDDLE EASTERN MOTHERS' SATISFACTION .

#### Abstract:

Background: Pregnancy and giving birth are unique processes for almost all women. Every woman has her background, knowledge, expectations, and belief system. The health provider-patient relationship is a significant factor of care. Women in labor around the world feel the importance of having a special relationship with their caregivers. Caring for and supporting women during labor are essential things each woman wants. A positive Doctor-patient relationship increases women satisfaction, based on recent studies. In addition to that, respecting women's privacy during checkups and in labor is very important for almost all women. This study is conducted to highlight some factors that affect women's satisfaction regarding their maternity care in public hospitals in the Middle East. The two major factors that this study is focusing on are women's relationships with their health providers and privacy. The collected studies are from seven countries in the Middle East (United Arabs Emirates, Saudi Arabia, Iran, Israel, Iraq, Turkey, and Jordon).



Objectives:

a- To review Middle Eastern literature regarding women's satisfaction during childbirth and learn about the most common factors that affect women's satisfaction. (Systematic Review).

b- To conduct a meta-analysis of the effect size of two most common factors viewed in the literature on women's satisfaction in the Middle East to plan for a new study using these factors in Saudi Arabia.

Methods: Two databases were searched: PubMed and Science Direct up to the 7th of March 2018. Four hundred eighty-eight studies were found. Three hundred ninety-two studies were from PubMed, and 94 were from Science direct. Two common factors were included: a good relationship with health providers and privacy.

Results: We identified ten studies that have the two selected factors: Health provider-patient relationship and privacy. Two separate analyses were run for each variable. The first analysis was significant, with a total effect p-value of (0.00). Also, it has a confidence interval (CI) of (0.565 -0.615) . The conducted heterogeneity test shows an I-squared of  $99.191 > 50$ . That means there is no similarity and overlap among the included studies, and the results were precise. The Q-value (Cochran's Q) was (870.026) with a significant p-value=0.00.

The second analysis was for the privacy variable, and it was significant with a total effect p-value of (0.00). Also, it has a confidence interval of (0.210-0.308). The conducted heterogeneity test shows an I-squared of  $99.016 > 50$ . That means there is no similarity

and overlap among the included studies, and the results were precise. The Q-value (Cochran's Q) = 406.582 was significant with p-value 0.00.

The study suffers from publication bias based on Orwin's Fail-safe N. In order to observe effect size to be null, another 4,170 studies need to be located to render the observed effect to be non-significant ( $P > 0.05$ ).

Conclusion: Women found that it is crucial to have a good and understandable relationship with their health providers during their stay in the hospital for childbirth. Furthermore, respecting patient's privacy before, during, and after giving birth increases their satisfaction. Further studies should consider the effect of these two factors on women satisfaction in Saudi Arabia.

Keywords: Maternity care- satisfaction -- giving birth – birth- patient's experience- middle east.

Note: MeSH technique was not used in search with the above-listed keywords.

## 2.1 Introduction:

Middle Eastern countries (16 countries in total) have a poor number of studies regarding satisfaction compared to advanced countries. There are 16 Middle Eastern countries that vary in research publications. Based on the Middle East studies that were reviewed, women were not satisfied regarding their maternity care in public hospitals. Two of the most common issues that matter to Middle Eastern women were their relationship with health providers and privacy. Middle Eastern studies' have proven that women find it importance to have an excellent and understandable relationship with their providers. Unlike private hospitals' patients, overwhelmed doctors and nurses working in public hospitals are not including women in decision making most of the time. Physicians do not explain everything to their patients. So, most of the times, women go through the childbirth process without fully understanding the decisions that have been made for them. In addition, nurses in public hospitals do not treat patients with compassion due to the vast number of patients they see in public hospitals (Yanikkerem,2009).

Furthermore, lack of privacy is a critical issue in public hospitals in the Middle East. Women who seek a public hospital for giving birth are expected to share the same room with other patients. Studies show that privacy is a vital indicator of increasing patients' satisfaction (Almalik,2017).

## 2.2 Materials and Methods:

### 2.2.1 Search strategy and inclusion criteria:

Two databases have been searched: PubMed and Science Direct, with all extant articles that were published up until and including the 7th of March 2018 being included

in this project. All the abstracts in both databases have been pooled using the following keywords: "maternity care- satisfaction – giving birth – birth- patients experience- Middle East." It is important to note that MeSH technique was not used in the two searched databases. Covidence software was used to import the articles and to perform the PRISMA diagram. Four hundred-eighty eight references were imported for screening. Three hundred ninety-two are from PubMed, and 96 are from Direct science. Ninety-six duplicates studies were removed. After that, 392 studies abstracts were reviewed and 307 studies excluded. We had a remaining 77 studies assessed for full-text eligibility. We analyzed these studies for potential analysis. Sixty-six studies were excluded from them for two reasons: 42 studies have a different setting, and 24 studies have different outcomes. This analysis has only ten studies included.

#### 2.2.2 Description of included studies:

While reviewing the abstracts, some common factors that affect women's satisfaction have been noticed. For this study, only two factors have been chosen: health providers-patients relationship and privacy. Each of the ten studies provided information about p-value or correlation quantitative numeric values and sample sizes about the outcomes . Figure 2.1 is the PRISMA diagram for data extraction of the ten studies. We used Covidence online program to review titles and abstracts and to perform the PRISMA diagram.

A specific inclusion and exclusion criteria have been set. For the studies to be included, they should be in English or Arabic due to the researcher's lingual limitation. All studies were in English in this analysis. Also, they should be from the Middle East.

Furthermore, all studies should be about patients' satisfaction or experience and maternity care in order to be included. These studies should have numerous results stated in the paper.

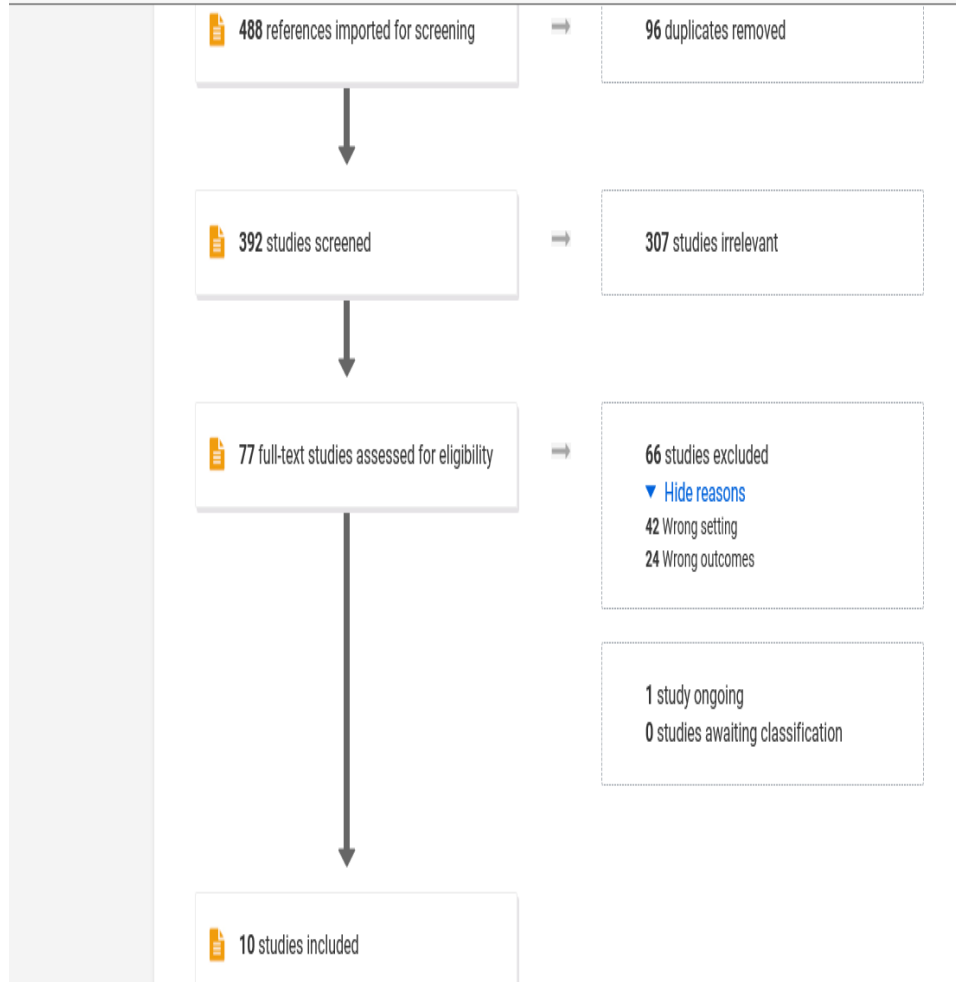


Figure 2.1 PRISMA diagram

The exclusion criteria were set as well. One of the reasons for excluding a study is that the study was not in English or Arabic. Also, studies were excluded if they were not about maternity care or patient satisfaction/experience. Moreover, if no numerous outcomes were stated in the article, we excluded them. Table 2.1 shows the exclusion and inclusion criteria.

Table 2.1 Inclusion and Exclusion Criteria

Inclusion	Exclusion
patient satisfaction	Not Middle East country: Australia, Nigeria, South East Asia countries.
Maternity care	not maternity care
Middle East	Not patient satisfaction
Patient experience	No data
	different outcome
	different setting

### 2.3 Data extraction and categorization:

Two separate meta-analyses were conducted for both variables because only six studies included both variables. An analysis was run for each factor to insure that the factor is available in all the included studies in the analysis. From each of the ten articles, the correlation and p-value were extracted for both outcomes: relationship with health providers and privacy. This study has 3,836 participants (N=3,836).

#### 2.3.1 Statistical methods:

In this study, the Comprehensive Meta-Analysis software (CMA) version three was used to conduct the two analysis. These steps have been followed: a table that includes: study name, sample size, P-value, or correlation was made of each outcome for all the ten studies (Table 2.2) .Then, the sample size was set as a moderator to study the association

between sample size and the effect size. The software calculates the regression for both fixed and random effects for each variable. Although the measurement scales were different (correlation and p-value), CMA can scale them and pool the weights (power) from all studies to calculate the total effect.

Moreover, Forest plots were conducted after the statistics from the same program. Publication bias was evaluated using the funnel plot method. The funnel plot was conducted by CMA as well. Last but not least, a sensitivity analysis was performed.

Table 2.2 The Included Studies in the Meta-analysis

Author	Country	Sample Size	Variable	Statistical Value
Jafari, 2017	Iran	340	Providers' skills and attitude	P = 0.024
Shabila, 2015	Iraq	37	Providers' skills and attitude	P= 0.038
			Privacy	P = 0.029
Amir, 2012	Israel	167	Privacy in check up	85.6%
			Providers' skills and attitude	70.1%
Yanikkerem. 2009	Turkish	433	Privacy check up	54.8%
			Providers' skills and attitude	71.8%

Rizk, 2001	UAE	715	Providers' skills and attitude	14% / P=0.001
Rizk, 2002	UAE	303	Privacy check up	P <.0001
Mosallam, 2004	UAE	400	Providers' skills and attitude	% 56.4
			Privacy	% 40.7
Hatamleh R, 2013	Jordan	460	Privacy	37% / (OR 1.5, p = 0.01).
Lamadah, 2012	Saudi Arabia	150	Providers' skills and attitude	% 86
Hijazi , 2018	Jordon	831	Providers' skills and attitude	% 95

#### 2.4 Results:

In the inclusion and extraction of studies , the literature search yielded 488 studies after the keyword search. Out of these 488 studies, 307 were irrelevant. Some of the studies were not about maternity care. Other studies were not about satisfaction or patients' experiences. The remaining 77 studies were assessed for eligibility, and 66 studies were excluded due to setting or outcomes irrelevance. The excluded studies that have different setting are the ones that were not from any of the Middle Eastern countries. Some studies were about Middle Eastern women, but in Australia, for example, and so such studies were excluded.



Furthermore, some of the excluded studies were about breastfeeding or educational services. We did not consider these studies since they did not have the same outcomes that we set: Patient-health provider's relationship and privacy. The remaining ten studies were ideally included in the analysis. Three of these studies were from the United Arab Emirates (UAE), two from Saudi Arabia, one from Jordan, one from Iran, one from Turkey, one from Iraq and one from Israel.

This Meta-analysis is a systematic method for synthesizing quantitative results of different empirical studies regarding the effect of “Health provider-patient relationship” and "Privacy" on the defined outcome, which is here women satisfaction. CMA was used to conduct the meta-analysis for this study using the sample size, the P-value, or correlation for each study. Forest plots for each factor were conducted. Forest plot is “ a graphical display of estimated results from several scientific studies addressing the same question, along with the overall results”(Lalkhen,2008).

In the first analysis, we included eight studies that had the health provider- patient relationship factor. The countries that these studies have been conducted from are: Iran , Iraq, Turkey, Saudi Arabia, United Arabs Emirates, Jordan, and Israel. The forest plot for this factor is in Figure 2.2 below. The sizes of the boxes represent the weight for each of the included studies. As it is shown in the graph, all boxes are not consistent, but the one estimate effect (The diamond shape), which shows the point estimate, is significantly based on the p-value (0.00) in this analysis. Moreover, the z-value of the first analysis has a value of (34.74), and its confidence interval is tight (0.565 – 0.615).

## Meta Analysis

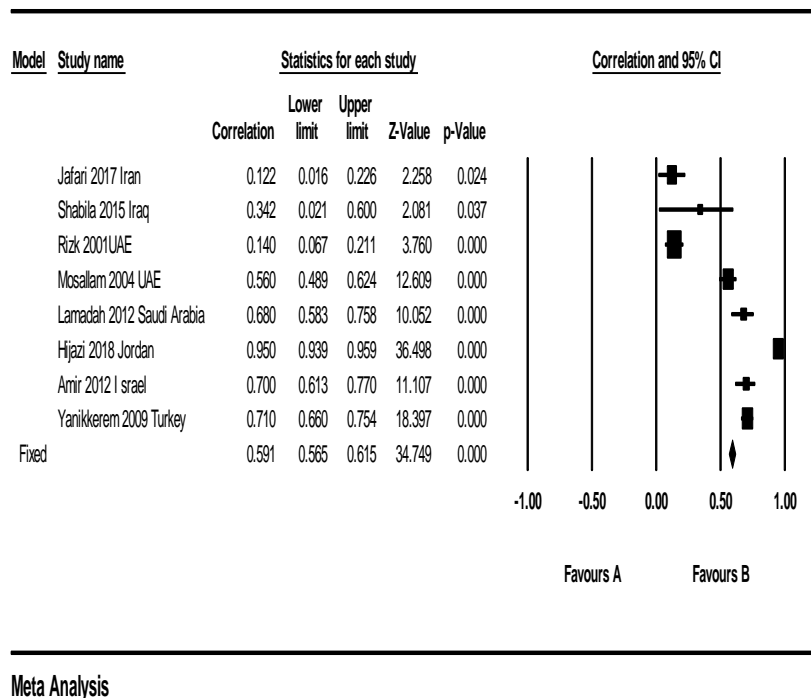


Figure 2.2 Forest plot of the Health Providers-Patients Relationship.

The second analysis was about the privacy factor. Five studies from five countries were included :Turkey, Iraq, Israel, United Arab Emirates, and Jordan. As the first plot shows, the boxes were not consistent (Figure 2.3) . However, the point estimate is significant with a p-vale of (0.00). The Z-value of the second analysis has a value of (9.90), and its confidence interval is between (0.21 – 0.308).

The thin horizontal lines show the confidence interval (CI) for each study. The shorter the CI, the more reliable the data is. Studies with big boxes are meaningful to the data. The bigger the box and the shorter the CI means that the data from that study is

reliable and meaningful. The weight of the included studies put more power in the total effect of the meta-analysis. All boxes have short CI except (Shabila, 2015).

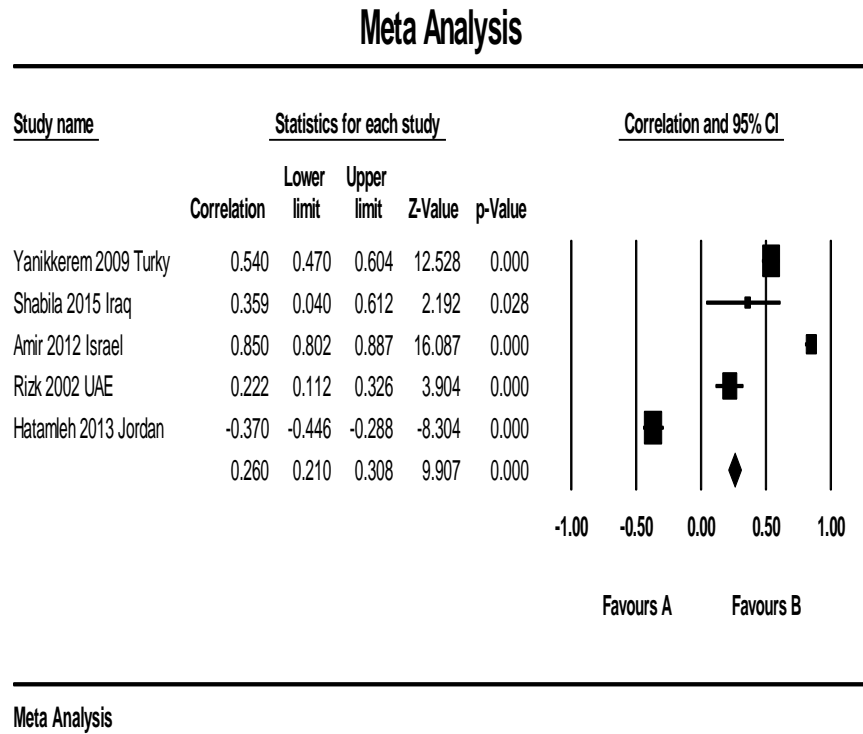


Figure 2.3 Forest Plot of the Privacy factor

The heterogeneity of the two analysis have been calculated as well using CMA. The I-squared describes the percentage of variations across studies. If heterogeneity level is less than 50% , this means that the analysis has low chance to have it and shows a similarity between the included studies. The I-squared here is 99.19 for the health providers-patient relationship. That means there is no similarity among studies. The Q-value was (Cochran's Q) = 870.026 and it has a significant p-value=0.00 . Cochran's Q

“calculated as the weighted sum of squared differences between individual study effects and the pooled effect across studies, with the weights being those used in the pooling method” (Borenstein,2009). On the other hand, the privacy’s heterogeneity analysis has an I-square value of (99.016) and Cochran's value of (406.58). Again, that indicates that there is no similarity among the included studies, and that means that the analysis has high heterogeneity (Borenstein,2009).

## 2.5 Publication bias and quality assessment:

The potential of publication bias has been assessed using the funnel plot of the combined analyses. We used comprehensive, Meta-analysis software to do so. Please see the plot below (Figure 2.4). The vertical line of the funnel plot indicates the fixed-effect mean. The funnel itself is for the 95% confidence interval as a function of the standard error (SE) of the fixed-effect mean. The circles show the studies. If studies are not distributed symmetrically around the mean effect sizes, one can say that this analysis may suffer from publication bias. Based on the funnel plot that we computed, we can say that this study may have publication bias. The circles "studies" are distributed on the top of the funnel. Some studies are asymmetrically distributed in the funnel, but 6 of them are outside the funnel.

Based on Orwin’s Fail-safe N, (Table 2.3) In order to observe effect size to be null, another 4,170 studies need to be located to render the observed effect to be non- significant ( $P > 0.05$ ).

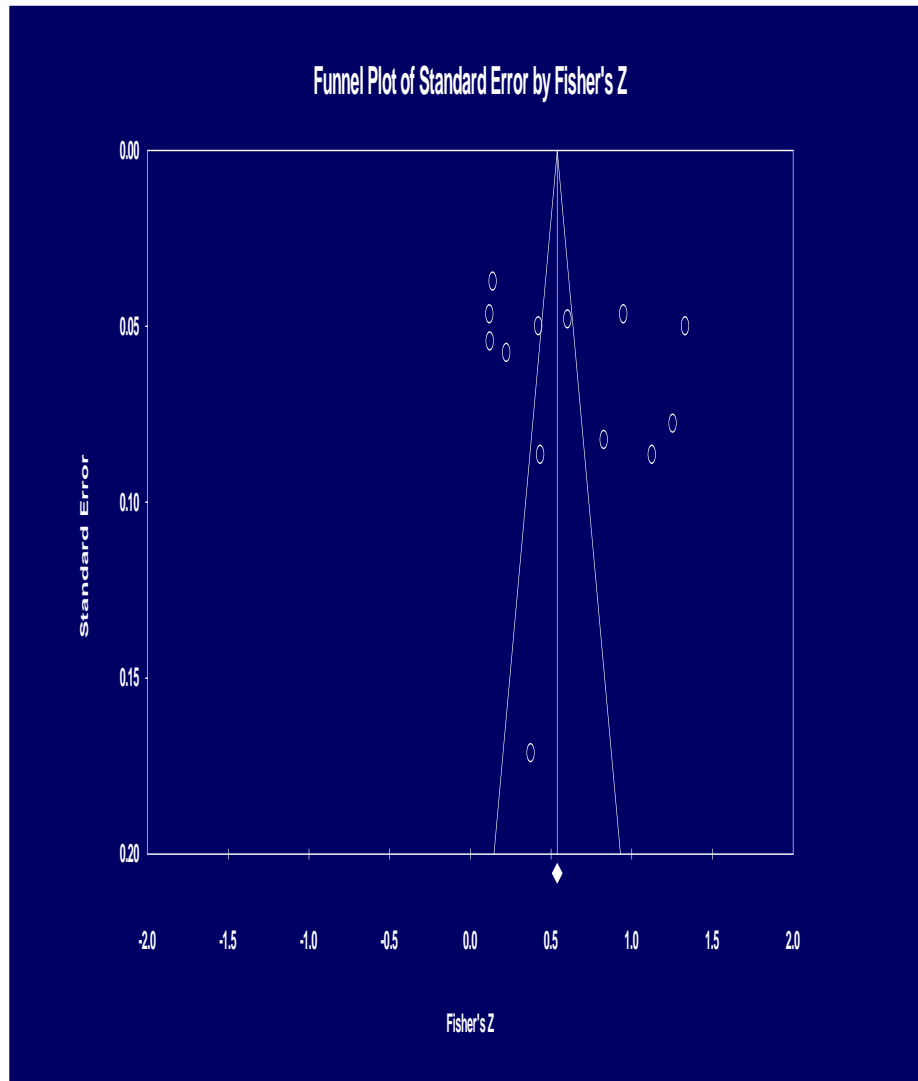


Figure 2.4 Funnel Plot

## 2.6 Sensitivity analysis:

Sensitivity analysis is an important step to do for checking a common problem in meta-analysis which is the publication bias. This is a step that is trying to fit the studies inside the funnel (Figure 2.4). A sensitivity analysis has been performed by erasing one study and re-running the analysis again; no significant differences in the p-values was found for both variables.

