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Toward Development of Human Resource Strategy: The Case of Midwives in Palestine

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Dedication

I would like to express my sincere gratitude to my wonderful mother (Om Sameer Al Turk) and all my families in Gaza and West Bank.

To all midwives in the world especially in our Beautiful Palestine who encouraged me all the way through this study … without their support and encouragement, this work would not be completed …

I would like to convey my appreciations to all those who contributed to the completion of this thesis.

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Samar Maghari
May 2015

Declaration

I certify that this thesis submitted for the degree of Master in Human Resource Development and Building-Institutions, is the result of my own research, except where otherwise acknowledged, and this study (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Signature:

Samar Farouq Mohammad Maghari

Abstract

Shortage of health care professionals especially midwives is considered a universal issue. This study aimed to identify midwives' job satisfaction and to examine organizational and social support in order to develop retention strategies for midwives working in Governmental hospitals in the West Bank. The researcher used descriptive, cross sectional design with combined quantitative and qualitative method. The sample of the study consisted of all midwives currently working in the governmental hospitals in West Bank, their total number was 114 midwives distributed on nine hospitals. For data collection, the researcher used Job Satisfaction Survey (JSS) of Spector (1994), perceived organizational Support questionnaire developed by the researcher, Social Support questionnaire developed by the researcher, and Anticipated Turnover Scale (ATS) of Hinshaw and Atwood (1984). SPSS version 20 was used for data analysis, including frequencies, mean score, (t) test, and One way ANOVA. The results showed that 81.7% of study participants had bachelor degree, 65% earn between 2000 – 3000 NIS, 74.6% were married, and 53.5% are working as midwife for less than five years. The results also showed that 90.4% of midwives were satisfied from education program, and they attributed that to the flexibility, applicability, and comprehension of the program. 81.5% reported having protocols at work place, 59.6% reported that they had adequate training on these protocols, and 79% reported that they apply the protocols during their work. In addition, 45.6% reported that they were satisfied from improvement opportunities at their organization. The overall average mean score obtained on JSS was 3.305 which indicates ambivalent job satisfaction. Midwives were satisfied from supervision, coworkers, and nature of work, while they were dissatisfied from pay, promotions, and operating conditions. The results also showed low perceived organizational support with overall mean score 2.68 (53.50%), moderate social support with mean score 3.62 (72.40%). The overall mean scores obtained on ATS was 2.82(56.40%). The results also indicated statistically significant positive relationship between anticipated turnover and job satisfaction and perceived organizational support. Furthermore, there was statistically insignificant differences in anticipated turnover, job satisfaction, perceived organizational support, and social support in relation to midwives' age, qualification, marital status, number of children, place of work, years of experience, income, and job position. Interviews with midwives showed that main cause of job satisfaction was the fact that the midwives like the midwifery profession, feeling of independency and ability to take decisions, and job security, while dissatisfaction was related to work overload, and unfair promotions. In addition, more than two-thirds of midwives wanted to stay in their work and one third have intention to leave due to social and family causes, and working night shifts. To develop the midwifery profession, the interviewee emphasized the need for clear written work protocols, providing in-service training programs, motivators and incentives, employing adequate qualified midwives, scientific research and exchange of experiences with other hospitals, and participation in decision-making. The study concluded that managers need to work toward increasing level of job satisfaction and organizational support to retain the available midwives and attract new midwives to be recruited to face the shortage of employed midwives in governmental hospitals. Attraction of midwives could be attained by increase wages, decrease workload, and expand the scope of midwifery role in the health system.

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List of Abbreviations

CBR	Crude Birth Rate
CDR	Crude Death Rate
GDP	Gross Domestic Product
GS	Gaza Strip
JS	Job Satisfaction
JSS	Job Satisfaction Survey
ICM	International Confederation of Midwifery
MDG 5	Millennium Development Goal 5
MOH	Ministry of Health
NGOs	Non Governmental Organization
NIOSH	National Institute for Occupational Safety & Health
OSHA	Occupational Safety & Health Administration
PASSIA	Palestinian Academic Society for the Study of International Affairs
PCBS	Palestinian Center Bureau of Statistics
PHC	Primary Health Care
POS	Perceived Organizational Support
SPSS	Statistical Package for Social Sciences
SS	Social Support
UNFPA	United Nations Population Fund Agency
UNRWA	United Nations Relief and Works Agency for the Palestinian Refugees
WB	West Bank
WHO	World Health Organization

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Chapter One

This chapter presents the introduction which explored the researcher's interest in conducting the study. In addition, the chapter presents the research problem, objectives of the study, context of the study and definition of study concepts.

1.1 Introduction

Employee's retention strategies are considered crucial human resources approach in order to achieve organizations' success and maintaining sustainability in high quality services (Government of Yukon, 2010). Employee's retention requires efforts by the organization to keep and maintain employees who have been hired previously, and without clear stated retention strategies, the ability of organization to retain employees will be questionable and weak (James, L. & Mathew, L, 2012).