Table 2.3 Orwin's Fail-Safe N test

<b>Classic fail-safe N</b>	
Z-value for observed studies	35.15441
P-value for observed studies	0.00000
Alpha	0.05000
Tails	2.00000
Z for alpha	1.95996
Number of observed studies	13.00000
Number of missing studies that would bring p-value to > alpha	4170.00000
<b>Orwin's fail-safe N</b>	
Correlation in observed studies	0.49158
Criterion for a 'trivial' correlation	0.00000
Mean correlation in missing studies	0.00000
Criterion must fall between other values	

## 2.7 Discussion and conclusion:

This descriptive meta-analysis was performed to study the effect of the most critical factors that affect Middle Eastern women's satisfaction in public hospitals. Only one reviewer conducts the analysis so, testing for reliability is hard. Four hundred and eighty eight studies from PubMed and Science Direct were reviewed using covidence software. Only ten studies were included in the analysis. The meta-analysis was conducted using CMA version 3. The p-value or the correlations were pooled from the ten studies to calculate the total effect. The sample size was set as a moderator. Two common outcomes

were found in the majority of the studies: privacy and relationship with physicians. Middle Eastern women were found unsatisfied with maternity care mostly due to the poor relationship with their health providers and due to lack of privacy in public hospitals.

Two crucial factors affect precision. One of them is sample size, and the other is the design of the study. The sample size is a dominant factor that affects precision in an obvious way. The sample sizes vary among all included studies. The sample size of all ten studies is 3,836. Usually, large sample size has more precision than smaller ones. In addition to that, study design affects precision as well. Surveys or interviews collected all data in the ten studies. Precision is paramount in primary studies and meta-analysis studies. After conducting the meta-analysis, the researcher ended up with the synthesis of the effect sizes from all the ten studies through two analyses. The more weight was assigned to the studies, the higher the precision they gave (Borenstein, 2009).

One of the strengths of this analysis is that it has a large sample size of (3,836). This large sample size provides the power to compute a statistically significant P-value (0.00) and high heterogeneity. Also, the significance of the heterogeneity across all studies is a good thing. Unfortunately, this study suffers from publication bias as determined by Orwin's Fail-safe N. This study should have 4,170 more studies to bring the p-value to a higher value than alpha.

One of the limitations is that studies in languages other than English were not reviewed. Although this study is about Middle Eastern women, Middle Eastern databases were not reviewed. Also, since data were collected via surveys, potential recall bias may occur. Moreover, there is an issue of reliability of this study since it has only one reviewer.

A further meta-analysis that includes Middle Eastern databases should be conducted. Last but not least, only one researcher conducted this analysis, and that affects its reliability.

As meta-analysis can be play a role in planning for new studies, this meta-analysis can serve as a first step to plan for a new study using the two factors of (health providers-patients relationship, and privacy ) in Saudi Arabia across the private and the public sectors.



## CHAPTER 3

### EXPLORING MOTHERS' SATISFACTION DURING THEIR BIRTHING EXPERIENCES IN PRIVATE AND PUBLIC SECTIONS OF NATIONAL GUARD HOSPITALS IN SAUDI ARABIA.

Abstract:

Background and Aim:

High-quality maternity care dramatically reduces infant and maternal morbidity and mortality. Patient satisfaction is an important indicator of the quality of care because it demonstrates the differences between what patients expect and the current level of care received. Vision 2030 represents a blueprint of Saudi Arabia's future that is focused on improving the quality of health care through privatization. In support of the Vision, Saudi women gained back the majority of their rights, including autonomy to make their own decisions. While some research has elucidated women's satisfaction with maternity care within the public sector of National Guard hospitals, none have examined the private sector or compared it across sectors. With transformation toward Vision 2030 underway, this study is designed to measure and compare women's satisfaction with their labor and delivery care in public and private sections of two National Guard hospitals in Jeddah and Riyadh.

#### Method:

A convenience sample of 78 women across the public and private sectors of National Guard hospitals in Jeddah and Riyadh were recruited. Participants consented to the study and completed 20 minute, face to face, semi-structured interviews. All interviews were recorded, transcribed, and coded. Codes were analyzed using grounded theory to build a conceptual framework regarding women's satisfaction with their labor and delivery care across sectors and locations. Frameworks were compared to draw distinctions in perceptions across sectors and locations.

Results: Women within the public sector feel less satisfied with their care as compared to the private sector because of a lack of privacy, and nurses' mediocre attention to their concerns. Women within the private sector did not face those issues and also expressed a great doctor-patient relationship.

Conclusion: Women within the private sectors of National Guard hospitals are more satisfied with the care, particularly when it comes to the privacy and care provided by nurses. As Saudi Arabia transitions to privatization, careful attention should be paid to how women within the public sector are transitioned during the privatization efforts.

Specifically, attention should be given to the privacy that all women receive during labor and delivery as well as how women are cared for by nursing staff. How to maintain the level of the care provided in the private sector of hospitals while expanding care to meet the needs of all women given finite resources is a direction for future research.

## 1. Introduction:

Patient satisfaction is a critical indicator of the quality of care (Srivastava, 2015 ). Patient satisfaction is a comparison between what patients experience and what they expect (Pascoe,1983). Patient satisfaction is a goal now in every hospital in Saudi Arabia (MOH,2016), because it affects hospitals' reputations as well as patient outcomes. Studies have shown that satisfied patients usually tend to comply with medical treatments and therefore have better outcomes (Alnemer, 2015).

One can define women's satisfaction in childbirth as " the positive evaluation of distinct dimensions of childbirth" ( Linder-plz,1982). Two critical dimensions that women value are the safety and psychosocial wellbeing of themselves and their child (Alnemer,2015). Every woman deserves to have well-designed maternity care that can fulfill their expectations and personal, socio-cultural beliefs (Downe,2017). Due to the fast urbanization and the socio-economic transformation in Saudi Arabia, women are demanding high-quality health care services (Alnemer,2015). According to the World Bank, around 91% of female adults in Saudi Arabia are literate ( MOE,2017), and rising literacy rates suggest higher expectations for health services ( Lamadah, 2012). Higher expectations for healthcare means lower satisfaction because women are considering more dimensions to their care, and these women may not get them. Educated women usually tend to be more dissatisfied with maternity services than other women. For example, a descriptive study from Almadinah, in Saudi Arabia showed that older, non-educated housewives were more satisfied with their childbirth experiences as compared to younger, highly educated working women ( Lamadah, 2012).

As women's expectations rise, obstetrician and gynecology departments in Saudi Arabian hospitals must try and keep up. These departments are among the busiest as they try to deliver care that supports a high birth rate (18.3 births/1,000 ) while reducing infant mortality (13.2 deaths/1,000) (CIA,2017).

Studies around the world have proven that women's satisfaction in their experiences with prenatal care and giving birth reduces infant mortality (Lamadah,2012)(Govender,2018). Also, it reduces the risk of postpartum depression, which can lead to serious chronic diseases and chronic depression ( RIES,2018 ). Early detection of pregnancies' issues usually tends to be solved with prenatal visits and open communication between women and health providers. Currently, 99 percent of maternal death is located in developed countries ( WHO,2010). Maternal mortality is higher in poor communities and in rural areas. "The maternal mortality ratio in developing countries in 2015 is 239 per 100 000 live births versus 12 per 100 000 live births in developed countries"( WHO, 2018).

A Saudi study concluded that access to maternity care is not the only solution to improve maternity outcomes and reduce infant mortality.( Lamadah, 2012). The care that is delivered also must be of high quality and meet women' needs (Lamadah,2012). High-quality maternity care encompasses four pillars: clean and safe delivery, good quality antenatal care, family planning, and essential obstetric care (Cohen,2005). However, because women usually do not have clinical experience, their expectations and satisfaction are influenced by non-clinical factors such as health providers' good behaviors, kindness, and privacy (Alnemer,2015).

Within Saudi Arabia, assessing patient's satisfaction faces additional challenges that are associated with the structure of the system. Hospitals within the Saudi health system have a public and a private sector. To clarify the differences between the two sectors, the private sector plays a significant role in providing high-quality health services, but it is costly (Alkhamis,2017). Women obtaining private sector services may pay out of pocket or be covered by private insurance. Women in the private sector have their own private rooms and can have companions during admission. In comparison, women in the public sector can access public hospitals and receive medical services free of any cost. However, the long waiting lines and the low quality of the services are two major issues in such hospitals ( Alkhamis,2017 ). Women in the public sector share rooms with other women. Such women cannot have companions with them due to hygiene and infections concerns.

It has been noted in a Saudi study, which was conducted in 2018, that Saudis are willing to pay for high-quality services in the private sector instead of suffering low quality and long waiting time, but free services, in the public sector. Patients who were recruited from some public hospitals were dissatisfied with the low quality of services, health providers' attitude, and the long waiting time ( Alkahames). It should be noted that patients are seeking timeliness and high quality of care in the private sector even though they will pay for its services. No studies have asked women in labor about their health sector preferences yet and in which sector they will be more satisfied.

Based on a meta-analysis (chapter two of the dissertation), Middle Eastern women in public hospitals were not satisfied with the relationship with their health providers and the amount of privacy during their hospital stay. However, little is known about how

women within Saudi Arabia feel about the maternity care they receive. To date, only two studies have examined women's satisfaction with antenatal (before birth) and post-labor and delivery care within the public sector in Saudi Arabi. In the first, one-third of women who received antenatal (before birth) care from primary health care centers in Madinah, Saudi Arabia were not satisfied with their health providers' interaction with them (Lamadah,2012). The second assessed women's satisfaction with their care 24 hours after birth in three public hospitals. This study found that women felt that the relationship with their provider was the leading cause for a more satisfying birth experience and that hospital rules and policies could decrease satisfaction if they were implemented without women knowing why they were necessary. Additionally, communication is a challenge, because most nurses in Saudi hospitals speak English, but only few women are fluent. Even for those who are fluent English speakers, women in labor may not be able to effectively use their second language to articulate their needs to nurses (Govender, 2018).

Despite this work, a knowledge gap remains in terms of understanding how satisfied women are with their maternity care in the private sector of Saudi Arabia's hospitals. Understanding women's satisfaction in the private sector is fundamental because of the Vision 2030, which plans to transform the kingdom through privatization of the health care sector. Furthermore, this study is going deeper and looking at a richer set of health providers' interactions with women. This study is considering how doctors, nurses, and hospital support staff affect women' satisfaction. Moreover, not only are OB/GYNs being considered, but also pediatricians and anesthesiologists.

In 2017, women gained back the majority of their rights to support the 2030 Vision (2030 Vision, 2017). With such a transformation underway in Saudi society coupled with

women having more autonomy, this study is designed to measure and compare women's satisfaction with their maternity care during birth across the private and public sectors in two National Guard hospitals in Jeddah and Riyadh. The goal is to compare and contrast what underlies satisfaction in both sectors of a hospital that has the same policies and procedures towards maternity care. This understanding will inform policy makers about policies and improvements in the quality of the delivery of maternity care as the transition to privatization begins.

## 2. Methods

### 2.1 Research Design

This study employs qualitative semi-structured interviews to gather perceptions of women who delivered in public and private sectors of two National Guard hospitals in Jeddah and Riyadh. Data was collected using a standardized interview guide and three interviewers who were all trained to follow the guide in a standardized way.

### 2.2 Study Sites and participants recruitment:

To reach a convenience sample for the study and reflect population, two different locations were selected. This study has considered two various National Guard hospitals (NGHA) in Jeddah and Riyadh. Traditions, cultures, and lifestyle are different in both locations, which help us to see different perspectives of the problem. Moreover, geographical diversity may influence experiences, opinions, preferences, and points of views of each participant (Alhanawi, 2018). The maternity wards in the National Guard Hospitals are one of the busiest. The public sector has more women than the private sector. National Guard workers and their dependents have access to the public sector. On the other

hand, other women can pay for high quality services in well-trusted governmental hospitals in the private sector.

It is important to note that health providers and policies are the same for public and private patients. However, the structure of the hospital in the public sector forces women to share rooms with other women and their newborns. On the other hand, women in the private sector may have private rooms if available. Nurses are serving both sectors' patients in the same ward.

The recruitment strategy and interview logistics are as follows: First, co-investigators distribute recruitment flyers (Appendix A) to all eligible women in both public and private sectors and ask women if they wish to be interviewed after delivery and after recovery before their discharge. Eligible women are the ones who met the inclusion criteria which was set for this study. Women should be adult, be experiencing their second giving-birth or subsequent giving-birth, be in good health, have a healthy newborn, and be able to consent to the study's consent form. Women who were having their first child were excluded from this study. We excluded them because these women may be dissatisfied due to their lack of experience when it comes to birth difficulties. Also, we want women who had previous deliveries and navigated the health system to enrich our data with comparisons of their experiences.

The head nurse is the one checking the eligibility of women prior to interviewing them based on the inclusion and exclusion criteria. Furthermore, discharged women can be interviewed via phone for their convenience. Second, once women agree to participate, the investigator will explain the consent form (Appendix B), and women will consent by



signing the form. Co-investigators proceeded with a semi-structured, one-to-one interview with women in their room before their discharge or via phone after their discharge.

### 2.3 Data Collection

A convenience sample of women was recruited and interviewed. The sample of women was selected based on the willingness of participants to participate in the study following labor and delivery in order to understand women's perceptions of satisfaction in their interactions with their obstetricians, nurses, and support staff.

The interviews were conducted in Arabic for over ten months (July 2018- April 2019). All interviews were conducted by the first author (HA) and two co-investigators (HM, AA). The development of the semi-structured interview questions (Appendix C) was based on the available online published Middle Eastern literature in general and the Saudi literature in particular. The interview questions were divided into three sections. The first section covered the socio-economic and demographic information about each participant and women's general views regarding their satisfaction with the services provided. The second section gathers women's perceptions regarding how their interactions with doctors, nurses, and support staff contribute to satisfaction with their care. Specifically, we focus on how women are treated by these care providers concerning courtesy and respect. The third section focuses on privacy by asking women about the amount of privacy in their room as well as when they needed to communicate with health providers.

All participants were informed about the study aims and objectives. The interviews took place in women' rooms in the hospitals. Some women were contacted via phone after discharge, or the co-investigators met them in an affiliated clinic in the hospital. The

participants were informed that they could withdraw from the study at any time if they wished without providing any reason to the investigators. They were assured that the information provided would be anonymous and confidential.

The average length of the interview was on average about 20-40 minutes. Recorded interviews were stored on an Olympus recorder. De-identified interviews were saved on a computer hard-drive. Interviews were transcribed into a PDF for coding and theming by the co-investigators. Transcriptions were viewed by approved co-investigators in the project and kept only for the study purposes. We got the IRB approval from King Abdullah International Medical Research center in August 12, 2018 (#SP18.361J) (Appendix D). Furthermore, we received the IRB approval from the University of South Carolina in August 28, 2018 (#PROO00078703) (Appendix E).

#### 2.4 Data Analysis

A grounded theory approach was used to analyze the transcriptions (Bernard,2011). Investigators independently followed steps of familiarization with transcripts, coding, developing a working analysis, creating the application of a working analytical framework, charting data into a matrix, and lastly, interpretation (Gale,2013). Co-investigators applied an inductive analysis technique wherein the raw data was reviewed to identify patterns, ideas, or key themes that emerged (Thomas,2006). Investigators used the 'constant comparison' technique to review data to ensure that the full breadth of concepts emerged from the raw data. Investigators reviewed each unit of data several times to allow for meaningful concepts to emerge and to make connections between those concepts. Data was continually compared and reviewed until we reached saturation, wherein no new

themes or ideas appeared to emerge from the data. NVIVO qualitative software was used for the analysis.

Coding is the process of categorizing the data into meaningful categories. Initially, three investigators used open coding techniques to generate an initial list of emergent ideas or 'codes.' To ensure inter-rater reliability, the co-coders coded five interviews independently. After independent review, the three individuals compared their coding schemes, discussed discrepancies, and reached consensus on a coding scheme. Codes were synthesized into a list or 'code book' which outlined each code and its description. Following the initial open coding process, we moved to selective coding wherein remaining interviews were categorized based on the established categories outlined in the codebook. The selective coding process generated themes to illustrate and explain the observations in the study. Finally, we summarized themes and identified any emergent concepts that may be developed into a theoretical model for future study.

The theoretical model allowed co-investigators to describe commonalities, patterns, and significant themes that emerged from the transcripts. We compared the findings within and across both hospitals.

### 3. Results

#### 3.1 Descriptive Characteristics of the Sample

In this study, we reached saturation after interviewing 78 women from both locations in Jeddah and Riyadh. Saturation is defined as the point in which no new information is identified from conducting an additional interview.” Saturation of data

means that researchers reach a point in their analysis of data that sampling more data will not lead to more information related to their research questions” (Seale,1999).

Thirty-eight women were interviewed in Riyadh's National Guard Hospital, 20 women from the private section and 18 women from the public section. Forty women were interviewed (20 from each sector) in Jeddah's National Guard Hospital. Table 3.1 shows descriptive characteristics of the participants in the sample across Jeddah and Riyadh.

Table 3.1 Descriptive Characteristic of the participants

	Jeddah		Riyadh	
	Public	Private	Public	Private
	N=20 (%)	N=20 (%)	N=(18)	N=(20)
Age				
20-25	4 (20%)	2 (10%)	5 (28%)	1 (5%)
26-30	8 (40%)	10 (50%)	5 (28%)	7 (35%)
31-35	3 (15%)	3 (15%)	3 (17%)	5 (25%)
36-40	2 (10%)	5 (25%)	4 (22%)	4 (20%)
41-45	3 (15%)	0 *	1 (6%)	3 (15%)
Mean of age group	30.9	30.7	30.36	33.22
Nationality				
Saudi	19 (95%)	17 (85%)	18 (100%)	17 (85%)
No Saudi	1 (5%)	3 (15%)	0*	3 (15%)
Education				

Master	1 ( 5%)	0*	0*	0*
Collage	12 (60%)	13 (65%)	8 (44%)	11 (55%)
College student	0 *	1 (5%)	1 (6%)	1(5%)
Diploma	1 (5%)	0 *	0 *	0 *
High school	4 (20%)	5 (25%)	4 (22%)	6 (30%)
Middle school	2 (10%)	1 (5%)	3 (17%)	1 (5%)
Elementary School	0 *	0 *	2 (11%)	1 (5%)
Employment				
Employed	6 (30%)	5 (25%)	2 (11%)	4 (20%)
Housewife	14 (70%)	14 (70%)	15 (83%)	15 (75%)
Student	0*	1 (5%)	1 (6%)	1 (5%)
Newborn Order				
Second Newborn	9 (45%)	14 (70%)	6 (33.3%)	5 (25%)
Third Newborn	5 (25%)	4 (20%)	4 (22%)	5 (25%)
Fourth Newborn	4 (20%)	2 (10%)	2 (11%)	4 (20%)
Fifth Newborn	0*	0*	3 (17%)	3 (15%)

Sixth Newborn	1 (5%)	0*	3 (17%)	2 (10%)
Ninth Newborn	1 (5%)	0*	0*	1 (5%)
Mean of newborn Order	3.2	2.4	3.6	3.85
* No reported data				

The age of women recruited for this study ranged between 20 – 45 years old. The average age among women was consistency across locations and sectors, except for the private sector in Riyadh; it was a bit higher. The mean value among women in Jeddah was 30.9 in the public sector and 30.7 in the private sector. In Riyadh, the mean age was 30.3 in the public sector, and 33.2 in the private sector.

Regarding the nationality of the participants, the majority of them were Saudi Arabian. 95% of women were Saudis in the public section in Jeddah, and 100% of women in public Riyadh were Saudis. In the private sector, 85% of the women in both location where Saudis. Women, who were not Saudi, were of different nationalities, including Egypt, Syria, Sudan, Yemen, and Ethiopia, and they were legal residents in Saudi Arabia.

In terms of women' education, the majority of women in both locations were college degree holders. Sixty percent of the public women in Jeddah were college degree holders, 65% in private sector Jeddah, 44% in the public sector in Riyadh, and 55% in the private sector in Riyadh as well. Jeddah's women tend to have more college degree holders

than Riyadh's women. The highest degree was a master degree, which found in Jeddah's public sector. The lowest degree was an elementary degree found in private Riyadh.

In terms of employment, the majority of women in both locations were housewives. This feature of the sample is consistent with the patterns of the female employment rate in Saudi Arabia (23.37%) ( Global Economy, 2018 ). Within the sample, 30% of women were employed in the public sector in Jeddah and a lower rate of 11% in the public sector in Riyadh. In the private sector, 25% of the women were employed in Jeddah compared to 20% in private Riyadh. The employment percentages were not consistence for public women across both locations, but they were close across the private sectors. Furthermore, around 5% of the women were students in college in private Jeddah, and Riyadh's both sectors.

This study focused to focus on assessing the satisfaction of women when they had previous experiences giving birth. The majority of women were having their second newborn at the time of recruitment. However, the number of births ranged to as high as the ninth birth. The mean value of the number of newborns was calculated using the mean formula for frequency, and we found that the mean of the number of newborns in Jeddah's public women was (3.2), which is higher than the one in the private sector (2.4). In Riyadh, we found consistency in the mean of the number of the newborns (3.6 in public vs. 3.85 in private). Furthermore, we found consistency across both locations regarding the type of delivery in which the majority of women had a natural birth.

### 3.2 Major Themes and Sub-themes for Women's Satisfaction with Maternity Care

In this study, we found that women's satisfaction across sectors and locations was related to three major themes stemming from actions taken by the hospital, doctors, or nurses. Major themes and sub-themes for each sector and location are detailed in Figures 3.1 – 3.4. Under the hospital theme, the most common sub-themes are National Guard policies, quality of services, and privacy issues. For the doctors, caring, respectful, informative, and non-negotiables are some of the major subthemes. For nurses, competent, uncaring, rude, respectful, and kind were some of the major subthemes.

#### 3.2.1 Women's Satisfaction in the private sector in Jeddah's National Guard Hospital.

Figure 3.1 shows the major themes and sub themes for women in the private sector in National Guard hospital in Jeddah. The larger the bubble, the more important the issue was for the private patient in Jeddah. The two most glaring themes were hospitals and doctors , followed by nurses.

In Jeddah, one of the critical subthemes under hospitals is privacy. As seen by the bubble entitled "Good Private Room" in Figure 3.1, 12 out of 20 women in the private sector in Jeddah reported being satisfied by their private room. Overall, this is illustrated by women saying:

*"I had a private room for myself. I loved it. It was great and good privacy. The room was clean and good." (Patient 7).*

*"I had a private room because my husband asked them for one. Our insurance covers a private room for me right after the delivery". (Patient 18)*



Not all private women got a private room from the beginning of their hospital experience, in fact some struggled with the business center in order to be moved from a shared room to a private one. This is shown by the “Poor Business Center” is noted in Figure 3.1. Specifically, women noted: *“I had another problem with the Business center. My insurance coverage included that I will get a suite. I did not get a single room even. They were not collaborative with me nor informative on why I did not get the suite that I should have. The second day, they moved me”*. (Patient 2)

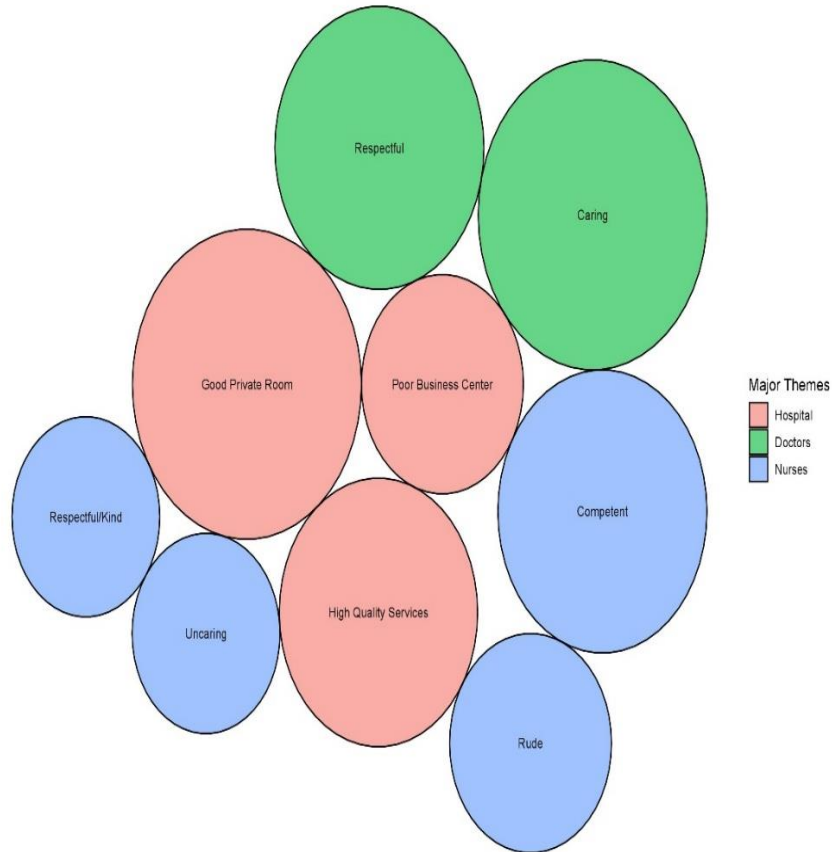


Figure 3.1 Major Themes of Women’s Satisfaction in Jeddah’s NGHAs-Private Sector

*"I did not like the room and the mattress. I can say the cleanliness of the room is %70 out of 100/ I did not like it. I was very disappointed when in the beginning they put me in a shared room! I paid SR 19000 (\$5000), and it is a common sense that I should have a room! A clean one". (Patient 1)*

In terms of satisfaction with the hospital, the majority of women felt that the most important reason for them to deliver in the National Guard is because of the good reputation and the high quality of medical services in this hospital. As seen in Figure 3.1, nine women noted the "high quality services," and women specifically said:

*"I came to the National Guard due to its great reputation. I liked that it is clean. I felt that I am at home not at a hospital. So warm and kind staff are here". (Patient 14).*

*"Because of the good reputation. The doctors here are famous of their excellent performances". (Patient 8).*

*"I choose the best hospital in Jeddah because of the good reputation, especially with childcare. I knew that I might be in a shared room, but I accepted because I needed good care for my baby" ( Patient 5).*

In terms of the major theme of doctors, women stated very clearly that they paid for honest and trusted governmental doctors who supported normal deliveries. Undoubtedly, women were pleased by their doctors, and most commonly saw them as respectful and caring (Figure 3.1). Specifically, a woman said:

*"I delivered the first baby in a private hospital. They delivered me via c-section. I planned to deliver in a public hospital as a private patient so I can deliver normally. It is well known*

*that public hospital is not seeking unnecessary c-section. So I chose a well-known hospital with a good reputation for quality" (Patient 6).*

*Another one added: "I delivered my first baby with c-section . and in this pregnancy, I was following up in a private hospital. But I wanted to deliver normally, and I was advised to go to the National Guard. I came over late Friday, and I found two Saudi female doctors. They were wonderful. They helped me in a natural delivery. I would choose the National Guard next time if I got pregnant." (Patient 7).*

*"look, the doctors are the best, their excellent experience and their Diagnosis of the condition were very good actually. The surgery went great, and they were kind and respectful" (Patient 19).*

Besides having respectful and caring doctors, many women commented about the nurses who cared for them. As seen in Figure 3.1, the majority of private women in Jeddah found their nurses to be competent, respectful, and caring. One woman said:

*" the nurses were so kind and collaborative. They helped me a lot. Even in the bathroom, they helped me and massaged my back. They helped me with breathing and relaxing. They were so kind" (Patient 2).*

*"after the delivery, I had the best care ever. Best than what you can imagine. The nurse I had was the best. She took me to the bathroom and gave me a bath; then she gave me a meal and a hot drink. She was holding my hand during the delivery and the stitches. Great care and emotional support" (Patient 10).*

However, women also noted frequently that the nurses were rude and uncaring as it is shown in (Figure 3.1). Complaints about nurses negative attitudes were emerging from patients interviews including:

*"not all nurses are nice. One nurse came at night and saw my sister as a companion. She yielded at us and asked my sister to leave. My sister said that she is not leaving because she is a companion to a private patient (me) . and we are moving to a private room. The nurse threat to call security. My sister went to the head nurse to tell her what is happening; Then the nurse came apologized for the misunderstanding of the situation"* (Patient 17).

Another woman complained by saying:

*"the delay and nurses attitude. They were rude and as if they were bothered"* (Patient 19).

### 3.2.2. Women's Satisfaction in the public sector in Jeddah's National Guard Hospital.

Figure 3.2 shows the major themes and sub themes for women in the public sector in National Guard hospital in Jeddah. The larger the bubble, the more important the issue was for the public women in Jeddah. From the three major themes, the hospital themes was the most palpable issue among these women followed by doctors.

In terms of the (hospital) theme, the majority of the women in public Jeddah choose the hospital due to its excellent reputation and high quality of medical care as well. As the figure 3.2 shows, one of the important things that matters to women was the quality of the services in the National Guard hospital. A woman Said:

*"I know their great reputation in medical care, and I have a file here since my husband works in the National Guard"* (Patient 20).

Another woman told us:

*"The National Guard has a well-known reputation for good services. It is much better than all hospitals of the ministry of health"* (Patient 8).

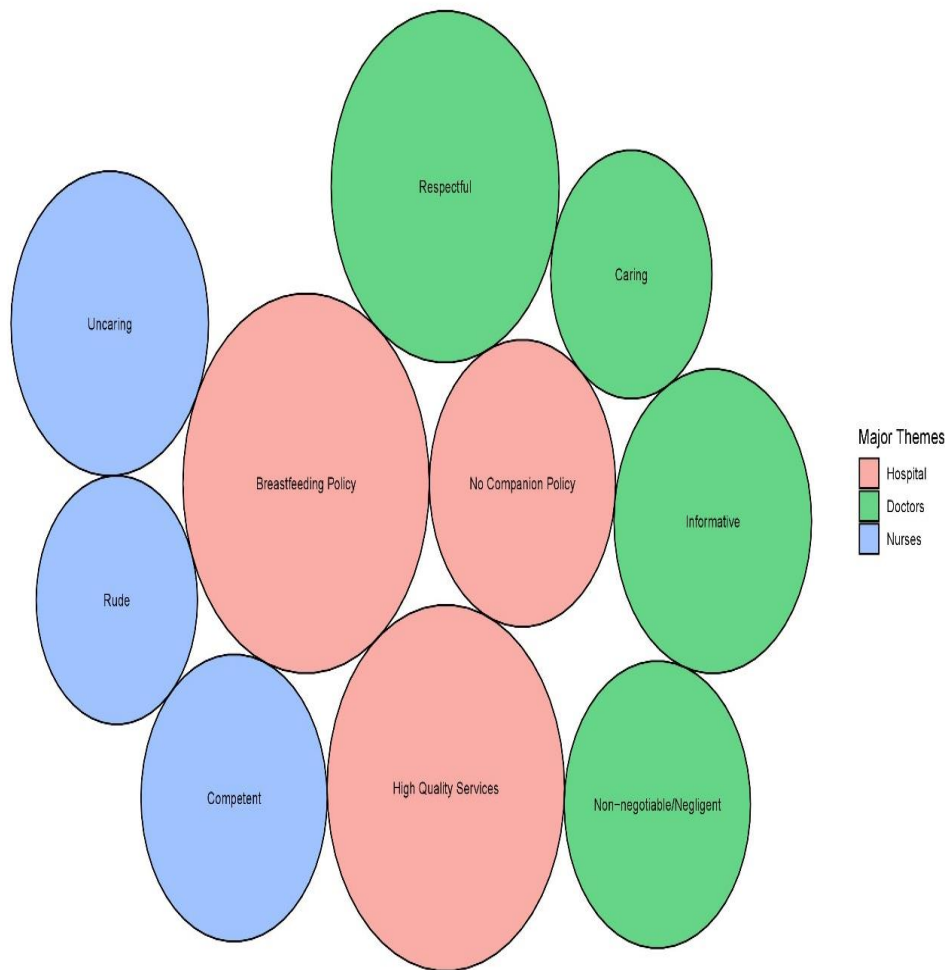


Figure 3.2 Major Themes of Women's Satisfaction in Jeddah's NGHA- Public Sector

However, women were not found satisfied with other non-medical issues like strict policies (Figure 3.2). For instance, the National Guard hospital supports breastfeeding and newborns are located with their mothers for bonding and feeding. Public women in the shared room found it extremely difficult, especially without companions to help. For instance , a woman said: *"I wanted a companion to stay with me, and I wanted the nurses to take the baby to the nursery. Taking care of a newborn while you are tired is hard"* (Patient 5)

Another woman complained:

*"they don't take babies to the nursery room even if mothers are tired and they don't allow a companion to stay and help!"*(patient 6)

Moreover, in terms of the (doctors) theme, women were pleased with their caring, respectful, and informative doctors. A women said: *"I was following up with a female doctor. She was so nice. And I was lucky enough to find her in the delivery room with me .She is so respectful and informative. She helped me a lot, and she was above and beyond"* (Patient 18).

However, some women found doctors hard to negotiate with. Some women tried to talk to their doctors and take more information form them but doctors were not open with them for instance, a woman said: *"some doctors were not opened to talk. I wanted to know sometimes more about test results, but the doctor talks very little about it or only say: your test result is normal. I couldn't ask her for more details because she was busy reviewing or writing in the computer"* (Patient 19).

Furthermore, some women complained about their doctors' negotiation techniques with their women . A woman told us how doctors were hard to listen to their women and ask them about what they prefer, unlike other doctors in private hospitals.

*" do you think doctors here like the ones in other private hospitals listen to you and ask you about what you prefer? No, my dear, No negotiation or what so ever"* (Patient 1) In terms of the (Nurses theme), the majority of women found their nurses to be medically competent. However, many complained about the carelessness and the rudeness of the nurses (Figure 3.2).

*" when I ask the nurse for any help, I feel as if I am begging her."* (Patient 3)

Moreover, another woman told us: *"Some of the nurses are rude and do not care to help me. Others are very slow in coming"* (Patient 7).

### 3.2.3 Summary and Comparison of Results in the Private and Public Sector in Jeddah

There are some similarities and differences between the two sectors in Jeddah's location. The primary reason that made women come to deliver in the National Guard was its good reputation of high-quality medical services. However, one of the bothering issues for private women is not having a private room from the beginning and the difficulty in dealing with the business center. Nevertheless, public women were bothered by two policies: the breastfeeding initiative policy and the no companion policy. Women found having their newborn with them the whole admission time without companion and without nurses help extremely difficult, especially for women who delivered their newborn via c-section. Undoubtedly, these policies were not an issue for private women in their private rooms. Those women have companions with them.

Furthermore, private women found their doctors caring and respectful, just like public women. However, some public women found it challenging to negotiate with their doctors; sometimes, others found them informative.

Another similarity between the two sectors is that women found nurses medically competent. The majority of the private women found nurses were kind and respectful. However, some private women were in shared rooms, and they have been treated as public women. These women and many other public women found nurses were rude and uncaring.

#### 3.2.4 Women's Satisfaction in the private sector in Riyadh's National Guard Hospital.

Figure 3.3 shows the major themes and sub themes for women in the private sector in National Guard hospital in Riyadh. The larger the bubble, the more important the issue was for the private women in Riyadh. The most distinct theme here is the doctors theme followed by hospitals and nurses.

Regarding the (hospital ) theme, women in the private sector in Riyadh came to the National Guard hospital seeking high quality. The reputation of the hospital is well known among many of them (Figure 3.3) .

One woman told us:

*"I am their loyal patient since my first delivery of my first baby, 17 years ago. I delivered him in the National Guard and all my other kids. I love this hospital. You can trust them. They make the right decisions at the right time"*( Patient 10).



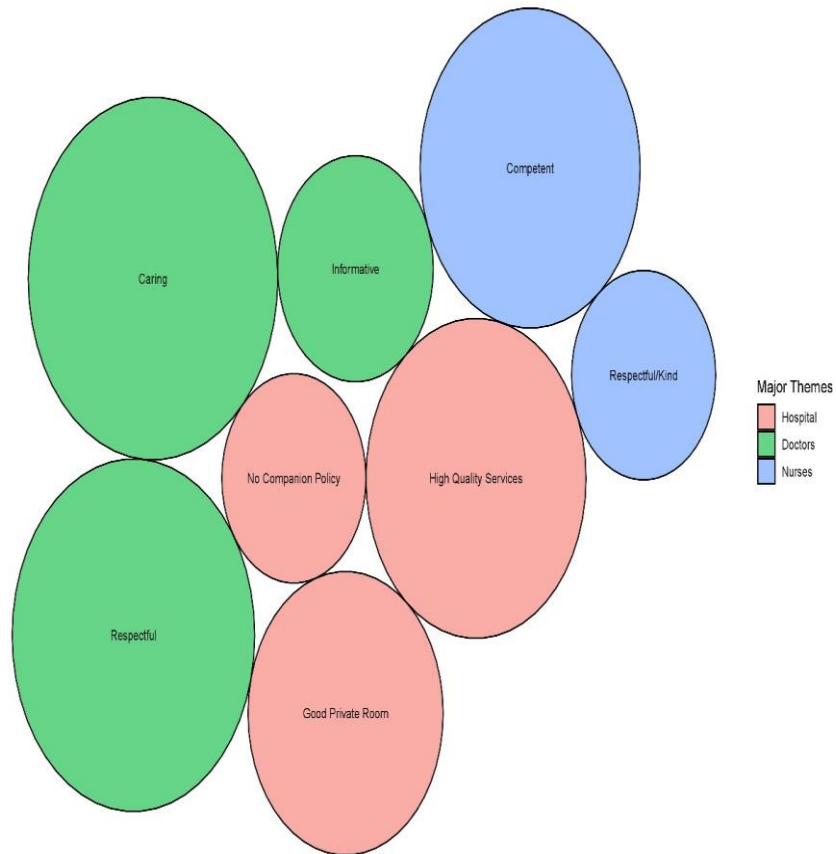


Figure 3.3 Major Themes of Women’s Satisfaction in Riyadh’s NGHA -Private Sector

Another woman said:

*“In my point of view, I trust having medical care from a governmental hospital. This hospital has a good reputation in Riyadh concerning maternity care.”* (Patient 14).

Regarding privacy, women who had their private rooms were delighted with its privacy and its comfort.

*“had a private room, thanks to God, it was so nice and comfy”* (Patient 17).

Moreover, one woman told us : *“the room was private, clean, and comfortable.”* (Patient 5).

However, the women who have shared room were frustrated and bothered. They complained about noise, hygiene issues, and lack of privacy. They were angry because they paid for a private room, but unfortunately, they could not get one for vacancy issues. For instance, a woman said: *“ here is the chocking experience. The nurses, after the delivery, told me that the OB ward is fully private and shared beds. They took me to a shared room with old ladies. They were chatting and having visitors the whole time. I couldn't rest nor nurse my baby. I asked the nurse multiple times to bring the baby to me, but she said that she couldn't. The room is too dangerous to the baby ! it was not safe for me as well. Emotionally I was divested! Not as I imagined at all. I had great insurance, and that did not help. I told them that I need to go to another hospital then! I was so nervous. It was after 9 hours or so when they took me to the OB word and gave me my baby but still in a shared room. I had no privacy in both location”* (patient 11).

Concerning the (doctors) theme (Figure 3.3), women were pleased by their doctors in general. The majority of the private women in Riyadh found the doctors caring and respectful while some of them found them informative . One woman told us:

*“very nice, very respectful. I went to follow up in another private hospital that is closer to my house, but I did not feel comfortable, I went back to the National Guard which I was very comfortable with its doctors”*(Patient 1).

Many women praised their doctors and were please by their good attitudes. A woman told us: *“The doctor was fast and professional; this is what I liked the most. She*

*was handling my pain in patience, and she was supporting me very kindly. She respected my privacy, and I was comfortable throughout my stay. She very respectful and answered all my questions fully and kindly”(Patient 2).*

However, not all doctors were professional in communicating with mothers regarding their health and their newborns’ health. For example a woman told us::

*“My OB was nice and kind, she respected my privacy, but the pediatrician was rude and unrespectful. Also, he scares me to death regarding my baby's health. The doctor scared me that my baby may not be able to hear or see, my baby is fine and healthy. If these are possibilities, the doctor should learn how to talk to mothers gently so mothers can adjust the information” (Patient 10).*

Some women complained about their doctors; attitude, and some felt some barrier in dealing with them. We had a woman complained about this issue by saying: *“The treatment of the female doctor who delivered me, she was unrespectful and uncaring. I told her that I feel the baby is coming, and she said, no not yet. In a rude manner. I told her, can you check, please? She checked, and she screamed: do not push, hold yourself. She covered my private area with a blanket and treated me without any respect. I was so angry and nervous. What kind of treatment is this?” (patient 16).*

Moreover, a woman told us about a lingual barrier that affect her communication with her non -Arabic speaking doctor.

*“it was very hard talking to her ( her doctor ), so I asked her a few questions that concerned me the most. It was hard talking to my doctor because she was Indian and cannot speak Arabic well. And my English is not that much”(Patient 4).*

Regarding the (nurses) theme (Figure 3.3), nurses were found medically competent by the majority of the women, and many women were pleased with their caring and kind attitude. A woman noted: *“They are respectful. They are caring. They are beyond nice; they do excuse before entering my room. They stopped by frequently to ask about me and to see if I need anything”*(Patient 5).

However, some women, especially who were in shared rooms, complaining about their rudeness and carelessness. One woman complained about the carelessness of some nurses saying : *“They are the worst. Because the doctors are not around usually, the nurses are the ones who decide to make you comfortable or not. They were uncaring; I can't describe how much uncared they are. I told a nurse that I need a juice, I need some sugar I am diabetic. She ignored me. Also, she saw me shaking because it was cold, I told her I need a blanket, she ignored me again, I am a private patient; I wish I went to another private hospital. I would receive the greatest services with the same money I paid here”* (Patient 16).

### 3.2.5 Women’s Satisfaction in the public sector in Riyadh’s National Guard Hospital.

Figure 3.4 shows the major themes and sub themes for women in the public sector in National Guard hospital in Riyadh. The larger the bubble, the more important the issue was for the public women in Riyadh. The most recognized theme here is hospital followed by doctors and nurses.

In regards of the (Hospital ) theme, and like the other women, women in the public sector in Riyadh came seeking high quality and trusted the reputation of the National Guard hospital.

A woman told us :

*“I did not like my last delivery in another public hospital. So my husband told me to deliver here due to the good reputation of this hospital since I have access to it because my husband works for the National Guard. It is far away from our house but yet, I decided to deliver here seeking good quality”*(Patient 10).

Many women in the public sector came to this hospital because they were dependents to National Guard employees so they have access to it. Besides, they were seeking high quality as well. Many witnessed such high quality in their previous deliveries.

A patient noted,

*“my husband works for the National Guard, but I delivered all my children here because it is the best hospital in Riyadh.”*(patient 14).