Many issues are considered in employees' retention strategies such as decreasing barriers for retaining and adopting plans that enhance retention, so modification in work setting that will increase loyalty and commitment to the organization should be implemented including having a learning supportive environment, affording good salaries, annual leaves, reasonable sickleave days, clear job description and responsibilities, equitable promotions opportunities. In addition, employee's relationship with managers is important aspect, which needs to be considered in developing any retention strategy (James, L. & Mathew, L., 2012; Government of Yukon, 2010). Also, Job Satisfaction (JS) and Perceived Organizational Support (POS) are considered important issues that should be explored in the process of developing a retention strategy, as these two factors

usually associated with less turnover intention (Tourangeau, et al., 2010; James, L. & Mathew, L.; 2012).

In health sector, different challenges threaten the human resources (HR) responsible for planning and delivery of health care, among these challenges low pay and staff motivation, unequal and inequitable distribution of the health workforce, and poor staff performance and accountability remain key obstacles to health sector development. Additional challenges include increasing coverage and staff retention to ensure adequate and equitable delivery of priority health services, ensuring availability of key competencies and skills in the health workforce, increasing staff performance against objectives, and strengthening capacity for planning and managing HR in the health sector (Martinez and Martineau, 2002).

The attraction and retention of health professionals with appropriate skill sets, knowledge, and competence is a key issue for the competitiveness of health organizations. Investments in manpower will increase the loyalty of employees over time. As long as the employees are still with the organization, their productivity will surely gradually improve. This is particularly true with highly-trained employees (Wang, et al., 2012).

Midwifery is an important profession in the health system, and midwives should have adequate knowledge and skills to perform their tasks safely and effectively. The State of the World's Midwifery (2011) recognized midwifery services as the central role to implement the global strategy for women's and children's health, which couldn't be

achieved without real international and national commitments to educate and employ more midwives in health sector to face the shortage of professional midwives.

Globally, there is a shortage of professional midwives, and in this regard, the United Nations Population Fund Agency (UNFPA) and International Confederation of Midwifery (ICM) joint statement in the midwifery day on 5th May 2013 reported the need for 350,000 midwives all over the world (UNFPA, 2013).

In order to formulate applicable strategy to compact the global shortage in midwives, World health Organization - WHO (2010) recommended formulating deep understanding for midwifery workforce and situation analysis for factors that influence midwives decisions to leave their work in advance. By providing suitable and safe environment, supportive supervision, in-service training, profession development opportunities and responsiveness to offer secure and safe way to reach work place considering gender issues especially in rural areas, night shift work, we can retain health care professionals (Akuoko & Ansong, 2012).

Previous studies focused on social, economic and professional factors of health care providers including nurses and midwives in order to develop employee's recruitment and retention strategies (Government of Yokoun, 2010), while other studies focused on predicting turnover rate by knowing employees' intention to leave or stay in work (Barriball & Coomber, 2007; McCarthy, 2002).

According to Palestinian Ministry of Health report of human resources (MOH, 2012), there are only 136 midwives working in governmental hospitals in West Bank (WB), 106 of them have bachelor degree and 30 had training courses or 2-years diploma, and the

number increased to 114 midwives with bachelor degree in 2014, while in Gaza Strip (GS), 208 midwives are working in Governmental hospitals, 93 of them have bachelor degree and 115 have 2-years diploma (MOH, 2014). No clear data about midwives who work at non-governmental and private hospitals in terms of numbers and qualifications. Midwives who work in governmental hospitals offer maternity services to all Palestinian society especially for women who don't get services from private hospitals. Therefore, Palestinian midwives play crucial role in women's health, especially during labor and post-partum period. So, retaining midwives who work in hospitals and decreasing turn over must be a priority besides educating new midwives, therefore, we need to identify their JS level to keep them working in hospitals and improve their performance (El-Jardali, et al., 2009).

In the Palestinian context, there is lack of studies that aim to examine Palestinian midwives work conditions, JS and organizations support in order to develop retention strategy (Hassan & Narrainen, 2009).

For these reasons, this study aims to explore work condition of Palestinian midwives who are working in governmental hospitals, considering satisfaction factors and organizational support they get from their workplace, which in turn will help in developing retention strategy that will decrease midwives turnover, improve productivity, and increase the competency of midwives in Palestine.

1.2 Research problem

The global shortage of nurses and midwives affects both developed and developing countries and that would have negative impact on the safety and effectiveness of health

services. The Millennium Development Goal 5 (MDG 5) was "to improve maternal health" and MDG4 was "to reduce child mortality" (The State of the World's Midwifery, 2011), and to achieve these goals, there is a need to have enough and qualified midwives.

In WB, more than 60,000 deliveries take place every year, and 50.6% of these deliveries take place in governmental hospitals (MOH, annual report 2012), on the other hand, only 136 qualified midwives are working in governmental hospitals, which indicates the low ration of qualified midwives compared to the number of deliveries, and that reflects the high load on midwives who are working in governmental hospitals. The high load will increase pressure on midwives both physically and psychologically, and in consequence, midwives would suffer from burnout, and the intention to leave and looking for another job with less load and higher salary.

Identifying the determinants of turnover, besides examining level of satisfaction, perceived organizational and social support would be of great importance to understand the midwives status and enable decision-makers to consider strategies that would increase midwives commitment to their workplace and their intention to stay in work.

1.3 Justification of the study

According to the Palestinian Central Bureau of Statistics - PCBS (2014), the population in the Palestinian Territory was estimated to be 4.49 million at end of 2013 and one-third of the total population are youth, in reproductive age, with fertility rate 4.1 births in 2010. This high fertility rate in addition to the large percent of population in reproductive age increase the need for plan to supply health sector with skilled health workers especially midwives and to retain those who are already working. Nowadays many international and

national institutions support midwifery education programs in Palestine such as UNFPA, MOH and local universities in order to combat shortage of midwives in hospitals.