Although women came to the National Guard seeking quality (Figure 3.4) , many complained about the shared rooms and the lack of privacy. Women complained about hygiene issues and noise in such rooms. One woman complained:

*“I feel suffocated! Curtains surround me in a small area. It is very annoying, and I am bothered having other women with their newborns all in one room”* (Patient 13).

Another woman said:

*“I am not satisfied at all. The section of the room is fine, but the noise was very high. Also, the cleanness is not very good, especially in the bathroom. Four women in one bathroom and they clean the bathroom twice a day only! It is very gross”* (Patient 6).

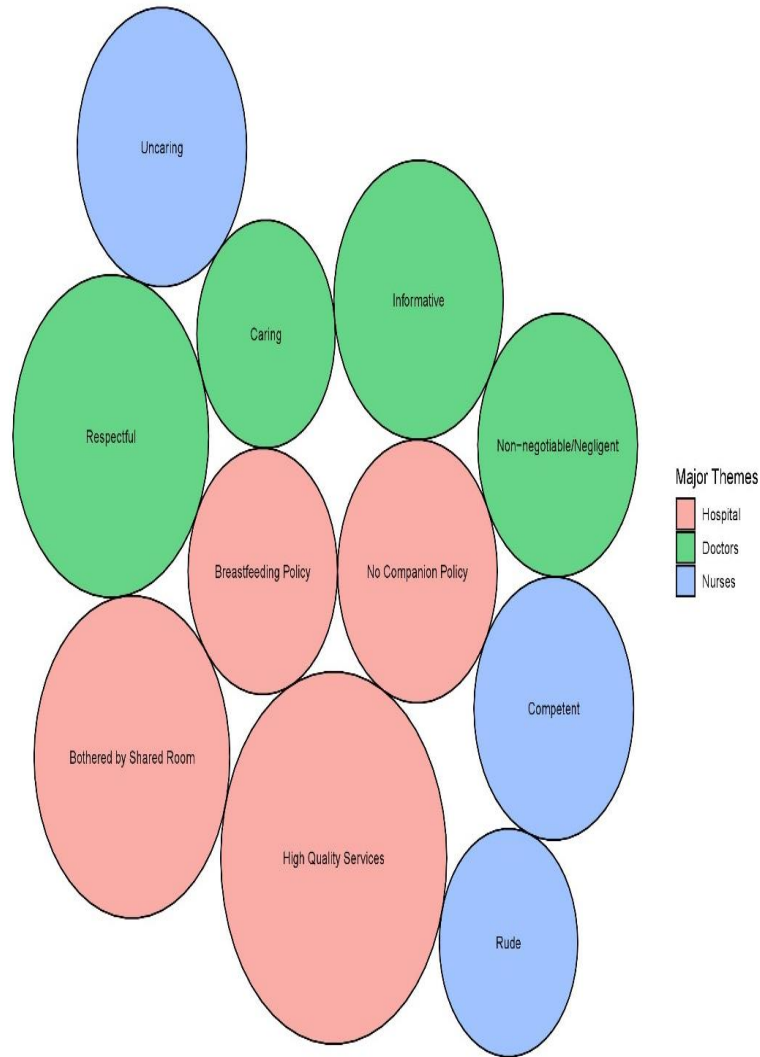


Figure 3.4 Major Themes of Women’s Satisfaction in Riyadh’s NGH- Public sector

Moreover, women were complaining about the policies just like the women in public Jeddah. Women felt it hard to take care of their newborns in their shared room and without any help from a family member or nurses.

*“the most important thing to me is to have a companion with me, or they take the baby in the nursery room for me to get some rest.” (Patient 11).*

Regarding the (Doctors) theme, women found doctors caring and respectful. However, some women felt their doctors were informative and some felt their doctors unnegotiable A woman said:

*"I never had a problem with the doctors. They were caring and above respectful. I felt they were listening to me. They gave me the support and care I needed."* (Patient 3).

Furthermore, one woman told us:

*"I liked the mercy in Saudi doctors' hearts. They are full of mercy, although my doctor did not listen to me from the beginning, I don't lie when I say he was so merciful and good"* (Patient 6).

However, a patient complained about the attitude of her doctor saying:

*"But the doctor who was in the delivery room me was angry because I was screaming out of pain. She told me with anger, why you are screaming? I told her I think you know I am in pain! she told me this is not even your first child!"* (patient 18).

In regards of the (Nurses) theme (Figure 3.4), women were satisfied with their nurses' medical competence. However, the majority of them complained about the carelessness of some nurses. A woman said:

*"The nurses' attitude. All the nurses here are acting very rude ( Have psychological problems perhaps). They are mean and rude even when they handle me the baby they do so without mercy! They are not gentle. Not like the nurses in the delivery room, they were better. I asked a nurse to help me to go to the bathroom; she told me to go by yourself! I*

*told her I am sick, and the c-section is making me moving hard. She told me: go to ICU then why you are here! Imagine that!” (Patient 6).*

Another woman noted:

*“Look, not all nurses are respectful. Some nurses are rude. For example, I called a nurse when I needed her to help the most. She came angry and rude; she did help me but with anger”(patient 16).*

Nevertheless, some women found nurses to be kind and respectful. One woman noted:

*“Nurses are the best! They are so professional and excellent”( Patient 5).*

Another woman added:

*“They are so respectful. Even when they measure the pressure, they excuse. They are informative too. They are telling me in details about any medication or procedure they do”(Patient 9).*

### 3.2.6 Summary and Comparison of Results in Riyadh’s Private and Public Sectors

Both private and public women believed in the high quality and good reputation of the medical services in the National Guard. Furthermore, the policy issues are apparent in the public section; however, some of the private women, who had shared rooms, complained about the " No companion" policy. Moreover, women in both sectors felt that doctors were caring and respectful. As well as that, they believed that nurses were medically competent. In spite of that, public women felt the carelessness and the rudeness of some nurses.



#### 4. Discussion

The study has elucidated the similarities and differences in women's satisfaction with their labor and delivery care across the private and public sectors of two National Guard Hospitals in Jeddah and Riyadh. As seen in Figure 3.5, women's satisfaction was driven by three main themes: hospital, doctors, and nurses' actions. These three main components of a woman's maternity experience and satisfaction established a cyclical effect, wherein each major component continuously influenced the other, and, therefore, each and every woman and their satisfaction. All of these themes are tangled together, framing women's satisfaction (Figure 3.5). For instance, hospital's policies are affecting nurses in dealing with women. The misunderstanding that happened between women and nurses regarding the new breastfeeding policy can explain such interaction. The problem was not from nurses nor from hospital's policy. The issue was in linking the dots between the hospital and nurses. There can be a disconnect in between whether or not nurses fully understand the policy, which in turn affects how the nurses explain it to the mothers.

It is important to note that women in both sectors have the same doctors and nursing staff. The things that may differ between the two sectors are some of the policies and the rooms. For instance, the "No companion" policy is different between the public and the private sectors. After admission, private patients are the only ones who can have one companion to stay with them in their private rooms. However, patients in both sectors can have a family member to support them during delivery. Moreover, private patients are allowed to have private rooms since they are paying for the medical services. This is unlike public patients, who are expected to share rooms with each other.

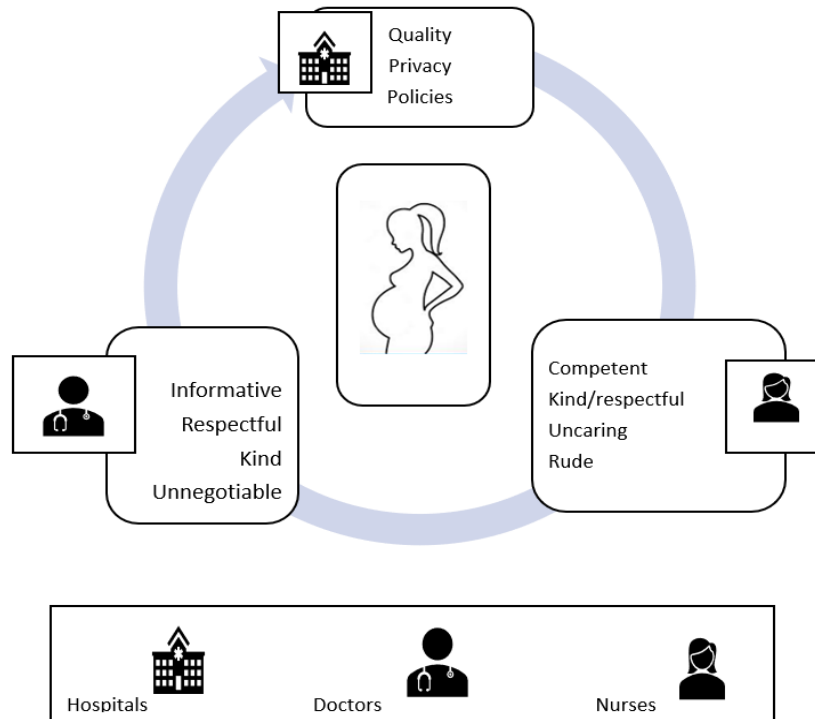


Figure 3.5 Framework of Women’s Satisfaction across Locations and Sectors

#### 4.1 Women’ satisfaction regarding the hospital:

Women’s satisfaction with the hospital was driven by its reputation for quality and its ability to afford privacy. National Guard hospitals’ quality of services was the number one reason for choosing the hospital among women across locations and sectors. woman in the private sector were willing to pay for excellent services that are provided by doctors who have a good reputation and work for the government. These women frequently commented that they trusted that their doctors knew what they were doing, and they believed that the hospital was not revenue seeking. In fact, this is a reason why most women chose to deliver in the private sector of a governmental hospital and not in private, revenue seeking, hospitals. Although women in the public sector have chosen the hospital because

they have accessibility due to being dependents to National Guard workers, the majority of them agreed that the quality of services was a strong motive for them to deliver in the National Guard.

Women were dissatisfied because of two main policies in the National Guard hospitals: the “No companion ” and the “Breastfeeding Initiative” policy. Regarding the “No companion “ policy, women in the public sector could not have family support and help after admission. These women tend to be more dissatisfied than women in the private sector, who had companions. Having companions in the public shared rooms could be a challenge for the hospital because it may increase noise and infections for the women.

Many women in the public sector suggested allowing them to have some help from their family to ease the process of breastfeeding their newborns, which is the second policy bothering many women.

It is important to note that both public and private sector’s women were having their newborns in their rooms during their hospital stay. However, women in the public sector tend to be more dissatisfied about this new policy than private women. The reason behind this dissatisfaction may be linked to the other policy, which is the "No companion "policy in the public sector.

Regarding that, we noticed that women in the public sector, across both locations, were more dissatisfied with this policy than women in the private sector. The reason behind such dissatisfaction may be because of a simple fact that women in the public sector were not allowed to have companions with them, unlike women in the private sector. The private sector’s women who complained regarding both policies are those unlucky women who

could not get private rooms. These women were kept in shared rooms and had been treated as such.

Regarding privacy, almost all women in both locations did not feel that their privacy was violated during checkup and delivery. Still, the amount of privacy in the shared room was an issue for many women in the public sector and for women in the private sector who had shared rooms. Riyadh public sector's women were bothered more than the ones in Public Jeddah. The major complaints about women in shared rooms regarded noise and hygiene issues, especially during the visiting hours. When visitors come to visit, the shared rooms tend to be overwhelmed, and women find it difficult to go to the bathroom during visiting hours.

It is important to note that not all women in the private sector were guaranteed a private room; it was up to the vacancy in the delivery day. Some women in the private sector were moved to shared rooms after delivery due to unavailable vacant private rooms. Such women were treated as public patients, and nurses who served in those shared rooms had no idea regarding women's ability to pay. This fact was an issue in Jeddah more than in Riyadh. We found some angry women who complained about the business center, which is responsible for arranging services for private patients.

#### 4.2 Women satisfaction regarding dealing with doctors:

Regarding satisfaction with doctors' care, the majority of women were very pleased with their caring and respectful doctors across both locations and sectors ( Figure 3.5). However, some women in the public sector in Jeddah's hospital felt that doctors were informative but not negotiable. The same feeling was felt among Riyadh's women in both

sectors. Some women felt doctors were hard to negotiate with because of a language barrier or a doctor's attitude. Some doctors were from India for example. Because some women could not speak English well, and Indian doctors could not speak Arabic well, language barriers were created and women did not feel open with their doctors. Moreover, women felt some emotional distress while dealing with some doctors. It is important to note that we included all types of doctors that women interact with and not only OB/GYN. Some women complained about the way doctors were pushing them to make fast decisions when they were worried and considering other options. Other women in both locations complained about pediatricians' attitude and the way they inform mothers about their newborn health.

#### 4.3 Women satisfaction regarding dealing with nurses

In addition to dealing with doctors as a matter of concern to women during delivery, dealing with nurses was also critical for women's satisfaction (Figure 3.5). Indeed, dealing with nurses is very critical for all women. Nurses are the ones who spend the most time with women. It is important to note that there are more public patients housed in the National Guard hospital, than there are private patients. Therefore, nurses may be under pressure taking care of a larger number of women in the public sector. Moreover, women in the public sector may be demanding more care from nurses due to the complete absence of family support during admission. Private patients, on the other hand, can have companions to stay with them in their private rooms, therefore, may demand less help from nurses.

Women across locations and sectors found nurses to be medically competent; however, there were some issues. For instance, the majority of the women in the public in both locations felt that nurses were slow, rude, and uncaring. Few women found them kind, and they complained about the delay in nurse response. Some women distinguished between nurses in the delivery room and those who serve in the women' room. These women found delivery room nurses to be caring and kind, not like the ones serving in the women' room.

Apart from this, women in the private sector, who had private rooms, in both hospitals were more satisfied with the respectfulness and kindness of nurses. Contrary to women in the private sector, who had shared rooms, they found nurses to be rude and uncaring. As mentioned before, some private patients could not have private rooms during their stay because of the unavailability of such rooms during their due date. These women shared rooms with other public women and reported experiencing the same low-quality treatment that public sector women had attested to.

It is important to note that private patients who had companions tend to be more satisfied with the nurses' services than public women in both locations. The reason behind this fact may be because private patients may be less demanding for care because they have more comfort in their private rooms and because they have companions.

Above all, we asked women about their overall experiences in the National Guard hospitals, and we found that the majority of women reported that their experiences were good but with some issues. The majority of these women were in Public Jeddah and private Riyadh.

Many women reported that they had an excellent experience. Women in Riyadh tend to have had a better experience than those in Jeddah. Women in the Public sector in Riyadh were the most among all women to report the excellent experiences. The group with the second highest approval rating for their hospital experience was women in the public sector of the same hospital. Since the Breastfeeding Initiative policy was a common issue among public women, future research is warranted to ease the process among public patients.

#### 4. Implications for Hospital Administrators, Health Manager, and Policy Makers:

There are some implications that health administrators and hospital managers should take into account. One of the essential things is training doctors and nurses to deal with women under pressure and treat women with kindness, especially in the public sector that has more women. The social behavior of health providers has a tremendous effect on women . As the National Guard hospitals are famous for their good reputation, due in part because of their high quality services, investing in training health providers to have bedside manners with women will affect women's satisfaction. Furthermore, considering having enough nurses in each ward may improve the attitudes of nurses and therefore improve the satisfaction of the women, especially in the public sector. Another important thing is having better bed management and reducing the number of women per shared room as much as possible to guarantee privacy and increase satisfaction. In addition, women's voices and complaints should not be underestimated because women voices could aid in the continuous improvement of the hospitals' performances, and contribute to the avoidance of these issues in the future. Hospital administrations should look at women's complaints and suggestions to improve the satisfaction for future women.

For policymakers, since policymakers were debating on the success of privatization and questioning its outcomes, this study should be a clear comparison for policymakers in regard to satisfaction in both the public and the private sectors in one of the most critical fields, maternity care. Given the exigence of this study, just before privatization, this report shows what improvements should be done in the public sector during the transition to privatization while maintaining quality care in the private sector.

#### 4.6 Study strengths and limitations:

Although a convenience sampling method was followed in this study, we collected data from a large sample size (78 participants). One of the strengths of this qualitative study is that we reached saturation across sectors in the two locations. Furthermore, this study was conducted from two different locations in Saudi Arabia, and that gave us multiple perspectives of the problem.

#### 5. Conclusion:

As this study compares satisfaction of women during their delivery experiences across public and private sectors in two National Guard Hospitals, we found general similarities and some specific differences. The first general finding was the reason that made women choose to deliver their babies in the National Guard. The majority of women in both sectors chose the National Guards hospitals for delivery due to the excellent reputation for the quality of services and privacy within the hospital, as well as the respectful and kind doctors and competent nurses. However, a common complaint from public women in both locations was privacy in shared rooms.



The first major difference between both sectors is that private sectors' women did not complain about the hospital's policies . On the other hand, the public sectors' women complained about the new breastfeeding policy and about not having companions with them in the room to help them during their hospital stay. Moreover, public sectors' women found nurses to be rude and uncaring . However, this was not an issue in the private sector, except for private sectors' women who had shared rooms. Furthermore, some women found doctors hard to negotiate with, especially in the public sector. In short, women complained about the social interaction with health providers, not about the medical services provided to them.

In conclusion, maternity care varies across settings and sectors. For this reason, and because privatization is underway and many new hospitals are under instructions, it is important to consider privacy during delivery and during admission. For future research, it is important to consider exploring ways to maintain the level of the care provided in the private sector of hospitals, while expanding care to meet the needs of all women given finite resources.

## CHAPTER 4

### UNDERSTANDING THE DESIRE OF THE MOTHERS TO PARTICIPATE AND ENGAGE IN PATIENT-CENTRIC CARE WITHIN SAUDI ARABIA.

#### Abstract:

Background: Patient centric-care (PCC) is a concept that involves both patients and their families in the decisions about their care plan. It is a concept that began in developed countries but is evolving globally because involving the patient in their care holds the potential to improve health outcomes. Therefore, patients and their families should be educated and empowered to participate in their care process, especially when it comes to maternity care. However, given the limited rights and autonomy women had prior to 2017 in Saudi Arabia, little is known regarding the perceptions of mothers on their conceptualization and willingness to participate in PCC.

#### Objectives:

This study evaluates and compares the baseline levels of knowledge regarding what constitutes patient-centric care for women in both hospitals. It also examines how women's goals, values, and priorities for maternity care can be integrated into the public and private sectors of two National Guards hospitals in Riyadh and Jeddah.

Methods: A convenience sample of 78 women participated in face-to-face, semi-structured interviews. All interviews were recorded, transcribed, and coded for analysis. Codes were developed into major themes, and those themes were used to construct a conceptual framework illustrating similarities and distinctions in women's conceptualization of PCC across sections and locations. The conceptual framework informs how PCC can be effectively integrated into clinical care.

Results: The majority of women across locations and sectors felt included and show the desire to contribute in the decision-making process with their health providers. Also, the majority of women preferred to have family support before and after delivery but not during it, they prefer to be alone inside the delivery room. Husbands and mothers were noted as the best supporters for women. Furthermore, the majority of women reported poor level of women's rights knowledge. However, Jeddah's women tend to know more about their health rights. Across locations and sectors, women tended to misunderstand the Breastfeeding Initiative Policy and needed more support in nursing their newborns.

Conclusion:

Many women seeking maternity care knew about their health care rights and wished to participate in medical decision making. More education is needed to inform women about the extent of their autonomy and the purpose of some policies such as breast-feeding initiatives. Health providers can play a considerable role to empower women in decision making, but providers also need training regarding how to create those opportunities within clinical care.

## 1. Introduction:

One can know the development of a country by knowing the quality of its health care (Alqarni, 2018). Saudi Arabia is a rich country that has high annual health expenditure yet the poor quality of health care services. Due to that, the government is planning to privatize the health sector by the year 2030 (subdivision,2017). National Guard Hospitals are well known governmental hospitals that have public and private sectors. The public sections are for National Guard employees, and the private sections are for other people who want to pay for excellent quality services. Currently, these hospitals are adopting the six dimensions of health quality put forth as health care delivery goals by governments and leading health agencies such as the Institute of Medicine. These dominions are safety, efficacy, timely, efficient, equitable, and patient-centric care (Agency for Healthcare Research & Quality, 2015) (NGH, 2016).

Patient centric-care (PCC) is one of the most critical dominions in quality of care ( Qidiwai,2013) The National Academy of Medicine defines it as "the care that is respectful of and responsive to patients' preferences, needs, and values and ensures that patients' values guide all clinical decisions ( 2015 ). It is a concept that has emerged as a primary approach to the delivery of care in developed countries and is being adopted globally (Delaney, 2018) (Hall, 2014)(Alqarni,2018). For example, in Canada, patients value PCC because it is associated with better outcomes and fewer overall tests and referrals when compared to the more physician-centered care approach (Stewart et al., 2000). Moreover, the PCC approach has been practiced over a decade in Australia. An Australian study showed that the traditional paternalistic approach to health care received massive criticism. This traditional kind of care focuses on health decisions to be made by health care providers

and focusing on patients' opinion and preferences ( Delaney, 2018). Within Sweden and the United States, patients preferred that doctors consider a more holistic approach such as PCC by considering their emotions and feelings in addition to their disease (Hall et al., 2014) (Alqarni,2018). However, even within these developed countries where the transition to PCC has been underway for some time, some patients' still prefer not to play an active role in their care process and let health providers decide what is best for them (Alqarni,2018).

Within the Middle East and especially in Saudi Arabia, the understanding and application of the concept of PCC to the delivery of health care is entirely new. For example, a recent study within the Middle East found that only one-third of the patients prefer the PCC model in which the patients wants to be active in the decision-making processes. (Qidwai et al., 2013). Also, a study that was conducted in Saudi Arabia found out that the majority of patients understood the idea of patient-centric care, and the majority of physicians supported it (Qidwai, 2013). Moreover, when it comes to the delivery of care Saudi hospitals are beginning to orient their health system policies around the preferences and needs of patients because it has the potential to improve patients' satisfaction with care as well as their clinical outcomes (Siddiqui, 2011). While the understanding of PCC exists among the health systems and providers in Saudi Arabia, less is known about how patients perceive the concept and how it should be practiced in order to improve the delivery of care.

When it comes to maternity care, there is a knowledge gap in how to apply the practice of PCC to be inclusive of mothers in the decisions making process surrounding labor and delivery practices. Unlike in western countries, Saudi men used to make

decisions for their wives and unborn babies because males held authority over women for medical decision making (Alamoudi, 2017). Culture reinforced by hospital policy dictated that health providers speak to the male guardians regarding any form of consent for care. As part of Saudi Arabia's move toward the Vision of 2030 (discussed in Chapter 1), this practice ended by royal decree in March 2017. The decree gave women their autonomy back in terms of the ability to make their own health care decisions (Durry,2017). However, after such a long-time period where women were unable to make medical decisions, women's perceptions regarding how they wish to participate in patient-centric care are unknown.

In order to support women in their health care decisions, the Saudi Ministry of Health has authorized women health organization "Rofaida" which educates, trains, and supports women about their health rights. Rofaida was founded recently by princess Modi Alsaud in order to support Vision 2030. It was named after the first Arabian female doctor who lived a thousand years ago and built the first hospital or health shelter at that time. In fact, the meaning of her name, Rofaida, is the "safe shelter." The Rofaida organization believes in educating women about their health rights to improve their physical and mental health throughout the pregnancy, the labor, and delivery processes ( Rofaida, 2018). Rofaida is encouraging women to have a birth plan and supports them in the creation of it through a website. Saudi women embraced this idea, as a recent study found that women believe that birth plan increased their knowledge about their pregnancies, and the formation of a birth plan had a positive influence on their beliefs and decisions surrounding labor and delivery (Rofaida,2018). In addition to the Rofaida, the Ministry of Health has authorized an app "It Is Your Right" aimed at educating women about their health rights (MOH,

2018). The MOH also runs educational campaigns throughout the year to educate women about their rights (Fiske, 2017). These efforts aimed at women hold the potential to improve society as a whole because when women are more actively engaging in their care, this may lead to better outcomes (Al-Almoudi, 2012).

Because of the recent changes in legislation that now allow women autonomy in their medical decisions, little is known about how women understand and perceive the concept of patient centric care as it applies to their labor and delivery decisions. More specifically, to date, no studies have addressed what women perceive of patient-centric care to support its future implementation within the labor and delivery setting. This study will fill that knowledge gap by being the first to collect baseline knowledge and perceptions of patient-centric care as it applies to the labor and delivery setting within both the public and private sectors of two National Guard hospitals in Saudi Arabia.

## 2. Methods

### 2.1 Research Design

This study employs qualitative semi-structured interviews to gather perceptions of women who delivered in public and private sectors of two National Guard hospitals in Jeddah and Riyadh. Data was collected using a standardized interview guide and three interviewers who were all trained to follow the guide in a standardized way.

### 2.2 Study Sites and Participant Recruitment:

To reach a convenience sample for study and ensure it reflects population, two different locations were selected. This study has considered two various National Guard

hospitals (NGHA) in Jeddah and Riyadh. Traditions, cultures, and lifestyle are different in both locations, which help to elucidate different perceptions of patient-centric care. Moreover, geographical diversity may influence experiences, opinions, preferences, and points of views of each participant (Alhanawi, 2018). The maternity wards within National Guard Hospitals are one of the busiest. The public sector has more women than the private sector. National Guard workers and their dependents have access to this sector. On the other hand, other women within the private sector are paying directly for the hospitals' high-quality services.

The recruitment strategy and interview logistics are as follows: First, co-investigators distribute recruitment flyers to all eligible women in both public and private sectors and ask women if they wish to be interviewed after delivery and after recovery before their discharge. In order to be considered eligible for the study, women need to be adults over the age of 18, have a second birth or subsequent birth, in good health status, delivered a healthy newborn, and able to provide consent the study into the study. Women who had their first child were excluded from this study. We excluded these women because these women lack experience with the birthing process and this lack of experience may lead to systematic dissatisfaction which would bias our study's perceptions. Thus, women who had previous deliveries also could enrich our data with comparisons of their birth experiences.

The head nurse is the one checking the eligibility of women prior to interviewing them based on the inclusion and exclusion criteria. Furthermore, discharged women can be interviewed via phone for their convenience. Second, once women accept to participate, the investigator will explain the consent form (see Appendix A), and women will consent



by signing the form. Co-investigators proceeded with a semi-structured, one-to-one interview with women in their room before their discharge or via phone after their discharge.

### 2.3 Data Collection

A convenience sample of women was recruited and interviewed. The sample of women was selected based on the willingness of women to participate in the study following labor and delivery in order to understand women's perceptions of satisfaction in their interactions with their obstetricians, nurses, and support staff.

The interviews were conducted in Arabic over a period of ten months ( July 2018- April 2019). All interviews were conducted by the first author (HA) and two co-investigators (HM, AA). The development of the semi-structured interview questions (Appendix B) was based on the available online published Middle Eastern literature in general and the Saudi literature in particular. The interview questions were divided into three sections. The first section was for general warm-up questions to cover the socio-economic and demographic information about each participant and general points of view regarding their current hospital stay.

The second section was for the first aim of this study which is to evaluate and compare the baseline levels of knowledge regarding what constitutes patient-centric care for mothers who are giving birth in public and private sectors of National Guard Hospitals. This section has questions that cover four principles of patient-centric care: coordination and integration of care (Decision making, and Communication), information and education ( women's rights, source of knowledge, signing document), involvement of family and

friends and emotional support ( family support, best supporters, and delivery room companions).

The third section was for the second aim in this study, which is to understand the roles and desire of the mothers to participate and engage in patient-centric care by being involved in decisions related to their delivery and follow- up care. This section has questions that lie under two principle of PCC: respect of women' preferences and physical comfort. In this section women were asked about their willingness to participate in their care, the kind of support they needed, what they liked or disliked, what matters to them the most, and what would they change if they could.

All participants were informed about the study aims and objectives. The interviews took place in women' rooms in the hospitals. Some women were contacted via phone after discharge, or the co-investigators met them in an affiliated clinic in the hospital. The participants were informed that they could withdraw from the study at any time if they wish without providing any reason to the investigators. They were assured that the information provided is anonymous and confidential.

The average length of the interview is about 20-40 minutes. Recorded interviews stored on an Olympus recorder. They are saved in a secure computer and turned into an MP4 for transcription. No identifying information about the patient will be recorded in the interview. The interviews transcribed into a PDF for coding and theming by the co-investigators. The transcriptions backed up on a thumb drive which will be kept in a locked location with the primary investigator. Transcriptions will be viewed by approved co-investigators in the project and kept only for the study purposes.

## 2.4 Data Analysis

A grounded theory approach was used to analyze the transcriptions (Bernard,2011). Investigators independently followed steps of familiarization with transcripts, coding, developing a working analysis, creating the application of a working analytical framework, charting data into a matrix, and lastly, interpretation (Gale,2013). Co-investigators applied an inductive analysis technique wherein the raw data was reviewed to identify patterns, ideas, or key themes that emerge (Thomas,2006). Investigators also used the 'constant comparison' technique to review data to ensure that the full breadth of concepts emerges from the raw data. Investigators reviewed each unit of data several times to allow for meaningful concepts to emerge and to make connections between those concepts. Data was continually compared and reviewed until we reached saturation, wherein no new themes or ideas appear to emerge from the data. NVIVO qualitative software was used for analysis.

Coding is the process of categorizing the data into meaningful categories. Initially, three investigators used open coding techniques to generate an initial list of emergent ideas or 'codes.' To ensure inter-rater reliability, they co-coded five interviews independently. After independent review, the three individuals compared their coding schemes, discussed discrepancies, and reached consensus on a coding scheme. Codes were synthesized into a list or 'codebook' that will outline each code and its description. Following the initial open coding process, we move to selective coding wherein remaining interviews were categorized based on the established categories outlined in the codebook. The selective coding process generated themes to illustrate and explain the observations in the study. Finally, themes were summarized, identifying any emergent concepts that may be developed into a theoretical model for future study.

The theoretical model allowed co-investigators to describe commonalities, patterns, and major themes that emerge from the transcripts. We compared the findings within and across both hospitals.

### 3. Results

In this study, we reached saturation after interviewing 78 women from both locations in Jeddah and Riyadh. Saturation is defined as the point in which an additional interview provides no new information being identified (Seale,1999). Therefore,78 interviews across two sectors and two locations provided enough data to answer these chapters aims. Thirty-eight women were interviewed in Riyadh's National Guard Hospital, 20 women from the private section and 18 women from the public section. Forty women were interviewed (20 from each sector) in Jeddah's National Guard Hospital. Descriptive statistics for the sample of participants across sectors and locations is shown in Table 4.1

Table 4.1: Descriptive Characteristics of the Sample

	Jeddah		Riyadh	
	Public Sector	Private Sector	Public Sector	Private Sector
	N=20 (%)	N=20 (%)	N=(18)	N=(20)
Age				
	4 (20%)	2 (10%)	5 (28%)	1 (5%)
26-30	8 (40%)	10 (50%)	5 (28%)	7 (35%)
31-35	3 (15%)	3 (15%)	3 (17%)	5 (25%)

36-40	2 (10%)	5 (25%)	4 ( 22%)	4 (20%)
41-45	3 (15%)	0 *	1 (6 %)	3 (15%)
Mean of age group	30.9	30.7	30.36	33.22
Nationality				
Saudi	19 (95%)	17 (85%)	18 (100%)	17 (85%)
No Saudi	1 (5%)	3 (15%)	0*	3 (15%)
Education				
Master	1 ( 5%)	0*	0*	0*
Collage	12 (60%)	13 (65%)	8 (44%)	11 (55%)
College student	0 *	1 (5%)	1 (6%)	1(5%)
Diploma	1 (5%)	0 *	0 *	0 *
High school	4 (20%)	5 (25%)	4 (22%)	6 (30%)
Middle school	2 (10%)	1 (5%)	3 (17%)	1 (5%)
Elementary School	0 *	0 *	2 (11%)	1 (5%)
Employment				
Employed	6 (30%)	5 (25%)	2 (11%)	4 (20%)
Housewife	14 (70%)	14 (70%)	15 (83%)	15 (75%)
Student	0*	1 (5%)	1 (6%)	1 (5%)
Newborn Order				

Second Newborn	9 (45%)	14 (70%)	6 (33.3%)	5 (25%)
Third Newborn	5 (25%)	4 (20%)	4 (22%)	5 (25%)
Fourth Newborn	4 (20%)	2 (10%)	2 (11%)	4 (20%)
Fifth Newborn	0*	0*	3 (17%)	3 (15%)
Sixth Newborn	1 (5%)	0*	3 (17%)	2 (10%)
Ninth Newborn	1 (5%)	0*	0*	1 (5%)
Mean of newborn Order	3.2	2.4	3.6	3.85
* No reported data				

We found the mean age across sectors and locations to be approximately 30 years. The only exception was in the private sector of Riyadh where women were slightly older at 33 years. The mean value among Jeddah's women in both sectors were similar. The mean of age of women in the public sector in Jeddah was 30.9 and 30.7 in the private sector.

The majority of women were between the age of 26 to 30 years old, which is expected due to the usual age of childbearing. However, this study did include women over 40 years of age. The majority of women, who were over 40 years old, were found in the public sector of Jeddah and the private sector of Riyadh. In this study, no mothers were

found less than 18 years old due to the recent forbidden marriages law for young girls, which was issued in 2015. Recruiters did not find any mothers less than 18 years at the time of recruitment.

Regarding the nationality, 95% of women were Saudis in the public sector of Jeddah, and 100% of women were Saudis in the public sector of Riyadh. This is expected because the majority of women in the public sector were married to employees who work for the National Guard. National Guards' officers cannot marry non-Saudi women in Saudi Arabia. Within the private sector, 85 % of the women in both location were Saudis. The women from the different nationalities were from Egypt, Syria, Sudan, Yemen, and Ethiopia, and they are legal residents in Saudi Arabia.

Furthermore, about the education of the participants, all women were literate. The highest degree was master degree which was found in the public sector of Jeddah. The lowest degree was an elementary school degree found in private Riyadh. The majority of women in both locations were college degree holders. In Jeddah's public (60%), Jeddah private (65%) , Riyadh public (44%), and Riyadh private (55%). Women in Jeddah tend to have more collage degree than women in Riyadh.

In terms of employment, the majority of women in both locations were housewives. The employment rate in this study is low and consistent with the low employment rate of female in Saudi Arabia (23%) . We found only 30% of women were employed in the public sector of Jeddah and a lower rate of 11% in the public sector of Riyadh. In the private sector, only 25% of the women were employed in Jeddah compared to 20% in Riyadh. While the employment percentages were not consistent for women in

the public sector across both locations, they were similar in the private sectors. Furthermore, around 5% of the women were students in college in the private sector of Jeddah, and both of Riyadh's sectors.

Moreover, this study excluded women who had their first newborn as it was mentioned earlier. We wanted to recruit women who navigated the health system before. Besides, usually, women found it extremely difficult when they have their first newborn, and the difficulty may interfere with their satisfaction. We found that the majority of women had their second newborn in the time of recruitment followed by the third newborns. Despite this finding, we had a patient who delivered their sixth and ninth newborns. The mean value of the number of newborns was calculated using the mean formula for frequency, and we found that the mean of the number of newborns in Jeddah public (3.2) was higher than the one in the private sector (2.4). In Riyadh, we found that the mean of the number of the newborn is close to being similar (3.6 in public vs. 3.85 in private). Furthermore, we found consistency across both locations regarding the type of delivery in which the majority of women had a natural birth.

#### 4.1 Major Themes and Sub-themes about the baseline levels of women's perceptions of Patient-Centric Care (PCC).

The first aim of this study was to evaluate and compare the baseline levels of knowledge regarding what constitutes patient-centric care for women in National Guard Hospitals in Jeddah and Riyadh. Four main themes emerged under this aim: communication, decision making, presence for support inside and outside the delivery room, and women rights' knowledge. The following sub-sections detail findings in each



sector and location, and then a comparison of perceptions across sectors and locations is presented.

#### 4.1.1 Baseline levels of Women's perceptions of Patient-Centric Care (PCC) in the private sector in Jeddah.

Figure 4.1 shows the major themes and sub-themes of women's perceptions of patient-centric care in the private sector in Jeddah. The size of the bubbles reflect the number of women who spoke about the specific sub-theme within the interview. In terms of the major theme of communication, Figure 4.1 shows a large bubble labeled "women directly," which represents that more than 80% of women reported health providers were communicating directly to them. A woman noted: *"So the doctor was clear with me about what is the type of delivery and the time. She updated me regarding my health. She was amazing" (Patient 14).*

Another one added:

*"I delivered all the babies via c-section. I had a complete discussion with my OB and with my anesthesia's doctor. I was involved in the whole process" (Patient 20).*

When women discussed their women perceptions of decision-making, four main sub-themes emerged. Women felt that when it came to making decisions about their care either: doctors decided, the women decided, both doctors and women decided together, or the husband and women decided as a family. In the private sector in Jeddah, more than half the women decided with their doctors (Figure 4.1), followed by only the doctor who decided based on the women's preference for them to make the decision. Some women expressed that they decided for themselves.

One woman noted:

*“I: How far do you want to be involved in the decision making?”*

*P: I want to make my decisions by myself”.*

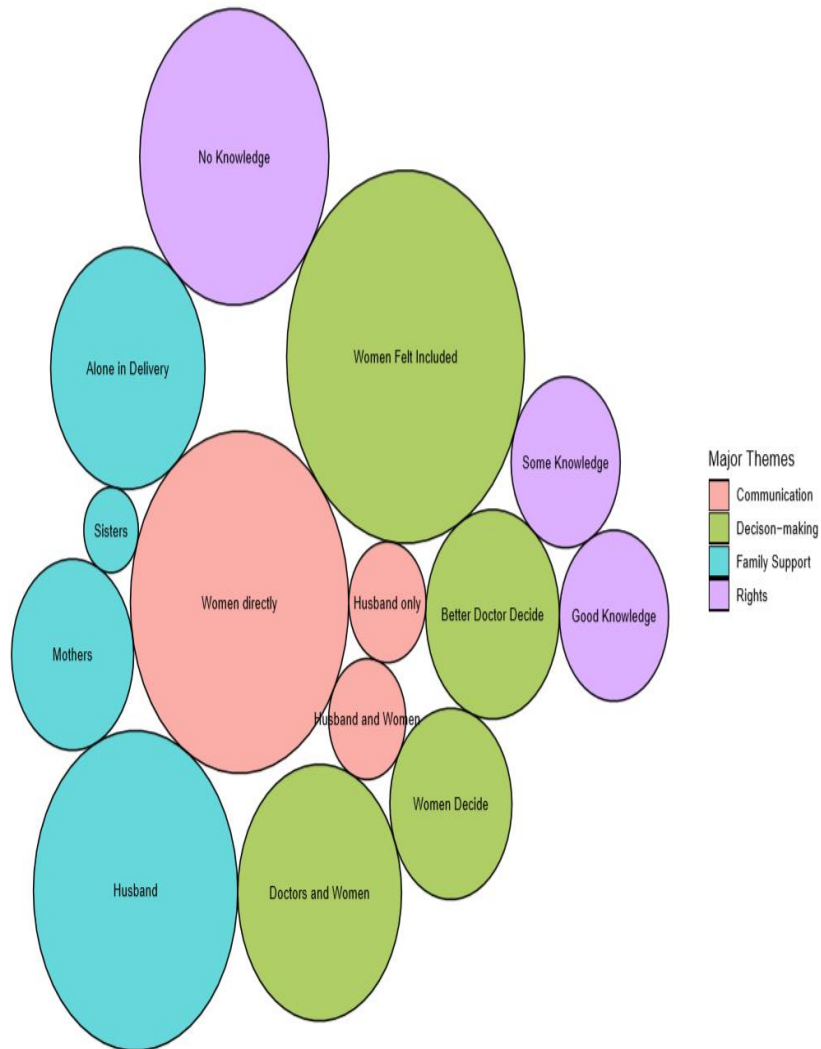


Figure 4.1 Major themes and subthemes of women's perceptions of PCC in Jeddah's NGHAs- private sector

In articulating how women made decisions women with their doctor, one said: *“ I would*

*have shared decision making. The doctor tells me what is best for me and I see if I am comfortable with that decision or not" (Patient 13).*

To illustrate a preference for the doctor making the decisions, another woman noted:

*" Since I don't have the medical background that the doctors have, I do not prefer to involve in decision making. I want the doctors to decide what is best for me" (Patient 2).*

When it came to the major theme of family support noted in Figure 4.1, women told us about the family and how specific members supported them during their hospital stay. Women also expressed the family support that they wished they could have. The majority of women emphasized the importance of having family support before and after delivery, but not during it. When it comes to delivering their child, many women in the private sector of Jeddah preferred to be alone in the delivery room (Figure 4.1). The reasons behind this vary. Some women could not see how husbands would play a supporting role and be helpful to them inside the delivery room. Others could not handle their beloved one's nervousness and worries, a woman noted:

*"I do not see it (as) important in the delivery room. I had my mother with me in the delivery room 10 years ago. She was so nervous and tired. I prefer to be alone with health provider" (Patient 1).*

Moreover, a woman told us *"It supposed to be my husband. But unfortunately, he does not support me that much. You know, not all husbands are supportive" (Patient 3).*

However, some women preferred their husbands to accompany them and support them inside the delivery room, followed by women who preferred to have their mothers.

One woman stated:

*“my husband was with me, I insist on having him with me like my first delivery in the States” (Patient 17).*

Besides, another woman said: *“ I wanted my husband to stay with me in the delivery room and I was happy that they allow him to stay with me” ( Patient 7).*

Some women did not know that they have the right to have a companion inside the delivery room with them. For instance, one woman told us in surprise:

*“I think it was not allowed to have anyone with me in the delivery room” (Patient 9).*

Another woman told us:

*"I heard about that, but here in the National Guard a nurse told me that it is not allowed. He was not outside the delivery room, he was away outside the department" (Patient 11).*

While most women wanted to be alone the in the delivery room, women still expressed an idea regarding who their best supports would be and when and where they could be most helpful. Best supports were individuals who can provide women the needed support during their stay in the hospitals. Women stated that they needed support from their family members before and after delivery but not inside the delivery room. As seen in Figure 4.1, the majority of the women preferred their husband to be with them, some preferred their mothers, and only few preferred their sisters.

One woman told us about the reason why she wanted to be alone in the delivery room, saying:

*“no one, I do not prefer to have anyone with me. I was busy about myself, I do not want to worry about anything at that time. I went inside the delivery room as a companion with my*

*sister, I was terrified. I do not want anyone to be terrified with me while I am delivering my child. My husband and my mother were with me before and after the delivery, I do not need them inside the delivery room "* (Patient 5).

Under the theme of women's knowledge of their rights, we found that almost 60% of Jeddah's private women had poor knowledge regarding their health rights (Figure 4.1). However, the majority of them felt included in their care and signed their health documents (95%). The best source of knowledge to them were the media and health providers. Only 10% of the women reported that they learned about their rights from reading about women rights. A woman told us that health providers taught her , she said:

*"From where you learned about these rights?*

*p: from the health providers in the hospital"*(Patient 12).

In addition , another woman said:

*"I signed my documents. The doctor came with the documents and she said that it is my decision and I should sign for that"* (Patient 14).

Also, a woman educated herself by reading , she said:

*" I read about these rights."* (patient 7).

Some women were working in the health sector and they learned their rights from the regulations of Ministry of Health , a woman told us:

*"I: From where you learned about these rights?*

*p: I am an employee in the Ministry of Health, I knew that."* ( Patient 20)

*Also, one patient said: "I have a maternity website that I subscribed in. I learned many things from this educating website" (Patient 16).*

Women were glad about signing their own hospital's documents and making their own health decisions, for instance , a women told us.