From the researcher experience and through communication with midwives, it was clear that obstetric services suffer from shortage in professional midwives, work overload, low salaries, lack of equipment, beside other factors such as inability to reach work place in some areas due to sudden closure of roads and military actions by Israeli occupation forces.

There is no clear information about Palestinian midwives turnover rate or their job satisfaction level, except some Master's Thesis that assessed level of Job satisfaction for Palestinian nurses. So, this study is needed to highlight insight about the midwives satisfaction and their intention to stay or leave their work.

1.4 Goal of the study

The goal of the study is to identify midwives' job satisfaction and to examine organizational and social support in order to develop retention strategies for midwives working in Governmental hospitals in the West Bank.

1.5 Objectives of the study

- To explore the level of job satisfaction among midwives working in Governmental hospitals in West Bank.
- To identify the degree of organizational support midwives get from their hospitals and colleagues.
- To determine the level of social support midwives get from family and community.

- To investigate the relationship between job satisfaction, perceived organizational support, social support, and anticipated turnover among midwives in Palestinian governmental hospitals in West Bank.

- To determine differences in job satisfaction, perceived organizational support, social support, and anticipated turnover related to selected socio-demographic variables (age, marital status, number of children, qualification, monthly income, years of experience, job position, working shifts, and place of work).

- To acquire recommendations from the midwives to develop the midwifery profession in Palestine.

- To develop recommendations on midwife retention strategy that utility will promote human resource strategy.

1.6 Questions of the study

- What is the level of job satisfaction among midwives in Governmental hospitals in West Bank?

- What is the degree of organizational support midwives get from their hospitals and colleagues?

- What is the level of social support midwives get from family and community?

- Is there a relationship between job satisfaction, perceived organizational, social support and anticipated turnover among midwives who are working in Palestinian governmental hospitals in West Bank?

- Are there differences in job satisfaction, perceived organizational, social support, and anticipated turnover among midwives related to selected socio-demographic variables (age, marital status, number of children, qualification, monthly income, years of experience, job position, working shifts, and place of work)?

- What are the main suggestions to develop the midwifery profession in Palestine from the midwives' perspectives?

1.7 Context of the study

1.7.1 Socio-demographic context

Historical Palestine lies within an area of 27,000 Km^2, expanding from Ras Al-Nakoura in the north to Rafah in the south. Due to Israeli occupation, Palestinian territory is divided into three areas separated geographically; the WB 5.655 Km^2, GS 365 Km^2 and east Jerusalem. At the end of December 2013 total population of Palestinians globally was 11,806,735 divided as follows: 4,485,459 in Palestine (2,754,722 in WB and 1,730,737 in GS), 1,430,212 inside the green line, 5,225,776 in Arab countries, and 665,288 in foreign countries. The population density (capita/km^2) is 745 in Palestine (847 in WB and 4,742 in GS) (PCBS, 2014). The Crude Birth Rate (CBR) in the Palestinian territory estimated to be about 32.6/1000 population in 2013 (29.7/1000 in WB and 37.1/1000 in GS), and the Crude Death Rate (CDR) in Palestine was estimated about 3.8 /1000 live birth (4.0 /1000 in WB and 3.7 /1000 in GS) (PCBS, 2013). The WB consists of 11 governorates; Jerusalem, Ramallah and Al Bireh, Hebron, Bethlehem, Jericho and Al Aghwar, Salfit, Qalqiliya, Nablus, Tulkarm, Tubas, and Jenin, while GS consists of 5

governorates: Gaza, North Gaza, the Middle governorate, Khanyounis, and Rafah (PCBS, 2014).

1.7.2 Economic context

The Palestinian economy is under increased pressure to create decent and productive jobs, reduce poverty and provide economic security on an equal basis for all social groups in a rapidly growing and urbanizing population. The poverty rate has traditionally been higher in GS than in WB, in 2011, 18% and 39% of individuals in WB and GS, respectively, were below the national poverty line (PCBS, 2012). Economic status in the Palestinian territories is very low. Gross Domestic Product (GDP) is estimated about 9.3%, and the workforce participation 43.6, unemployment is very high and reached a rate of 23% (19% in WB and 31% in GS), paid employment is the main source of income in the Palestinian territories, GDP per capita was 6,797 USD Million (5,030 in WB and 1,766 in GS) (PCBS, 2013).

1.7.3 Health care system

Health care services in Palestine are provided by five sectors including the MOH, United Nations Relief and Works Agency for the Refugees of Palestine (UNRWA), Medical Military Services for Police and General Security, Non-Governmental Organizations (NGOs) and private sector (non-and for-profit hospitals). MOH is the main health care provider; it provides primary, secondary, and tertiary services and purchases some services from private providers domestically and abroad (MOH, Annual Report 2006). The Palestinian territories have had relatively adequate health indicators compared to other lower middle-income countries and their neighbours in the Middle East. However,

the negative socioeconomic impact of the political conflict has affected access to health care and is undermining progress in health status (MOH, Health System Assessment Report, 2008). The total number of employees who are working in MOH in 2013 was 14,339 employees (32.0 / 10,000 population), of them 6,700 (46.7% in WB) and 7,639 (53.3% in GS), nurses and midwives who are working in MOH facilities was 3,909; of them, 2,406 (61.6% in WB) and 1503 (38.4% in GS), distributed as 3,579 nurses and 330 midwives (MOH, June 2014).