*" I feel freedom, freedom to decide, choose, and to sign. I am not Saudi, but I do feel happy for Saudi women. In Egypt, we decide and sign for ourselves" (Patient 14).*

Moreover, a woman added:

*" This is the best thing that happened to women in Saudi Arabia." (Patient 15).*

In summary, women in the private sector in Jeddah felt included in the care process. Women wanted to participate in the decision making regarding their health and their newborns' health with their doctors. Some women preferred to share the decision making with their doctors , some preferred their doctors to take the lead, and few wanted to decide for themselves. Women reported that doctors communicate directly to them. Moreover, women signed their medical consent although the majority of them reported poor knowledge of women's health rights. Although the majority of women preferred to be alone during delivery, they noted that husbands are their favorable supporters before and after delivery.

4.1.2 Baseline levels of Women's perceptions of patient-centric care in the Public sector in Jeddah.

The major themes and subthemes of women's perceptions of PCC in the public sector in Jeddah's NGHHA hospital is pictured in figure 4.2. As mentioned before, the size

of the bubble shows the importance the issue. The larger the bubble, the more women noted and discussed the theme in their interview. In Figure 4.2 the bubble that depicts women directly stands out because 65% of women reported that health providers were talking to them directly regarding any update about their health. In this sector, a few women reported that health providers were talking to the husband directly and some to both, women and husbands. Another large sub-theme noted in Figure 4.2 that emerged was “Women felt included” women felt included throughout their experiences. However, some women told us that health providers were communicating directly to their husbands, a woman said:

*“They talked to my husband directly, no one talked to me.” (patient 4)*

Another woman , who used to work in the same hospital, said:

*“ I am not aware of the procedure., the staff were talking to my husband and me at the same time. The decision was made based on my opinion and my husband's opinion. it was a shared decision. Maybe they were talking to me because I used to work with them, I have no idea” (patient 2).*

Furthermore, as figure 4.2 illustrated about decision making , women felt into three categories. The first category is for the group of women who decided hands by hands with their doctors (35%) These women preferred to make shared decision making with their health providers throughout the process of care. One woman said : *“they did, and I was updated all the time with anything during the delivery process. The doctor told me about the options, and I choose one. They supported my decision and I felt appreciated ” (patient 15).*

The second group is for women who preferred their doctors to make the decisions for them. These women believed that they should not make any medical decisions without having medical backgrounds. Some women feared making a harmful decision that may harm them or their newborns. Therefore, they preferred the doctors to decide since they are the ones who have medical background. The third group is the group of women who decided for themselves by themselves. Such women felt that they are cable to make their own medical decisions and able to handle the consequences. A patient said:

*"I am the one who decided everything. I was following up with doctors alone. My husband is so busy with his duty as a policeman so I was responsible for my health decisions"* (Patient 17).

Moreover, regarding family support, in the public sector in Jeddah, the majority of women, as like the private sector, preferred to be alone inside the delivery room , as Figure 4.2, indicated. The majority of the women had their mothers, and only few of the women had their husbands with them inside the delivery room.

One woman told us:

*"Having the support before the delivery is very important but in the delivery room, I don't think that. I prefer to be alone. My husband was not in the city when I delivered and my mother cannot watch a c-section delivery. I do not want anyone but health providers with me. Maybe if I deliver without surgery, I would prefer my mom to be with me. My husband's support may be useful too. But I prefer my mom"* (Patient 20).



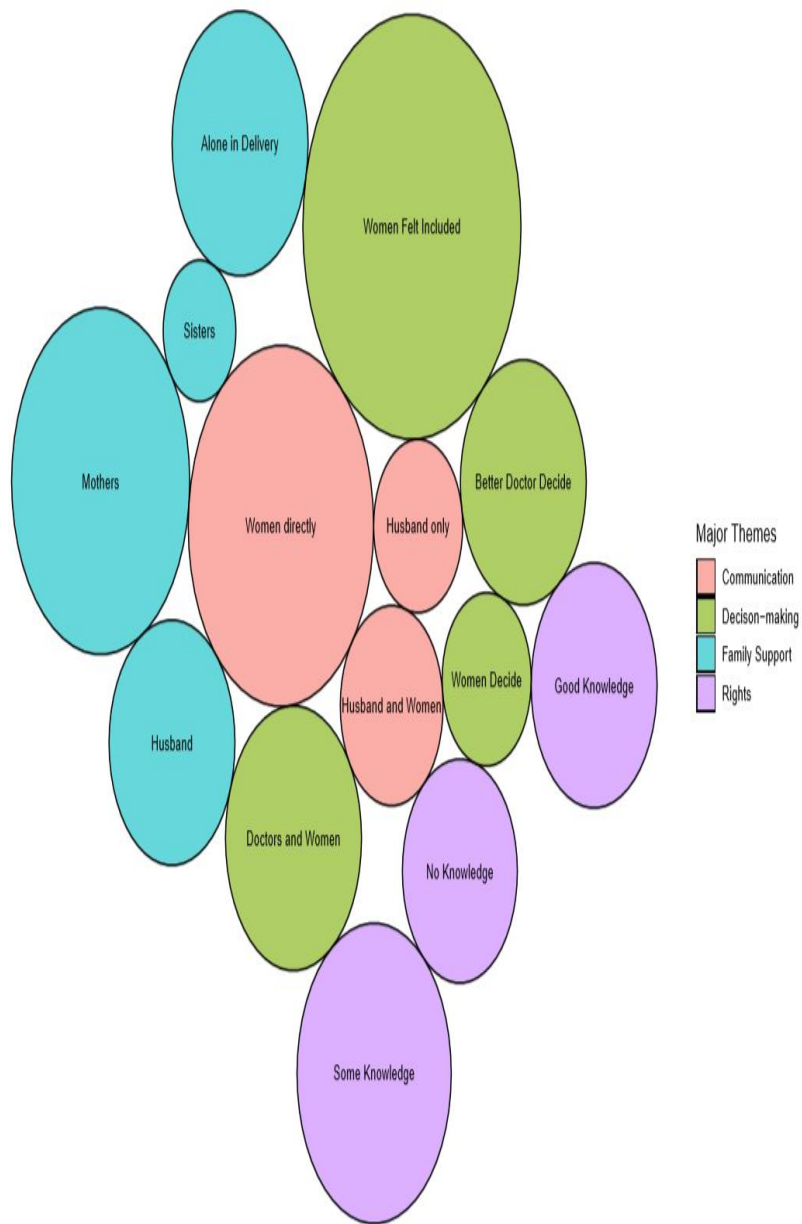


Figure 4.2 Major themes of women’s perceptions of PCC in Jeddah’s NGHA- public sector

Moreover, About 15% of the women did not know that they have the right to had a companion with them inside the delivery room. A woman said:

*“did they entered the delivery room?”*

*No, I think it was prohibited.*

*Whom did you want to be with you if you had the chance?*

*My husband, I wish if it was ok” (Patient 18).*

Regarding the best supporter of public women, the majority of the women found their mothers as the best source of family support. Husbands were preferred by only some of the women. For instance a woman noted:

*“ I wish My mother was with me but unfortunately, she has a very soft heart and I cannot ask her because of that. She was with me in my first childbirth. I was strong and not afraid and when I saw her crying, I lost my strength and felt worried. I prefer no one to be with me during my delivery” (Patient 8).*

Regarding Knowledge of women’s health rights, 45% of the public women in Jeddah had some knowledge about their recent earned health rights. However, 30% of the women had well knowledge , as illustrated in Figure 4.2. A woman said:

*“I signed the papers, although they were talking to my husband I signed the paper”.*

Another woman told us: *“Yes, I read about our health rights. I know that it is my rights to choose and sign not my husband's anymore ” (Patient 10).*

Some of these women were working in health care industries, so they knew the emerging regulations and rules. For instance, a woman said: *“Yes, I knew my health rights, I work in the private health sector, but I used to work here in the National Guard ” (patient 2).*

Women's point of views vary regarding earning their health rights and being able to consent for themselves. The majority of women were glad about having complete autonomy regarding their health care. A woman said: "*women are a human being, and they should have these rights as common sense. As a human being, we should be able to do these things without earning them. They should be ours from the beginning*" (patient 3).

Despite the level of knowledge among women in public Jeddah, 35% of the women did not sign their documents. Some reported that no one handed them any document to sign, husbands signed for them. A woman noted.

*"Did you signed any paper so far ?*

*P: No, I think my husband did"* (patient 7).

Although the majority signed their medical consent by themselves. However, there was an issue regarding signing the admission and the discharge documents in which the majority of women did not sign them.

In short, the majority of women in the public sector felt included in their care process and health providers communicate directly to them. However, some health providers communicated to husbands only and some communicated to the husbands and the women as a family. Although few women wanted to decide for themselves regarding medical decisions, the majority of women fell into two groups: those who wanted their doctors to decide for them and these who wanted to have shared decisions with their doctors. Not like women in the private sector, the majority of women in the public sector reported some knowledge regarding their health rights and some reported good knowledge

of their health rights. Women reported that mothers are the favorable supporters although they preferred to be alone in the delivery room.

#### 4.1.3 Baseline levels of Women's perceptions of patient-centric care in the private sector in Riyadh:

Major themes and sub-themes of women's perceptions of PCC in the private sector in Riyadh are illustrated in Figure 4.3. The larger the bubble is, the more women highlighted the issue. The majority of the women in the private sector in Riyadh reported that their health providers were communicating to them directly regarding their health issues. Therefore they felt included and heard.

One woman said: *"I had high blood pressure so the doctors decided to deliver me via c-section. And yes I was informed and included in the decision making"* (Patient 3).

Another patient added:

*"I: tell me if the doctor included you in the birth plan, or decisions?"*

*P: Absolutely, She did shared anything with me"* (Patient 17)

Only 5% of the women did not feel included and their health providers were talking to their husbands instead of them. Another 5% of the women reported that health providers were talking to them and to their husband at the same time as Figure 4.3 illustrated. One patient told us regarding whom health providers were communicating to:

*"to my husband because I do not like to ask that much. On the other hand, my husband is so careful and asked about all the details that concern him . I found my doctor talking to him more"* (Patient 17).

Regarding decision making, some of the women wanted to be involve throughout the care process but to give the lead to their doctors, a woman told us:

*“Look, it is better to go with the doctor’s recommendation but taking my point of view is very important to me as well. I want to be involved to the care and I want to understand what will happen to me”* (patient 5).

Other women wanted to have shared decision making process with their doctors , a woman reported: *“Since this is not my first baby, I have knowledge and experience now about delivery and birth so I would prefer having a shared decision making. If this was my first baby, I would follow the doctor’s directions of course”* (Patient 15).

Nevertheless, the majority of women wanted their doctors to decide for them due to their lack of medical background or because they do not want to choose a harmful option. For example, a woman told us:

*“I want to be involved in what the doctor see it is better for me. I don't want to insist on a decision and then this decision hurts me”* ( Patient 20).

We had conversations with women regarding women empowerment and autonomy to make health decisions for themselves. The majority of women supported the idea of deciding for themselves and signing their documents. However, we had few women, who did not care about deciding for herself and found it silly to talk about women’s empowerment, one woman said:

*“(Laughing in sarcasm) Why are you talking about women's rights and women's empowerment? I do not care at all if I will sign or decide for myself. Sometimes I may*

*decide the wrong thing for myself and having my husband decided for me is beneficial!"*  
(patient 4).

Moreover, regarding the present for support, many women reported that they prefer to be alone inside the delivery room (Figure 4.3). There are many reasons that made these women preferring staying alone in the delivery room. Women found having their health provider is enough . Others felt nervous in previous deliveries to have beloved ones with them inside the delivery room. Indeed they felt the need of their families' support but not inside the delivery room. One woman noted :

*"I disagree with their( her family's support ) support (laughing). I feel nervous when they worried about me. I think doctors and nurses support is very enough"* (patient 10).

Another woman added:

*"no one, I prefer to be alone. I don't like to be nervous about having my family inside the delivery room. But of course, I want them to be with me right after the delivery. My sister entered my delivery room right after the delivery. She shared the beautiful moments of seeing the baby showed and checked up. These moments should be shared with the family. I loved it"* (Patient 9).

Moreover, some women preferred to have their mothers or sisters but the majority of them preferred to have their husbands as the best supporters , as it is seen in Figure 4.3. Besides, about 15% of the women thought that it was not allowed to have a companion inside the delivery room based on previous rules in other governmental hospitals.



Figure 4.3 major themes of women's perceptions of PCC in Riyadh's NGHA- Private sector

In addition, about the perceptions of women's health rights , More than half the women in Riyadh had poor knowledge about their health care rights , as it is clear in Figure 4.3. The remaining 45% of the women were divided into two groups, a group who knows a little about their health rights and a group who had good knowledge about their health rights. Women reported that they learned about their health rights from different sources.

Fifty-five percent of the women found that health providers are the best source of education regarding their health rights . Few women said that they know about their health rights from the media. A woman said:

*“I: From where you learned about these rights?”*

*p: from twitter.”( Patient 9)*

Despite the medium knowledge level about women's health rights, about half the women did not sign their documents and their husbands signed for them. Few women knew that it is their right to sign their hospitals' documents, but no one handed them any document to sign, not an admission nor a discharge documents. One woman said:

*"I heard about that but I did not sign anything. My husband did"(Patient 13 ).*

Other women in the same hospital , did not know that it was one of her health rights to sign her documents. She signed them because health providers handed her the documents. she told us :

*“ they gave the documents though, I signed them” (Patient 12)*

Another woman added:

*“I: Who signed your admission papers?”*

*P: I did because they gave me the papers to sign to me, not to my guardian.*

*I: do you know that it is your right to do so?*

*P: No, I did not know at all” (Patient 3)*



Some women told us that they were thrilled about earning their rights back , others found it essential human rights. For instance, one woman told us:

*“honestly, it is a good thing for all women to decide for themselves and to do whatever they want without waiting for another person to decide for them”* (patient 15).

In sum, women in the private sector in Riyadh felt included in their care process and health providers were communicated directly to the majority of them. Many women preferred to have shared decision making with their doctors and some wanted to follow doctors recommendations and lead. Just like the women in the private sector in Jeddah, the majority of women in private sector in Riyadh had poor knowledge of their new health rights and about half of the women did not sign any medical document. Also, husbands were found to be the best supporters for these women before and after delivery and not during it.

4.1.4 Baseline levels of Women’s perceptions of patient-centric care in the Public sector in Riyadh:

Figure 4.4 embossed the major themes and subthemes of women’s knowledge of PCC in the public sector in Riyadh. As illustrated in the figure , The majority of the public women in Riyadh reported that health providers were communicating directly to them and 90% of the women felt included in their care. A patient told us:

*“yes, I was included in the care. The doctor gave me a clear plan of what should happen and what to do if any complication happened and he answered my questions and updated me clearly”* (patient 4).

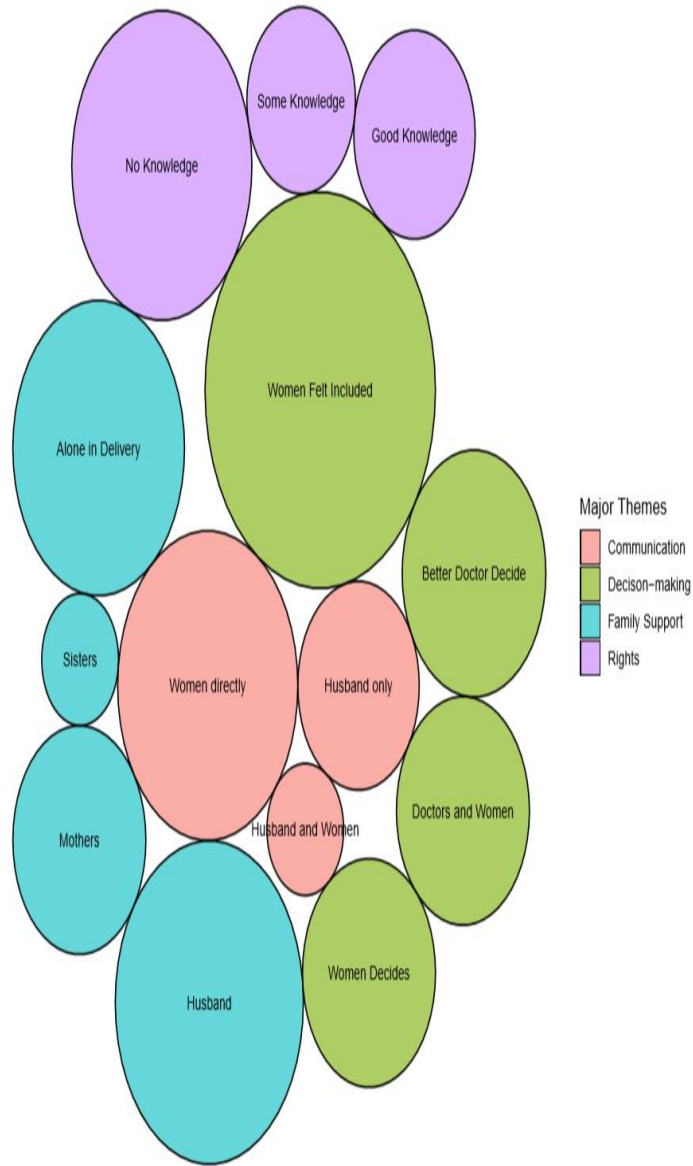


Figure 4.4 Major themes of women's perceptions of PCC in Riyadh's NGHA- public sector

Another patient said:

*"Yes, they were discussing all the plans and decisions with me. I know the steps taken due to their updates. I liked being informed in the care provided" (Patient 3).*

However, only 15% of women reported that health providers were communicating to their husbands only. Few women reported that the communication was directed to them and to their husbands at the same time .A woman stated:

*"With my husband when he is around. when I am alone with me. But my husband took all the decisions and signed the paper for me. I am fine with that and actually, no one asked me to sign anything" (Patient 3) .*

Another woman told us:

*"usually with me. Because I am the one in the hospital. When my husband is with me. They include him in the discussion" (Patient 16).*

In addition, Regarding decision making, women in the public sector in Riyadh were equally divided into three groups as it is denoted by the bubbles in Figure 4.4: women who wanted their health providers to decide for them, women who wanted to decide for themselves, and those who wanted to contribute to the decision making process with their health providers .

As mentioned before, some women feared harming themselves and their newborns by making medical decisions by themselves without listening to their doctors' recommendations. Some examples of such women :

*"I don't know, according to the doctor's guidance, better for me. I prefer not to say a thing and then I will be the one to blame" (Patient 2).*

Another woman added: *"of course I want the doctor to make the decision for me, he knows better. I know nothing about my health and I do not want to contribute to things I do not understand"* (Patient 5).

However, some women disagreed with the previous ones and wanted to make their medical decisions by themselves , one of them told us:

*"I want to make the decisions myself. For example, I did not want to have an epidural even though the doctor recommended to me. I read about it and I decided not to take it due to its long term effects. The doctor will not feel the long term effect for me, I am the one who would suffer!"*(Patient 9).

Regarding family support, inside the delivery room, many of Riyadh's public women preferred to be alone in the delivery room just like all the other women across locations and sectors. A woman told us:

*"I'd rather have no one with me, and God is enough"* (Patient 3).

Moreover, the majority of women preferred to have their husbands as the best supporters during labor and after delivery. Mothers came in second place , then sisters (Figure 4.4). One patient said or women who preferred their mothers, they felt mothers can support them better during labor. One woman said:

*"My husband was not here actually but even if he was here, I would still need my mom more. What would my husband do? nothing! my mom's support would make me feel strong and comfortable"* (Patient 9).

For those who preferred their husband to be with them, they felt that husband should take responsibility and share their pain because they are the fathers and they have to. For instance, one woman told us about that by saying :

*“My husband, since this pregnancy was a shared process between me and my husband and I want him to be involved in all the stages of the delivery” (Patient 8) .*

Also, the women in this sector are the least women to report that they did not have a companion with them because they thought it is not permitted. For example one woman noted us:

*“I: who was with you during childbirth?”*

P:No one

*I: Whom would you prefer to have with you in the birthing room?*

*P:My mother or my husband, but the hospital does not allow it.” (patient 2).*

Moreover, when we asked the public women in Riyadh about their knowledge of women’s rights, more than half the public women in Riyadh had poor knowledge regarding their health rights as Figure 4.4 denoted. However, some women had good knowledge and few reported that they had some knowledge. When we asked them about the source of their knowledge, the majority of them reported that they learned them from the media. Few reported that they learned about their rights from health providers, reading, or from their health sectors' work environment. For an instance, a woman told us:

*“I knew it from my experience since I had in the first delivery here. I signed the medical documents and surgery consent. I remember that the doctor talked to me first in details*

*about everything. He said, if you want me to talk to your husband to talk to you more about the surgery, I can do that. I liked the amount of information I heard that day. It made me so comfortable knowing all the steps and what to predict" (Patient 15).*

A woman noted that she learned about her health rights from health providers:

*"From where you learned about these rights?*

*p: from dealing with health providers in the hospital" (patient 4).*

Another patient said that she read about these rights:

*"I read about most of the new women's right." ( Patient 17).*

Briefly, the majority of women in the public sector in Riyadh felt included in the care process. Women in this sector were diverse regarding decision making. Some wanted to decide for themselves, others wanted to share the process with their doctors, and some wanted their doctors to decide for them. When it comes to health rights, the majority of them had poor knowledge of their health rights and many of these women did not sign their documents Regarding the best supporters for these women, husbands were preferred. However, the majority of women wanted to be alone in the delivery room.

#### 4.1.5 Comparison of findings of main themes across sectors and locations:

We found some similarities and differences across sectors and locations. One of the major similarity is that women felt included in both locations. Also, health providers were communicated directly to the majority of women. Women noted their husbands and mothers as "best" supporters across locations and sectors. However, across locations and sectors women preferred to be alone in the delivery room. The majority of women needed

family support before and after the delivery not during it. Regarding women's rights, women in Jeddah's hospital tend to know more about their rights than Riyadh's women and tend to sign their medical documents more than women in Riyadh.

#### 4.2 Women's desire to participate and engage in patient-centric across the public and private sector of National Guard Hospitals in Jeddah and Riyadh

The second aim in this study was to examine how mothers' goals, values, and priorities for maternity care can be integrated into patient centric care in the public and private sectors of two National Guards hospitals in Riyadh and Jeddah. In analyzing the emerging themes and sub-themes, there were no large distinctions between Jeddah and Riyadh however, the differences were found across sectors. Therefore this section is focusing on the public and the private comparison. Table 4.2 presents significant themes and sub-themes for this aim. The subthemes were ordered based on their frequencies. The more frequent a sub-theme was mentioned by women, the higher the order of it on the table. Women reported what their priorities are , what they liked the most, what they did not like, what they want to change and what support did they need during their childbirth in the National Guard hospitals across locations and sectors.

Table 4.2 Major themes and subthemes about Women's roles and desire to participate and engage in patient-centric care across sectors.

Theme	Private	F	Public	F
Women's priority	Pain Management	21	Companion	27
	Newborn's health	17	Private room	25
	Caring providers	14	Pain Management	14
	Companion	9	Newborn's health	14
What women Liked	Medical care	18	Medical care	17

	Delivery room	14	Delivery room	15
	Doctors' attitude	11	Doctors' attitude	12
<b>What women did not like</b>	Newborn's staying with mothers	14	Shared room	21
	Nurses attitude	14	Newborn's staying with mothers	16
	Shared rooms from the beginning	12	Nurses attitude	11
<b>Things to change</b>	Cleanliness and Hygiene	13	Private room	22
	Better communication	11	Take newborn to the nursery	17
	Private room	7	Better communication	14
	Take newborn to the nursery	6	Cleanliness and Hygiene	11
<b>The needed support</b>	Emotional Support	10	Breastfeeding support	17
	Family support	8	Family support	8
	Breastfeeding support	7	Emotional support	4

The above table was arranged based on the frequencies (F) of issues that women reported. There were 40 patients in the private sector and 38 patients in the public sector. First of all, women reported their priorities and what are the most important things to them during labor and birth. In the private sector, women reported similar priorities across both locations. Women' first priority was to have proper pain management. They cared about their newborn's health as well. Besides, they emphasized the importance of having kind and caring health providers as well as having companions to support and assist.

For instance, A private patient from Jeddah's location told us:

*“better pain management is the most important thing to me. And if I have a private room from the beginning, that would be great”*(patient 16).



Another patient from Riyadh's location said: " *the most important thing are having a companion and more psychological support and kind health providers. Like comforting worried mothers, for example*". (patient 6).

On the other sector, public women in both locations had similar needs. The first need was having companions or some family support. The majority of women affirm the urgent need of such support to assist them in taking care of their newborns. Women who had c-sections were the ones who emphasized on the need of the companions more. Moreover, Public women needed private rooms for themselves with private bathrooms. They wanted such rooms even though they did not pay for the services. The majority of them noted that having private rooms per patient is important for infectious control and privacy, besides it is important to feel some comfort during their admission. Some women reported the importance of having a comfortable, clean, and quiet place for the healing process. For instance , one public patient from Riyad told us:

*"I am not satisfied at all. The section of the room is fine but the noises are very high. Also the cleanness is not very good especially in the bathroom. Four women in one bath room and they clean the bathroom twice only! it is very gross"* (Patient 6).

Another patient from the same hospital added:

*"I don't like that the room is shared with normal birth parents and other caesarean deliveries, one shared bathroom may risk my health . I fear to get an infection or a diseases"* (Patient 1).

Public women reported the importance of having proper pain management and the importance of their newborns' health. However, they said these things last. As it was noted

earlier, patient in the public sector are allowed to have a companion to support in the delivery room but not in the shared room. These women are sharing rooms with other women and their newborns. Having companion per patient is infeasible. a public patient in Jeddah said:

*" Having a companion, which I really need."* (patient 7).

another patient from the Riyadh's location told us: *"the most important thing to me is to have a companion with me and if they take the baby in the nursery room so I can get some rest."* (patient 11).

As it is clear from the above priorities, they are different between public and private women. Women in the private sector, those who had to have their companions and private rooms, needed different things than the other women in shared rooms, who had no family support. Public women cared more about having family support (companions) during hospitalization. Besides, they cared about their privacy in the shared rooms . On the other hand, private women were comfortable and had proper privacy . However, these women were thinking about having proper pain management during labor and they worried about their newborns' health first.

Moreover, women shared with us what they liked in their experiences in the National Guard, interestingly, all the four groups had the same order of the things they liked. The first thing that they all agreed on was the excellent medical care they got. Women were pleased by the professionalism of the doctors and the medical care in the National Guard hospitals across locations and sectors. As mentioned earlier, National Guard hospitals considered among the best in the Kingdom regarding medical care.

A public patient in Riyadh told us regarding the medical care she received in the national Guard : *"The medical care is wonderful"* ( Patient 17)

A private patient in Jeddah told us about what she liked the most, she said: *"The surgery, the doctor, the perfect and beyond perfect care of my baby girl. Comparing this surgery with my previous surgeries in another private hospital, this one is perfect. The doctor is the best"* ( Patient 1).

The second thing they liked was the excellent care they got inside the delivery room, especially from the nurses (midwives) and how they supported them and encouraged them. It is important to note that the majority of women liked the nurses' attitude in the delivery room but did not like the attitudes of the nurses who served them in their rooms. Women did not know if the nurses (midwives) were kind because of the supervision of the doctors in the delivery room, or because they were trained well. Women were amazed at the excellent preparation in the delivery rooms and the staff in the delivery rooms.

one patient in the private sector in Riyadh said: *"I liked that they act fast. I love that. The doctors and the nurses they act fast, they are great! Also, privacy during care. The nurses are perfect in caring about me. They are beyond respectful"* ( patient 8).

Women liked the great services provided by the anesthesiologists. For instance, some women compared the side effects of the epidural that they had in other governmental and private hospitals with the side effects of the ones they had in the National Guard hospital. They preferred the National Guard's epidurals by far. They did not feel any bothering side effects. Furthermore, women were happy with the doctors' attitudes during

their experiences. The majority of women in both sectors and locations agreed on that. One patient in Riyadh's private sector told us:

*"The anesthesia and the after delivery nurse. I did not feel any pain during and after the surgery and did not suffer from the after anesthesia's side effect at all; also, the nurse was so caring and kind. She helped me in the bathroom a lot. I felt the care of"* (Patient 5).

Nevertheless, women reported things that they did not like. In both sectors, women did not have enough explanation of why their newborns were left with them during their hospital stay. Nurses did not explain to these women why they should have their newborns with them. The private women handled this policy better in which they had companions with them to help. On the other hand, public women assert on how much they did not like their newborns staying with them due to the complete absence of family help during admission.

A patient in the private sector in Riyadh said: *"leaving the baby with me. If I knew that they will leave the baby with me I would not come to her. When I delivered my daughter a few years ago, they took her to the nursery room. I do not know what happened this time! Honestly, it was a disaster, I was so tired and annoyed"* (Patient 9).

A patient in public Jeddah told us about the difficulty of taking care of a newborn right after the delivery :

*"I wanted the nurses to take the baby to the nursery. Taking care of a newborn while you are tired is really hard .The head nurse was nice and took the baby for hours to the nursery. I felt relaxed and I slept a little bit. The other nurses were not helpful and when I told them*

*that the baby is crying, they told me to nurse him! I don't have milk and the baby is hungry and I am tired and no companion is with me to help. It is difficult” (Patient 5).*

It is important to note that these newborns were forced to be kept with their mothers to encourage mothers for breastfeeding from the earliest hours of the newborns' lives. The Ministry of Health enforced the Breastfeeding Initiative Policy in all the government hospitals across the Kingdom. The policy itself is essential, but the problem is with its implementation. The patient did not understand why their newborns were with them during their stay. They compare their last experience with their previous ones when the policy was not implemented. They used to have their newborns to be kept in the nursery, and nurses used to bring the newborns for feeding every couple of hours.

This was not the only issue that bothered women, women complained about nurses' attitude as well. Private women, who were in shared rooms, complained about the nurses' attitude during their stay. The public women were complaining about the same issue. It is important to note that the nurses who serve both sectors are the same.

One patient in the private sector in Riyadh complaint about her experience with nurses:

*“The nurses' attitude. All the nurses here are acting very rude ( Have psychological problems perhaps). They are mean and rude even when they handle me the baby they do so without mercy! they are not gentle. Not like the nurses in the delivery room they were better. I asked a nurse to help me to go to the bathroom, she told me go by yourself! I told her I am sick and the c-section is making me moving really hard. She told me : go to ICU then why you are her! Imagine that!” (Patient 6)*

One patient in public Jeddah told us about nurses' attitude : “ *Educating nurses and teach them how to speak with tired and worried mothers*” (Patient 2:)

Furthermore, Public women in these rooms, did not like the noise and the cleanliness, especially after the visiting hours. Women also complained about the bathrooms and how it is impossible to keep it clean or to access it easily in the public sector. A public patient in Jeddah complained about the shared room and the lack of cleanliness by saying:

*“No privacy at all, but what can I do! four women in one place we hear each other and we smell each other”*(Patient 15).

Another public patient in Riyadh said: *“if we had more than one bathroom it would be great! One is never enough for four women. And each patient needs enough time for cleaning up after each visit to the bathroom. The other women cannot wait for their turns. The bathroom is not cleaned after each visit! it is discussing and not comfortable”*(Patient 3).

As a consequence of hearing what these women did not like, we asked them about things they wish they can change if they can. The majority of private women ,who had their private room, found pleased about their rooms. However, women who had shared rooms asked for improving the cleanliness and hygiene of such rooms and the bathrooms. Many private women were in a shared room until the business center moved them to private ones. Private women were expecting to have private rooms as they paid for, and when they did not get one they were disappointed. Those women saw differences in cleanliness and hygiene in the two sectors, so they mentioned that during the interviews.

Moreover, Private women wanted to have better communication with the health provider in general and with nurses in particular. Again, this was an issue, especially with the ones who had shared rooms. The majority of private women articulate the importance of having private rooms from the beginning since they paid for having them. Also, they highlighted taking their newborns to the nursery as the old times.

A private patient in Jeddah told us about what she would change :

*"providing a private room for private women."* (Patient 12).

A private patient from Riyadh told us: *"having a private room as what I paid for"*( Patient 20).

The public women reported that they want to change different things. For instance, they wanted to have private rooms, if they could or at least reducing the number of women per shared room. For instance, some women said, the shared rooms are fine, but if only two women were sharing it.

A patient in Jeddah complained about the number of women in one shared room saying :

*"four women in one room and one bathroom is a lot! if they put two women in a room at least, I think it would be ok. Four women are really hard!"* (Patient 15).

The second thing that public women across locations agreed on is to send the newborns to the nursery, just like what private women noted. Furthermore, they wanted to have better communication with their health providers, especially with nurses serving in the wards. The last thing these women wanted to improve is cleanliness and hygiene issues.

It was at the end of their list to change because they care about more essential things like privacy and breastfeeding support.

Another patient from the same hospital added:

*"Having a companion is one of the most important things here. Mothers should do everything by themselves alone. Also, not taking babies to the nursery room is so silly. How can a mother take care of her newborn without help in a crowded room? I think they should put each patient in a single room. Imagine, the basic stuff that, others need is not available in this hospital like creams and medication for the private area the kind of care that one can get from a private hospital. even babies' formula were out of stock !"* (Patient 1).

Last but not least, we find consistency across locations and sectors concerning what women needed support. The order of the necessary support was a little different among private women, but it is mainly about having breastfeeding support, family support, and emotional support. Interestingly, private women in Riyadh have reported emotional support more than other women. They said that the medical services were great, but extra focus on emotional support is needed especially when it is related to the newborns' health and communicating with pediatricians.

A private patient in Riyadh told us about her needed support that she wished she had: *"My mother in the delivery room I think, and a good listening doctor perhaps. Also, the most important thing feeling secure! I do not feel secure here, and I did not feel secure during my labor. This is my second bad delivery experience"* (Patient 6).



Another patient from the same hospital added: *“I needed some psychological support. I wish if I had a trained doctor or a person to support me emotionally. Other than my busy OB”*( Patient 8).

In short, women across sectors needed different things and therefore their priorities were formed differently. Women in the private sector needed proper pain management and worried about their newborn’s health . On the other hand, women in the public sector were concerned about their privacy and hygiene. They emphasized the need for family support during admission as well. In addition , women across sectors needed further support in breastfeeding their newborns. However, this was a bothering issue to c-section women in particular and to public women who lack family support during admission.

#### 4. Discussion

This study focused on what women experienced and desired regarding the practice of patient-centric care within the public and private sectors of two National Guard Hospitals in Jeddah and Riyadh. Figure 4.1 shows the themes and sub-themes we extracted from patient interviews denoting what women perceived as being vital to them in the context of labor, delivery, and post-delivery care.

The first aim in this chapter of the dissertation was about evaluating and comparing the baseline levels of knowledge regarding what constitutes patient-centric care. Four main themes emerged detailing women's value for communication, decision making, presence of support inside and outside the delivery room, and women rights' knowledge. These themes have sub-themes represented with the circles of Figure 4.5. They show the

significant components of patient-centric care that women in maternity wards experience or wish to experience during their labor and delivery process.

Figure 4.5 depicting direct communication as a large bubble that shows women reported that health providers communicated directly to them across both sectors and locations (Jeddah and Riyadh) within the National Guard Hospitals. This demonstrates that the majority of health providers are following the new regulations and focusing on delivering patient-centric care. However, a concerning finding is that a few of the health providers are still following a conservative culture in Saudi Arabia in which, if the provider was male, it is respectful to communicate with the husband, not the female patient. We found these instances to be more prevalent within the public sectors and more concentrated within Riyadh.

The majority of providers focused on communicating with women, therefore, women believed that they were included in their care. Therefore, Figure 4.5 shows the second major component of a feeling of inclusion in care. This inclusion was denoted by women expressing an ability to discussing issues about their health and their newborn's health with their provider.

Another significant factor that most women expressed was a preference to be alone in the delivery room (Figure 4.5). The rationale for not involving family during delivery stemmed from the fact that women felt more comfortable when they did not have to worry about a loved one. Women explained that having family members would not take the pain out of delivery, so it was not helpful to them to have the family member to be inside the delivery room.

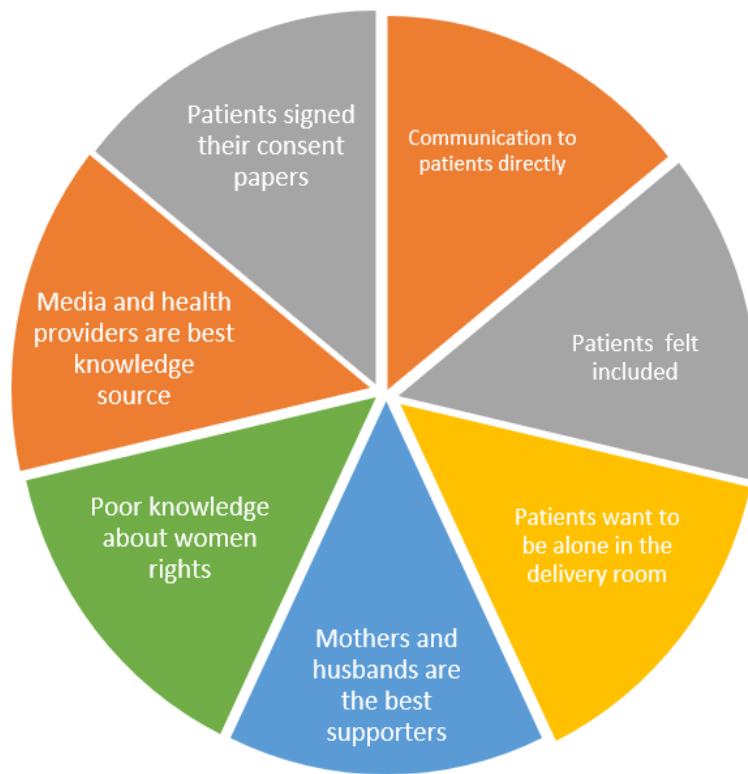


Figure 4.5 Significant components of PCC to women across locations and sectors

During delivery, women felt they could function better without their family because they could concentrate on their pain. Women did want to know that their loved ones were waiting for them outside the delivery room. While most women preferred to be alone, some women wanted their husbands to stay with them, sharing the delivery experience. Others wanted to have their mothers or sisters.

While most women preferred to be alone in the delivery room, they also expressed that family support was an important component to patient-centric care. More specifically, most women believed family support was essential before and after the delivery. Mothers and husbands emerged as the commonly described individuals who acted as "best"

supporters for women (Figure 4.5). Interestingly, husbands were the best supporters followed by mothers. Having family support in the inpatient rooms prior to and following delivery was an essential thing for many women across locations and sectors. This indicates that women need support at the right time and right place during the labor, delivery, and post-delivery process. The majority of women across locations and sectors reported the need for family support throughout the labor stages and right after the delivery but not during the delivery process. Women felt that being alone with health providers is enough inside the delivery room. However, they felt secure having their beloved ones waiting for them right after the delivery. On the other hand, some women felt the need for having husbands or their mothers with them inside the delivery room as well.

As a part of Vision 2030, Saudi women earned back many of their legal rights in 2017. One of these rights was full autonomy in health care decisions. In the past, women could not sign their consent paper, but now health providers are obligated to give women their consent for treatment papers to sign. In conducting our interviews, almost all women reported they signed their consent papers by themselves ( figure 4.5) . This finding shows that the National Guard hospitals are following the new women autonomy rules that were mentioned earlier in the Saudi constitution (Law # 33322), in which women should consent for themselves.

While women's actions in signing the consent forms were high, women's knowledge regarding their rights and entitlement to sign consent forms was low. Almost half of the women, across locations and sectors, did not know that they were entitled to sign their consent forms themselves. Most women signed their consent paperwork because health providers instructed them to do so. Despite an overarching lack of knowledge

regarding their rights, a small portion of the sample (30%) were aware that they recently earned the right to sign their medical documents. Women reported that their knowledge of the rights came from reading and the media. Public sector women tended to know more about their health rights than private women across both locations, and women in Jeddah's knew more about their rights as compared to Riyadh's. One reason could be because health providers in Jeddah may have a better understanding of women's rights. Besides, it may be because policies in NGHA in Jeddah has more precise guidelines to its health providers in regard of women's rights. Future research should be considered regarding this issue.

While the majority of women signed their consent forms due to hospital policy, there was a lack of consistency in women signing their admission and discharge documents. Some women reported signing these documents, while others did not. The majority of the private women in Jeddah (95%) signed their health documents compared to women in the public sector (65%) in Riyadh's both sectors ( Private 55%, public 56%). The majority of women across locations and sectors did not know that they can sign their documents, but they are willing to do so if the documents were provided to them.

It is important to note that the more educated the women is, the more she knows about her health rights. From the demographics of the participants in this study, we found that women who have college degree tend to know more about their health rights. These women reported that they signed their health documents. Besides, women who work in health sectors tend to know more about their health rights and tend to be included more into their care process. The more women knew about their health rights, the more they will engage with their health providers in decision making. These women can share their preferences, worries, and concerns with their health providers and can reach a deep

understandable relationship with their health providers. Women, who are familiar with their health rights, will not hesitate to ask for any support they might need during their birthing experience. In short, having an understanding of the extent of women's health rights is essential for women to engage in supporting patient-centric care in the ways they demand (Figure 4.5).

The second aim was to understand the roles and desire of mothers in participating and engaging in patient-centric care by being involved in decisions related to their delivery and follow-up care. Women reported what the things that matter the most to them, what they liked and disliked, what things that they may change if they could, and what are the needed support they wished to have during their birthing experiences in the National Guard hospitals.

The critical finding was that public women differ from private women in which their priorities were formed based on their needs. For instance, public women suffered from the lack of family support during the hospital stay and from the shared room that they had. Therefore, their priorities were having companions and a proper amount of privacy. On the other hand, these were not an issue for private women. These women needed proper pain management and worried about their newborns' health.

Moreover, women across locations and sectors found that the medical services were good, especially the ones inside the delivery room. Women distinguished between nurses (midwives) inside the delivery room and nurses in women rooms. The majority of women were pleased with the attitude of nurses in the delivery room (midwives) and their medical competence. On the other hand, public women were complaining about the attitude of the nurses serving in the shared rooms. However, this was not an issue with the private

women who had private rooms. The issue of the attitude differences, may be because of the pressure in the public sector. As mentioned before, the number of women in the public sector is higher than the number of women in the private sector.

Furthermore, public women in the shared room did not have family help during their admission. So these women requested nurses more for help than the private women. Unfortunately, they could not have their support because of the "No companion" policy. There are a minimum number of four women in each room in the public sector. Also, these women were have their newborns with them. Therefore, having companions with patient in such crowded rooms is infeasible.

Women in both sectors did not like nor understand the Breastfeeding Initiative Policy in which they should have their newborns to stay with them during their admission. The main goal of this policy is to give mothers the opportunity to breastfeed their newborns. Women in the public sector were suffering from this policy more than the ones in the private sector. For instance, public women were facing difficulties leaving their newborn unwatched during the nights and surrounded with strangers to go to the bathrooms. However, what comforts them that all newborns are having an electronic bracelet attached to them so no one can steal them and leave the hospital.

Above all, health providers should care about women' physical, mental, and emotional wellbeing. Women in both sectors reported their need for additional emotional support, especially private women in Riyadh. Moreover, the majority of women across locations needed further understanding and support in the process of breastfeeding. Some women recommended providing formulas for their newborns in case mothers could not nurse them, for example. Others recommended having additional lactations specialist.

Most importantly, women recommended having family support during their stay to assist during the breastfeeding process, especially public women and women who had c-sections.

## 5.0 Implications for Health Administrators and Managers

Since an understanding of women's rights is vital in order to engage in patient-centric care, many health organizations in Saudi Arabia have continuous education campaigns through Twitter and Instagram. Rofiadh is one of the authorized publicly available websites that teach women about their health rights. In terms of what was found in this dissertation, more work is needed to educate women about their health rights. One implication for health care administrators and managers is that a critical source of that education may stem from the health system itself. Since this dissertation found that many women were signing their consent forms simply because they were given to them, National Guard Hospitals need to be more actively engaging women in order to educate them. That education needs to take additional forms outside of simple process measures that hand forms to women. It should include using digital screens and posters around the hospital to educate the whole community about women's rights and not only women. The best time to educate these women is during their monthly maternity care not during labor and after delivery.