1.7.4 Midwifery health services in MOH hospitals

Maternity services are offered mainly at MOH hospitals, PHCs, private sector and UNRWA health centers. Palestinian midwives play crucial role in women's health, especially during labor and post natal period. Workload is high in the maternity departments due to the high birth rate (4.2 births per woman) (MOH, 2010) compared to the number of professional midwives (0.7/10,000 population) (MOH, June 2014). The percentage of females of reproductive age to the total population in Palestine was 24.2%, the fertility rate among women during the reproductive age was 4.9 in GS and 3.8 in WB (MOH, 2010).

According to MOH report of human resources (2012), there are 136 midwives working in governmental hospitals in WB (106 have bachelor degree and 30 are either had training courses or 2 years diploma holders), the number of midwives working in MOH hospitals in GS is 208 midwives (115 diploma and 93 Bachelor) (MOH, 2014).

Midwives in the government hospitals in which 53% of births take place, attend all normal deliveries and assist in high-risk cases. A study conducted in GS by Al-Madhoon

(2013) reported that during 2012 and 2013, the percentage of women delivered by midwives exceeded 40% of the total vaginal deliveries and more than 90% of low risk women were delivered by midwives. However, severe under-staffing restricts their capacity to ensure safe childbirth, and despite increasing caseloads and available applicants, the number of midwives have not been increased. Failure to license, support, and supervise a sufficient number of midwives to expand the use of community health workers for home-based maternal and newborn care is a missed opportunity to provide effective and simple interventions to those most in need (Abdul Rahim, et al., 2009).

1.8 Definition of study concepts

Midwifery

Midwifery is "a health care profession which encompasses care of women during pregnancy, labour, and the postpartum period, as well as care of the newborn. It includes measures aimed at preventing health problems in pregnancy, the detection of abnormal conditions, the procurement of medical assistance when necessary, and the execution of emergency measures in the absence of medical help" (WHO,2013)

Midwife

Midwife was defined by International Confederation of Midwifery (ICM) as "a person who has successfully completed a midwifery education programme that is recognized in the country where it is located, and that is based on the ICM essential competencies for basic midwifery practice and the framework of the ICM global standards for midwifery education; who has acquired the requisite qualifications to be registered and/or legally

licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery" (ICM, 2010).

Qualified midwife

The researcher defines qualified midwife operationally as any female who had been enrolled and graduated from a school of midwifery with bachelor degree, diploma three years, or post graduate diploma in midwifery, or master degree in midwifery and licensed to work as a midwife in any health facility in Palestine.

Job satisfaction

Job satisfaction is defined as "a construct from the field of organizational behavior that measures one's attitudes towards their work" (Blegen & Mueller, 1987), it is a term used to describe how an individual is satisfied or comfortable with his/her job (Omar, et al., 2012).

Perceived Organizational support

The concept of Perceived Organizational Support (POS) defined as "the employee's beliefs toward organization consideration to their cares about the organization wellbeing" (Eder & Eisenberg, 2008; Lew, 2009).

Turn over intention

The concept of turn over intention is defined as "the employee plan to leave work in the future. Therefore, when employee has intention to leave work he or she has vital insight to stop employment with the organization. This intention could be either hidden or obvious desire (Omar, et al., 2012; Lew, 2009).

Employee retention

Refers to the ability of an organization to retain its employees. However, many consider employee retention as relating to the efforts by which employers attempt to retain employees in their workforce. In this sense, retention becomes the strategies rather than the outcome (Allen, 2008).

1.9 Lay out of the study

This study composed mainly from five chapters: introduction, conceptual framework and literature review, methodology, results and discussion, conclusion and recommendations.

The first chapter tackled general introduction to the study, where a brief background regarding the subject of the study was provided. The researcher presented the research problem, justification for conducting the study, the general goal and specific objectives, research questions, definition of terms and context of the study.

The second chapter consisted of two parts: the first part is conceptual framework where the researcher provided a schematic diagram of the conceptual framework of the study. The second part is the literature review related to the study topic and variables. Indepth detailed inquiry including previous studies were presented.

The third chapter described methodology including study design, population, sample, instruments, pilot study including validity and reliability of study instruments, ethical considerations, and statistical analysis.

The fourth chapter presented the study results. The researcher treated the results in form of tables that make it easy for the reader to understand and make comments. The results

were discussed in relation to available previous studies that directly related to the topic of this study and its objectives.

Finally, in the fifth chapter, the researcher presented conclusion, recommendations and suggestions for further studies in the light of the study results.

Chapter Two

Conceptual framework and literature review

This chapter presents the conceptual framework and indepth review of available literature and previous studies, including the identification of study variables and their connectedness toward the development of HRS.

2.1 Conceptual framework

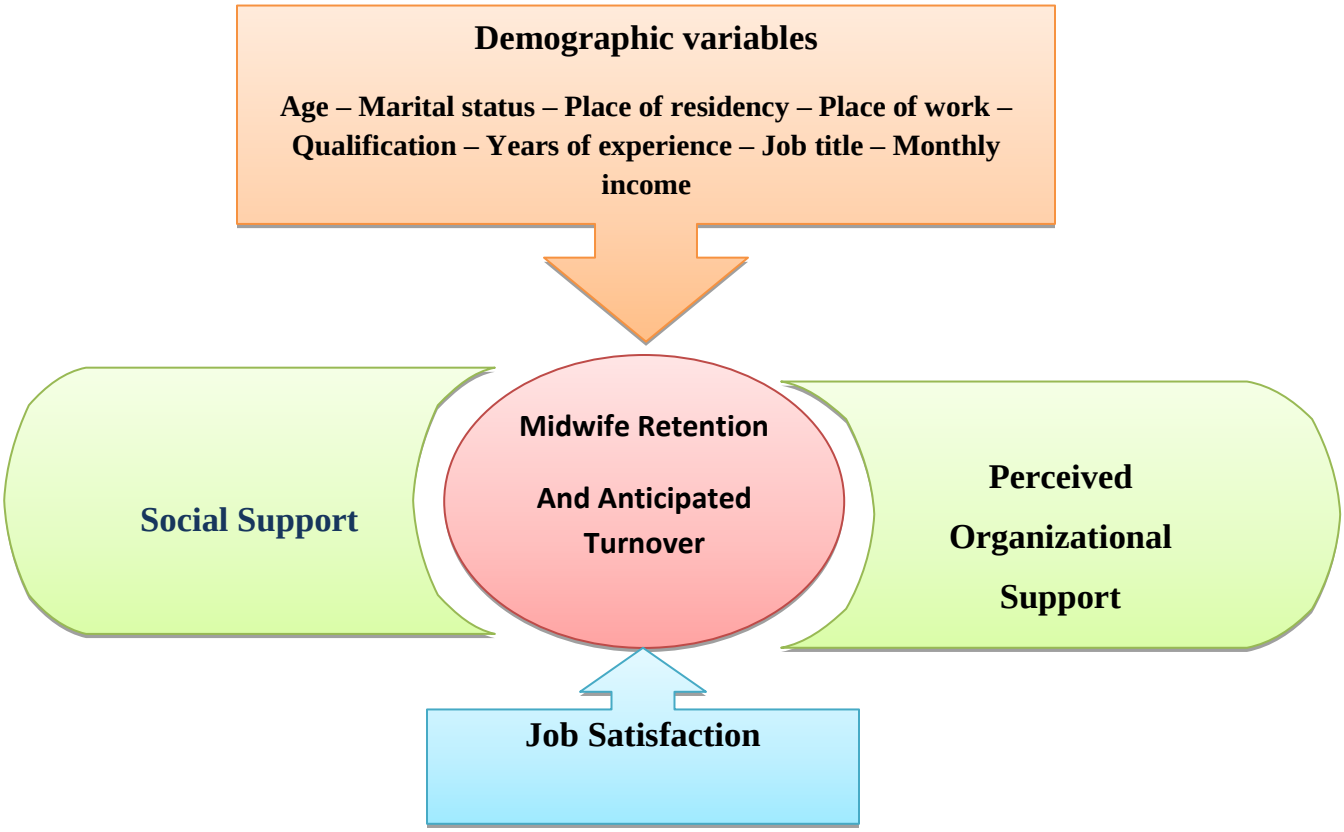

Figure (2.1): Diagram of conceptual framework

Based on the review of available literature, the researcher designed the conceptual framework. Conceptual framework is used to guide and direct the research process and to make research findings more meaningful.

The diagram denotes that four main factors are affecting midwives retention and intention to stay in work.

Demographic variables

Demographic variables include issues related to personal and social factors that may have an impact on midwives' opinion about midwifery profession and their intention to stay in their work. These factors include age, marital status, place of work, years of experience, qualification, and job title.

Job satisfaction

JS is another variable that may influence the midwives' intention to stay or leave their work. It is supposed that high level of satisfaction will lead to positive opinion about midwifery and decrease the chance for turnover. JS includes items as salary, promotion, policies, rules and regulations, administration, communication, fairness, tasks and workload (Gazioglu & Tansel, 2002).

Perceived organizational support

Organizational support is very important aspect in the workplace. It is supposed that midwives who get adequate support from their managers and colleagues will develop positive attitudes toward their organization and increase their intention to stay in work. Organizational support includes participation in discussions and decision-making,

availability of equipment and supplies, and availability of safety measures (Ali et al., 2010).

Perceived social support (PSS)

Social support (SS) is very important especially for nurses and midwives. Having positive views about midwifery by the family members and from the community will increase self-proud of being a midwife. Social support include receiving support from family members, relatives, friends, and the community.

2.2 Literature review

2.2.1 Background

Midwifery is an age-old tradition that has progressively adapted to social transformations over time and continues to play a major role in the world today. In-deed, traditional birth attendants are believed to assist two thirds of the world's births (Giacaman et al., 2005). Historically, laws governing midwifery appear to have been first established in Europe in the 16th century followed much later by the United States at the end of the 19th century. It also appears that regulations aimed at controlling midwifery reflected concerns for public health and a reformulation of the birthing experience in scientific as opposed to natural terms, ending with the abnormalization of midwifery (DeVries, 1996).