A second important implication for health administrators in the National Guard hospitals is the need to train health providers to communicate with the women themselves regarding the admission and the discharge documents. Since they could communicate with them regarding medical consent, it is possible to do that with the admission and discharge documents. Health administrators can consider giving women their admission documents, for example, when they are stabilized after giving birth. Currently, husbands are signing



the admission papers for the majority of the women to ease the process of the admission. Since women usually come to the hospital in labor, admin staff seek husbands' signature to ease the process of admission, not because of any discriminations against women. Regarding discharge documents, and per the list of the hospitals' regulations, the fathers of the newborns are the ones who should sign the discharge documents for their newborns and take the birth documents by themselves. Maybe that's why women in this study were waiting for their husbands to discharge them is because they wanted to leave with their newborns.

The government gave the mothers the rights regarding announcing their newborns' births to the authorities and receiving and submitting their newborns' documents in August 2019. The data was collected from mothers before this new regulations, in which only fathers could do that. With the new regulations, both fathers and mothers are considered to be guardians of their children.

One of the implications that should be considered among health providers, health administrative, health managers is to treat a patient as a whole. In other words, health providers should care about their women' emotions and mental health as much as their physical care. Women in labor can be in their weakest shape, and they need to be continuously supported emotionally throughout the delivery process. Moreover, health providers should be trained to educate women about their health rights. Indeed, health providers are the ones who are dealing with women regarding their health or their newborn's health, therefore taking the lead to teach women about their health rights is essential.

Moreover, designing a baby-friendly maternity wards is critical for women and their newborns. Allowing mothers to enjoy their newborns stay with them during admission is an important thing that National Guard hospitals should consider.

One of the limitation of this study is the convenience sample that been conducted. However, it was suitable for the aims of this study. Furthermore, not all the components of patient-centric care were included in the research question. In addition , only women who delivered in the National Guard hospitals in Jeddah and Riyadh were recruited. Future research is recommended for other public and private hospitals in the kingdom. Additional research is needed for a comparison between rural and urban areas across the kingdom to assess women's rights knowledge. Moreover, recruiting health providers to assess their willingness and desire to include women into the care process is needed.

One of the strengths of this qualitative study is that we reached saturation in the four sections in the two hospitals that we chose. Furthermore, this study was conducted from two different locations in Saudi Arabia, and that gave us multiple perspectives on the problem.

## 5.0 Conclusions

In conclusion, the first aim of this study was to evaluate and compare the baseline levels of knowledge and perceptions regarding what constitutes patient-centric care for mothers across the private and public sectors in two National Guard hospitals. We found that the majority of women across locations and sectors felt included and been communicated with directly throughout the care process. However, few health providers were talking directly to the husbands, especially in the public sector in both locations.

Moreover, private patients tend to be more willing to contribute into the care process than public patients. However, we found a consistent finding across locations and sectors in which some women prefer their doctors to make the medical decisions for them. Also, women, in general, prefer to be alone in the delivery room. However, they needed their family support before and after delivery. The majority of women signed their consent papers by themselves not because they knew their health rights, but because the consent papers were given to them. Private women in Jeddah were found to have the highest percentage of signing their documents by themselves among the other women. However, husbands still signing admission and discharge documents regarding their wives, especially in the public sector in Jeddah and Riyadh's hospital.

In aim two, we examined how mothers' goals, values, and priorities for maternity care can be integrated into the public and private sector. We found the consistency among the public and the private sectors in both locations in many things. For instance, we found that public women in both locations needed companions and private rooms as their top priorities. While in the private sector, women needed better pain management in and emotional support.

Interestingly, all women across locations and sectors liked the excellent medical care inside and outside the delivery room. Nonetheless, they did not like having their newborns with them the entire time, especially public women in shared rooms who had no companions. On the other hand, private women did not like not having their private rooms, which they paid for, from the beginning. Therefore, it was one of the first things they wanted to change if they could. Regarding public women, they wanted to have their private rooms or reducing the number of women in their shared room. Last but not least, women

across locations and sectors needed further breastfeeding support. Private women, especially in Riyadh, noted that emotional support was the most needed support.

## CHAPTER 5

### CONCLUSION AND FUTURE IMPLICATIONS

Labor and childbirth are crucial processes that affect the physical and psychological wellbeing of women. With proper holistic care, women and their newborns can achieve better outcomes. Women do not only care about physical care in child birthing; emotional care matters to them as well. Having a caring health provider, proper emotional support, and allowing women to be part of medical decision-making ,if they wish, can improve women satisfaction and women's health.

As it is well known, patient satisfaction is an important indicator to measure the performance of health services and their quality. Furthermore, putting the women at the center of care, by respecting their preferences, and listening to their concerns are critical things that lead to better patient satisfaction. Within National Guard Hospitals, this dissertation found that all women across locations and sectors selected to deliver because of these hospitals' reputations for the high quality of care. The majority of these women felt satisfied with the level of medical care received. However, some women expressed a need for further emotional and psychological care. For example, public women in both locations complained about lack of privacy in their shared room and the absence of their family support during their admission. Even some private women did not have given private rooms upon admission, although they been promised to have private rooms. This

lead to complaints about the operations of the business centers in these hospitals. Above all, the majority of women were pleased with the competence of their health providers, especially doctors. Nevertheless, nurses' attitudes were a problem among public women and some private women, who had to be in shared rooms.

Moreover, women across locations and sectors felt involved with their health providers throughout their experiences in the National Guard. Women felt heard and respected by the majority of doctors. Many women contributed to the decision-making side by side with their doctors. Moreover, although not all women knew their health rights, the majority of them signed their consent papers. However, admission and discharge papers are still signed by some of the husbands. Also, women's needs and priorities were formatted based on their sector. For instance, since public women needed more family support and privacy in their shared rooms, these were their priorities. On the other hand, private women needed proper pain management and emotional support. Last but not least, the majority of the women did not understand the new Breastfeeding Initiative Policy, and they needed further support in breastfeeding and newborns' care.

For health administrators and managers to improve the quality of maternity care, women's perspectives should be incorporated into the decisions making processes regarding the delivery of care. Listening to women's complaints and worries regarding sources of dissatisfaction and making an effort to fix the problems from occurring again are things that should be considered and not underestimated. Administrators and managers should decide upon targeted quality improvement efforts to enhance the satisfaction of women in maternity wards in both the public and private sector.

According to the results, managers should focus on some of the issues that affected patient satisfaction in the public and private sectors. In the public sector, issues like nurses' attitude, cleanliness and hygiene, privacy, breastfeeding support, and family support should be addressed to increase women's satisfaction and ensuring better application of patient-centered care. In the private sector, on the other hand, emotional support, breastfeeding support, and respecting patient's preferences are some of the issues that they should be considered for quality improvements during labor and child birthing. It is important to treat women well regardless of their ability to pay. At the same time, women who have paid for their care should get what they pay for.

Saudi Arabia is completely restructuring and reforming the health sector. The government is planning to privatize all governmental hospitals. The idea of privatization was under in-depth study for years. Some policymakers supported the ideas; others opposed it. However, the decision for privatization was approved and will start in 2020. This study can provide a blueprint for administrators, managers, and policymakers regarding elements of patient satisfaction to improve or maintain within National Guard hospitals in Saudi Arabia. In general, efforts must focus on being able to maintain the level of care within the private sector of these hospitals while addressing concerns surrounding nurses attitudes, family support, and privacy in the public sector. Additionally, as privatization continues, education efforts are needed to ensure that women understand and empowered to act on the newly found health care rights.

While maintaining the quality in the private sector, special attention should be paid to some satisfaction elements that can improve the public sector, since it is the one that needs further improvement. Privacy is a significant issue in this sector. Reducing the

number of women per room or providing a private room for every patient will fix this issue. As the kingdom is building new hospitals around the country concerning privatization, such attention should be paid. It is better to structure these hospitals while considering women' privacy. By fixing the rooms' privacy issue, women will be able to have their companions with them during their stay and will have adequate support and help. Thus, the burden on nurses will reduce since women will not call nurses that much due to their family supports they will have.



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## APPENDIX A- PATIENT'S RECRUTMENT FLYER



### الحمد لله على سلامتك و سلامة طفلك

هل ترغبين  
بمشاركتنا تجربتك  
في المستشفى  
والمشاركة في دراسة  
علمية تهدف إلى  
زيادة الوعي لدى  
النساء وزيادة الجودة؟

سوف تكون المقابلة عن :

- تجربتك في ولادة صغيرك في المستشفى ومدى رضاك عن الخدمات المقدمة لك .
- سبب إختيارك مستشفى الحرس الوطني لولادة طفلك .
- أكثر شئ أحببته خلال مدة بقائك في المستشفى .
- أكثر شئ لم تحببه خلال مدة بقائك في المستشفى .
- مدى إلمامك بحقوقك كمریضة .

متى يمكنك الحديث معنا؟  
لديك خيارين:

- يمكننا الحديث معك في غرفتك في المستشفى في أي وقت متاح من الساعة التاسعة صباحا إلى الساعة الرابعة عصرا قبل خروجك من المستشفى
- يمكنك إعطائنا رقم جوالك/منزلك ويمكننا التواصل معك في أي وقت مناسب لك إلى قبل موعد إنتهاء الدراسة البحثية: في آخر يوم في ديسمبر ٢٠١٨

**المرشحات للدراسة:**  
السيدات فوق سن الثامنة عشر ولدن أطفال بصحة جيدة وبدون مضاعفات ، من أي جنسية في مستشفى الحرس الوطني بجدة والرياض في القسم الخاص أو العام

إذا قررت أن أشارك في الدراسة هل يمكنني أن أغير رأيي؟  
**بالتأكيد !** يمكنك أن تسحبني من الدراسة قبل أو في أثناء المقابلة أو بعدها ! لا يوجد أي عقوبة مرتبطة بإنهاء مشاركتك في هذه الدراسة ولن تتأثر الخدمات الصحية المقدمة لك في المستشفى بأي شكل من الأشكال .



في هذه الدراسة نود أن نتحدث مع سيدات ولدن أطفال أصحاء في القسمين العام والخاص في مستشفى الحرس الوطني في مقابلة شخصية مدتها تتراوح من عشرين دقيقة إلى نصف ساعة .



## APPENDEX B - CONSENT FORM

 <b>National Guard Health Affairs</b> <b>King Abdullah International Medical Research Center</b> الشؤون الصحية بالحرس الوطني مركز الملك عبدالله العالمي للأبحاث الطبية	<b>RYD-18-417780-142209</b>
 <b>Cross-sectional surveys</b>	

<b>Informed Consent Form</b>	
Study Title: Examining Women's Perceptions of Maternity Care in the Public and Private Sectors of National Guard Hospitals in Saudi Arabia: A Qualitative Study	
Principal Investigator: Dr. Tahgreed Shams	Study No.: SP18/361/J

<p>You are requested to participate in research that will be supervised by <b>Dr. Tahgreed Shams, Consultant, Ob/Gyne, in the Department of Obs/Gyne, KAMC, MNG-HA, WR.</b></p> <p>This study is about <b>Women's perceptions of maternity care, comparing satisfaction of women's between the private and the public sectors based on their recent maternity care in two National Guard Hospitals.</b></p> <p>Your participation is voluntary and you have the right not to accept filling this survey without giving any reason and this will not affect your current or future medical care in MNGHA</p> <p>You don't have to sign this information sheet only you can choose to agree/disagree; your acceptance to complete the survey will be interpreted as your informed consent to participate.</p> <p>Your responses will be kept anonymous. However, whenever one works with email/the internet there is always the risk of compromising privacy, confidentiality, and/or anonymity. Despite this possibility, the risks to your physical, emotional, social, professional, or financial well-being are considered to be 'less than minimal'.</p> <p>If you have any questions about the research, please contact <b>Dr. Tahgreed Shams at <a href="mailto:shamsta@ngha.med.sa">shamsta@ngha.med.sa</a> or call 0554075756</b></p> <p>In case you have enquiries related to your rights as a research subject you can contact the Institutional Review Board on Tel. 8011111 Ext. (84) 94457.</p>	<p>انت مدعو للإضمام طوعية لدراسة بحثية سوف يشرف عليها <b>(بحريه شمس)</b> في <b>(قسم النساء والولادة في مستشفى الحرس الوطني بجدة والرياض).</b></p> <p>هذه الدراسة تهدف الى <b>(مقارنة مدى رضی السيدات حديثات الولادة بالخدمات المقدمة لهم ومدى ايمانهم بحقهم الصحية في القسمين الخاص والعام في مستشفى الحرس الوطني بجدة والرياض).</b></p> <p>ان مشاركتك في هذه الدراسة طوعية و لك الحق التام في عدم قبول تعينه الاستمارة او الانسحاب في اي وقت تشاء بدون ابداء الاسباب و لن يؤثر ذلك على العناية الطبية المقدمة لك حاليا او في المستقبل في الشؤون الصحية بوزارة الحرس الوطني.</p> <p>لا يجب عليك التوقيع على ورقة المعلومات هذه، فقط عليك الاختيار موافق/غير موافق فمجرد قبولك تعبئة هذا الاستبيان يعتبر بمثابة اقرارك بالموافقة على المشاركة في هذا البحث.</p> <p>ستبقى الردود على الاستمارة سرية. ومع ذلك، فإن العمل عن طريق البريد الالكتروني و الانترنت يبقى هناك احتمال لاختراق خصوصية البيانات و سرية المعلومات و لكن و بالرغم من هذه الاحتمالية تبقى الاضرار البدنية و العاطفية و الاجتماعية و المهنية و المالية المترتبة عليك ضمن الحد الأدنى من الخطورة.</p> <p>إذا كان لديك أي أسئلة حول هذا البحث، يرجى الاتصال <a href="mailto:shamsta@ngha.med.sa">shamsta@ngha.med.sa</a> 0554075756</p> <p>في حال كان لديك الاستفسارات المتعلقة حقوقك كموضوع بحث يمكنك الاتصال مجلس المراجعة المؤسسية على هاتف 8011111 تحويلة (84) 94457.</p>
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<input type="checkbox"/> Agree to participate	<input type="checkbox"/> موافق على المشاركة
<input type="checkbox"/> Disagree to participate	<input type="checkbox"/> غير موافق على المشاركة

Shall not be used, disclosed, or published  
Without written approval from King Abdullah International Medical Research Center

Version No. (Please change according to your study)      Version date: (please change as appropriate)      Page 1 of 1

KAIMRC-RO/ ICF SURVEYS BILINGUAL VERSION: 01  
Date: 15/05/2013 CROSS-SECTIONAL SURVEYS

## APPENDIX C- INTERVIEW GUIDE

The following list of questions was used as an outline for the focus group questions.

general questions:

- how old are you?
- Is this your first child?
- Is your child born normal? Caesarean?
- What is your nationality?
- What is your educational level?
- do you work? Where?
- Why did you choose National Guard Hospital?
- Describe your experience with health care providers: doctors, nurses, and administrators in general?
- What did you like most of the service offered?
- What did you did not like the most?

Aim two's questions:

Health Provider- patient relationship and Privacy

- Describe the relationship of the doctors with you? did they treat you with respect and courtesy?
- Describe the relationship of the nurses with you? did they treat you with respect and courtesy?
- Describe the relationship of the support staff with you? did they treat you with respect and courtesy?

Privacy:

- How far you are satisfied with the respect of the doctors to your privacy?
- How far you are satisfied with the respect of the nurses to your privacy?
- How far you are satisfied with the respect of the support staff to your privacy?
- Do you like the amount of privacy in your room?
- If you can change something, what would you change?

- can you describe your experience while having your newborn with you during admission?
- What do you know about the new Breastfeeding initiative policy? Did anyone explained it to you?
- what challenges have you faced for nursing your child?
- what support did you need during breastfeeding?

Aim three (A) questions:

- who was with you during childbirth?
- Who would you prefer to have with you in the birthing room?
- What do you think about the importance of family support?
- Who is the most important person supporting you during childbirth?
- For women who have given birth to a Caesarean birth or taken a needle back: You told me earlier in this interview that you gave birth to a Caesarean birth or took me back, how was this decision taken, and are you convinced of this decision?
- Did you understand why the cesarean section was performed?
- Do doctors or administrators contact you directly or with your husband / guardian?
- What kind of role do you want to play in your health care and your child? why?
- How well do you know women's health rights? (Surgical operations, signing of papers and documents)
- What do you know among these rights:
  - That one of your family can enter the delivery room with you
  - Signing out your discharge, admission, and all consents.
  - Health providers should talk to you directly and not to your guardian
  - You can ask any question and discuss any concern about your health care and your health provider should listen carefully to them
  - Share the decision making with your health providers
  - Where did you learn these rights? (From media - books - hospital signage - health care providers - educational edifice: educational curriculum)
  - What do you think about these new rights? ( are you satisfied)?
  - Tell me if you think that women's health rights can empower women and affect their lives? Explain
- Have you laid out your birth plan?-

- Do you share your plan with your doctor, why or why not? If the answer is yes ,- Is your doctor / doctor involved you in his care plan?
- Did you want to share with your doctor / doctor anything else? Did you want to share something else but could not?

Aim Three (B) Questions:

- What role do you want to play in your birth care? and in your baby's care?
- Are there specific things you wanted to support in this birth?
- If you can change something, what will it be?
- What are some of the things that were most important to this birth?
- Sort by priority: (not feeling pain - better response from the medical staff - private room - the presence of his facilities - better care of the child).

## APPENDEX D- IRB APPROVAL FROM KING ABDULLAH INTERNATIONAL MEDICAL RESEARCH CENTER IN SAUDI ARABIA



المملكة العربية السعودية  
وزارة الحرس الوطني - الشؤون الصحية

Kingdom of Saudi Arabia  
Ministry of National Guard - Health Affairs

King Abdullah International Medical Research Center  
(KAIMRC)

IRB NCBE Registration No.:  
H-01-R-005

(84) 46669 1515 94466  
Memo Ref.No. IRBC/1483/18 E-CTS Ref. No. irb@ngha.med.sa

IRB Office RYD-18-417780-142209

Study Number: **SP18/361/J**  
Study Title: **Examining Women's Perceptions of Maternity Care in the Public and Private Sectors of National Guard Hospitals in Saudi Arabia: A Qualitative Study**  
Study Sponsor: **Non Grant**  
IRB Approval Date: **12 August 2018**  
IRB Review Type:  Expedited Review  Full Board  
Study site(s): **Western Region**

Dear **Dr. Taghreed Shams**  
Consultant, Obstetrics & Gynecology, Department of Obs/Gyne, KAMC-Jeddah  
Ministry of National Guard – Health Affairs

**Sub-investigators: Hanin Almahmoud, Dr. Melanie Cozad, Hadeel Almahmoud and Abeer Al Atabani**

After reviewing your submitted research proposal/protocol and related documents, the IRB has APPROVED the submission.

The approval includes the following related documents:

Document/Title	Version	Date
Research Proposal	01	12 August 2018
Informed Consent	01	12 August 2018
Questionnaire & Flyer	01	12 August 2018

The approval of the research study is valid for **one year** from the above approval to expiration date.

**Terms of Approval:**

- Annual Reports:** An Annual report must be submitted for approval to avoid termination/suspension of your research.
- Financial report:** If your study is funded project, details financial report should be submitted with the scientific report.
- Final Report:** After completion of the study, a final report must be forwarded to the IRB.
- Retention of original data:** The PI is responsible for the storage and retention of original data pertaining to the project for a minimum of five years.
- Reporting of adverse events or unanticipated problems:** The PI is responsible to report any serious or unexpected adverse events or unanticipated problems, which could involve a risk to participants or others.
- Biological samples:** No biological samples to be shipped out of the Kingdom of Saudi Arabia without prior IRB approval.
- Participant incentives:** No financial compensation or gifts to be given to participants without prior IRB approval.
- Storage of biological samples:** All biological samples collected for the purpose of this research must be stored in the KAIMRC related repository.

13 AUG 2018

**Dr. Abdallah Adlan**  
Chairman, Institutional Review Board (IRB)  
Head, Biomedical Ethics Section - KAIMRC  
Ministry of National Guard - Health Affairs

GA/HK/rla

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تلكس: ٤٠٣٤٥٠



## APPENDEX E- IRB APPROVAL FROM UNIVERSITY OF SOUTH CAROLINA



OFFICE OF RESEARCH COMPLIANCE

### INSTITUTIONAL REVIEW BOARD FOR HUMAN RESEARCH APPROVAL LETTER for EXEMPT REVIEW

Melanie Cozad , PhD  
Arnold School of Public Health  
Health Services Policy & Management  
915 Greene Street  
Columbia, SC 29208

Re: **Pro00078703**

Dear Dr. Melanie Cozad:

This is to certify that the research study *Measuring Mothers' satisfaction and perceptions of patient-centered care in public and private sectors in two National Guard hospitals in Saudi Arabia: a Qualitative study* was reviewed in accordance with 45 CFR 46.101(b)(2), the study received an exemption from Human Research Subject Regulations on **8/28/2018**. No further action or Institutional Review Board (IRB) oversight is required, as long as the study remains the same. However, the Principal Investigator must inform the Office of Research Compliance of any changes in procedures involving human subjects. Changes to the current research study could result in a reclassification of the study and further review by the IRB.

Because this study was determined to be exempt from further IRB oversight, consent document(s), if applicable, are not stamped with an expiration date.

All research related records are to be retained for at least three (3) years after termination of the study.

The Office of Research Compliance is an administrative office that supports the University of South Carolina Institutional Review Board (USC IRB). If you have questions, contact Lisa Johnson at [lisaj@mailbox.sc.edu](mailto:lisaj@mailbox.sc.edu) or (803) 777-6670.

Sincerely,

Lisa M. Johnson  
ORC Assistant Director and IRB Manager