2.2.2 Definition of Midwife and midwifery

The ICM defined Midwife as "a person who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife', and

who demonstrates competency in the practice after successfully completed a midwifery education programed that recognized in the country where it is located and that based on the ICM essential competencies and standards for midwifery education" (ICM, 2010).

The State of the World's Midwifery (2011), acknowledged real need for international and national commitments to educate and employ more midwives in health sector in order to implement the global strategy for women's and children's health. In order to formulate applicable strategy to compact the global shortage in midwives. WHO (2010) recommended investment in human resources of midwifery and encourage retention of midwives through formulating deep understanding for midwifery workforce and factors that influence midwives decisions to leave their work in advance.

Midwifery is defined as "a health care profession through which midwife provides health care for women during pregnancy, labor, and the postpartum period, in addition to care of the newborn. Midwifery aims to preventing health problems in pregnancy, detect abnormal conditions, and manage emergency measures in the absence of medical help (WHO, 2013).

2.2.3 The global need for midwifery

Each year 350,000 women die from complications in pregnancy and childbirth (UNICEF, UNFPA, WHO, World Bank, 2010), over one million infants die under one month (Black, 2010) and 2.6 million babies are stillborn (WHO, 2011). Many of these deaths could be prevented by a midwife or other skilled birth attendant (save the children, 2011). However, 52 million births worldwide occur without attendants (UNICEF, 2009), while

in Asia and Sub-Saharan Africa less than 50% of births are attended by someone with the right skills (Ronsmans & Graham, 2006).

The worldwide shortage of skilled birth attendants has been widely recognized for several years, but the problem persists. In 2010, the Global Strategy for Women's and Children's Health noted that an additional 3.5 million health workers were required to improve the health of women and children substantially in the 49 lowest-income countries (United Nations Secretary-General, 2010). In 2006, the World Health Report estimated the global shortage at 4.3 million (WHO, 2006). In 2005, WHO reported that an additional 334,000 midwives would be needed over ten years to achieve 72% coverage of skilled birth attendance in 75 countries (WHO, 2005).

Globally, there is severe shortage of skilled midwives who are qualified to offer safe, appropriate care for women during pregnancy, labor and post-partum, and to face this shortage, UNFPA and ICM joint statement in the midwifery day on 5th of May 2013 expressed the need for 350,000 midwives all over the world (UNFPA, 2013).

Shortages of skilled birth attendants are triggered by a number of factors, including lack of institutional and practical training and varying standards in midwifery education, poor absorption into the workforce and ineffective regulations comprise service quality, in addition, poor working conditions, remuneration, support and supervision, and lack of career path, make it difficult to retain midwives, especially in rural areas (Koblinsky, et al., 2006).

WHO mentioned some factors that are needed to encourage midwives to stay in their work such as providing in-service training, profession development opportunities,

suitable and safe environment, offer secure and safe way to reach work place considering gender issues especially in rural areas, night shift work, support and supervision (Akuoko & Ansong, 2012; WHO, 2010).

2.2.4 Midwifery in Palestine

In Palestine, shortage of midwifery was addressed in the Palestinian MOH report of human resources (2012). Currently, there are only 114 midwives (5 have diploma certificate, and 109 have bachelor or higher degree) working in 9 governmental hospitals in WB and 208 midwives are working in governmental hospitals in GS (93 holds bachelor degree and 115 have 2-years diploma) (MOH, 2014). In 2006, approximately 24% of health care providers in the public sector were nurses, 17% were doctors, and only 1.8% were midwives (MOH, 2006). More than half of the Palestinian births (55%) occur in public hospitals free of charge, midwives attend almost all vaginal births, except for instrumental deliveries, and nurses are the main staff in the post-partum wards .

Few studies targeted Palestinian midwives; mostly they included them with nurses. In a descriptive qualitative study conducted by Hassan-Bitar & Narrainen (2011) to explore the challenges and barriers faced by Palestinian maternal health-care providers found that midwives reported many work difficulties and resource-constrained environment such as: high workload, poor compensation, humiliation in the workplace, suboptimal supervision and the absence of professional support and guidance. Midwives are perceived to be at the bottom of the health professional hierarchy. They conclude there is a need for managers and policy makers to facilitate the roles of midwives and nurses and creating a

more positive and resourceful environment, Palestinian midwives need to increase their knowledge and use evidence-based practices during childbirth.

There is a high need to increase midwives recruitment and retention in Palestine due to the high fertility rate in Palestine. The percentage of females in reproductive age to total population in Palestine was 24.2%. According to MOH (2010) records, the total fertility rate among women during the reproductive age in Palestine was 4.2 births per woman; 4.9 in GS and 3.8 in WB. The PCBS child statistics report (2013) indicated that the total number of newborns was 61,876 in WB in 2012, while the MOH mid-year report (2012) compared the number of deliveries with the number of midwives in all WB governmental hospitals (please refer to table 2.1) indicating the need for midwifery recruitment and retention.

Table (2.1): Distribution of total deliveries and midwives in WB governmental hospitals (Mid 2012)

Districts	Governorate / Hospital	Live births (frequency)	Midwives (frequency)
North	Tulkarm	818	9
	Qalqilya	676	5
	Nablus	2902	19
	Salfeet	602	6
	Jenin	2398	16
Middle	Ramallah	2278	24
	Jericho	491	5
South	Beet Jallah	836	5
	Hebron	3348	11
	Yatah	1289	6
Total		**13,360**	**106**

Source: MOH, mid-year report, 2012.

2.2.5 The role of midwife in health care system

Despite working in a challenging environment with persistent personnel shortages, midwives working in governmental hospitals play a key role in maternal health services. Midwives are a strategic component in reduction of maternal morbidity and mortality, as they attend births more frequently than other health care providers. A study carried out in Senegal found that hospital based midwives could detect obstetric complications, administer the necessary care and therefore expose their patients to a lesser risk of death more successfully than nurses and traditional birth attendants, and at a comparable level to doctors (Rouleau, et al., 2012). Workload is high in the maternity departments at governmental hospitals due to the high birth rate compared to the number of professional obstetricians and midwives. The scope of practice of midwives and nurses in the governmental and non-governmental clinics is restricted, despite their accessibility and women's preference for women providers. Midwives in the governmental hospitals in WB, where 53% of births take place, attend to all normal deliveries and assist in high-risk cases. However, severe under-staffing restricts their capacity to ensure safe childbirth, and despite increasing caseloads and available applicants, the number of midwives have not been increased (Abdul Rahim, et al., 2009). Failure to license, support, and supervise a sufficient number of midwives to expand the use of community health workers for home-based maternal and newborn care is a missed opportunity to provide effective and simple interventions to those most in need. According to Abdul Rahim, et al., (2009), the inadequacy of health information system means that effective maternal and child health interventions are difficult to plan based on prevalence of diseases and outcomes, delivery mechanisms, and health behaviors specific to this context. Rates of pregnancy-

related admissions, intrapartum complications, and maternal and neonatal re-admissions after birth are not available.

2.3 Job satisfaction (JS)

2.3.1 The concept of job satisfaction

Job satisfaction has been defined in many different ways; one of the most widely used definitions in organizational research is that of Locke (1976), who defines JS as "a pleasurable or positive emotional state resulting from the appraisal of one's job or job experiences", others have defined it as simply how content an individual is with his or her job; whether he or she likes the job or not (Spector, P.E., 1997). A more recent definition of the concept of JS is from Hulin & Judge (2003), who have noted that JS includes multidimensional psychological responses to an individual's job, and that these personal responses have cognitive (evaluative), affective (or emotional), and behavioral components (Hulin, & Judge, 2003). In addition, Rouleau, et al, (2012) defined JS as "A construct from the field of organizational behavior that measures one’s attitudes towards their work". Furthermore, Omar, et al., (2012) referred to JS as a term used to describe how an individual is satisfied or comfortable with his / her job,

Some researchers recognize that job satisfaction is a global concept that is comprised of, or indicated by various facets. The most typical categorization considers five facets of job satisfaction: pay, promotions, coworkers, supervision, and the work itself. Locke (1976) added few other facets as recognition, work conditions, company and management. Furthermore, it is better to separate job satisfaction into intrinsic and extrinsic elements whereby pay and promotions are considered extrinsic factors and coworkers, supervision,

and the work itself are considered intrinsic factors (Judge & Klinger, 1998). In order to explore job satisfaction among employee most researcher measured nine components of job satisfaction, which are; pay, nature of work, promotion, contingent rewards, supervision, operating procedures, fringe benefits, co-workers and communication.

2.3.2 Job satisfaction among midwives

JS is a frequently studied subject in work and organizational literature, this is mainly due to the fact that many experts believe that job satisfaction trends can affect labour market behavior and influence work productivity, work effort, employee absenteeism and staff turnover, moreover, job satisfaction is considered a strong predictor of overall individual well-being (Diaz-Serrano & Vieira, 2005), as well as a good predictor of intentions or decisions of employees to leave a job (Gazioglu & Tansel, 2002).

While there are numerous job satisfaction studies of health professionals, especially nurses and physicians, studies that explore midwives' job satisfaction are limited in number and scope (Hampton & Peterson, 2012). Job satisfaction among nurses and midwives is a common determinant for productivity and quality improvement. It is hypothesized that those who are satisfied from their job will put efforts to gain skills and knowledge and perform better than those who are dissatisfied from their job. The degree of satisfaction varies between different professions, different places and different work circumstances and conditions.

A range of findings derived from previous studies and literature regarding sources of job satisfaction among nurses. These sources include working conditions, interactions with patients/co-workers/managers, work itself, remuneration, self-growth and

promotion, praise and recognition, control and responsibility, job security and leadership styles and organizational policies, also, job satisfaction among nurses has been identified as a key factor in nurses' turnover with the empirical literature suggesting that it is related to a number of organizational, professional and personal variables (Lu et al., 2007). A study conducted in Saudia Arabia among 499 nurses from King Faisal University Hospital found that Nurses were least satisfied with the hospital's benefits, hospital policies, bonuses, fairness of the performance appraisal system, paid time off, and recognition of achievements. The mean general job satisfaction score was 2.2 ± 0.4, the study concluded that there are satisfaction dimensions other than salary and incentive that may be anticipated with the intention to stay in the hospital, such as challenging opportunities at work and leadership styles in the health organization (Zaghloul, et al., 2008). Another study conducted by Blaauw, et al., (2013) found that approximately 52.1% of health workers in South Africa were satisfied with their jobs compared to 71% from Malawi and 82.6% from Tanzania.

A study aimed to assess level of job satisfaction among community and hospital midwives, found that community midwives were more likely to report that their job was satisfying, offered a variety of work environment enabled them to use skills and knowledge fully, and offered opportunities for professional development, while hospital midwives were more likely to report following strict guidelines. Community midwives, however, disliked the long on call and unsociable hours, and reported disruption to family/social life (Todd et al., 1998). Another study by Skinner et al., (2007) examined the level of job satisfaction among Australian nurses and midwives reported that 96% of respondents were moderately or highly satisfied with their work and this was not

diminished by experiencing moderate amount of work related stress, in addition, factors positively related to high levels of JS were; enjoying their current area of practice, feeling well-suited to the particular type of work, wanting to stay in their current area of practice, and having no intention of leaving the profession.

One investigation found that midwives who left and later returned to their practices did so because of previous high JS experiences (The University of Sheffield, 2006). Another study demonstrated that midwives gained considerable overall JS by continuity of care for patients (Cattrell et al., 2006). Furthermore, an examination of midwives in birth centers showed high levels of JS because the midwives felt their skills were needed and gave high satisfaction to patients (Bainbridge, 2006). Another study conducted in Iran found that 49% of the midwives surveyed exhibited moderate levels of JS, 49% reported low satisfaction, and 2% conveyed high levels of JS (Mirmolaei et al., 2005). Another study among Estonian midwives found no significant association between JS and age, ethnicity, work abroad, or increased responsibility (Lazarus et al., 2005).

In Palestine, low concern was given for studying Palestinian midwives (Hassan-Bitar and Narrainen, 2009). An exploratory descriptive study among 152 nurses investigated JS and burnout among Palestinian nurses reported moderate levels of JS and moderate burnout. Palestinian nurses face many challenges in their daily work due to decreased chances of job advancement and emotional exhaustion which may lead to JS. In addition, health care administrators and policy-makers have a responsibility to find solutions to problems that cause job dissatisfaction and burnout among nurses to ensure the delivery of quality health care services (Abu Shaikha & Saca-Hazboun, 2009). Another study conducted in

WB found significant relationship between JS and marital status, distance travelled to work, number of years the nurse worked as an RN, and extended family responsibilities (Abu Ajamieh, et al., 1996).

2.3.3 Theories of job satisfaction

There are at least four different theories of job satisfaction, each one with the intention of shedding light and explaining how people find contentment and fulfilment with their jobs. The emergence of these theories expresses the thought that jobs are perceived as not only a means of earning a living, but also as an important extension of a person's identity. It is also observed that people who have a high level of JS tend to be more productive and become successful in their chosen careers. Some common theories of JS include the affect theory, two-factor theory, dispositional theory, and job characteristics model.

2.3.3.1 Affect theory

Among the theories of job satisfaction, probably the most widely-known is the "Range of Affect" theory, or simply, affect theory. Edwin A. Locke's Range of Affect Theory (1976) is arguably the most famous job satisfaction model. The main premise of this theory is that satisfaction is determined by a discrepancy between what one wants in a job and what one has in a job. Furthermore, the theory states that how much one values a given facet of work (e.g. the degree of autonomy in a position) moderates how satisfied/dissatisfied one becomes when expectations are/aren't met. When a person values a particular facet of a job, his satisfaction is more greatly impacted both positively (when expectations are met) and negatively (when expectations are not met), compared to one who doesn't value that facet. To illustrate, if employee (A) values autonomy in the

workplace and employee (B) is indifferent about autonomy, then employee (A) would be more satisfied in a position that offers a high degree of autonomy and less satisfied in a position with little or no autonomy compared to employee (B). This theory states that too much of a particular facet will produce stronger feelings of dissatisfaction the more a worker values that facet.

2.3.3.2 Two-factor theory (motivator-hygiene theory)

Fredrick Herzberg's two-factor theory (also known as motivator-hygiene theory) attempts to explain satisfaction and motivation in the workplace. This theory states that satisfaction and dissatisfaction are driven by different factors; motivation and hygiene factors. An employee's motivation to work is continually related to job satisfaction of a subordinate. Motivation can be seen as an inner force that drives individuals to attain personal and organizational goals. Motivating factors are those aspects of the job that make people want to perform, and provide people with satisfaction, for example achievement in work, recognition, promotion opportunities, these motivating factors are considered to be intrinsic to the job, or the work carried out (Aristovnik and Jaklič, 2013). Hygiene factors include aspects of the working environment such as pay, company policies, supervisory practices, and other working conditions, the hygiene factors are extrinsic factors and are under the control of the supervisor or someone other than the employee. The extrinsic factors affect job satisfaction and if not adequately fulfilled can cause dissatisfaction, even if the motivating factors themselves are addressed satisfactorily (DeShields, et al., 2005).

2.3.3.3 Dispositional theory

The dispositional theory suggests that individuals vary in their tendency to be satisfied with their jobs; in other words, job satisfaction is to some extent an individual trait, this approach became a notable explanation of JS in light of evidence that JS tends to be stable over time and across careers and jobs (Staw & Cohen-Charash, 2005).

A significant model that narrowed the scope of the dispositional approach was the Core self-evaluation Model, proposed by Timothy A. Judge, Edwin A. Locke, and Cathy C. Durham in 1997. Judge et al., argued that there are four Core self-evaluations that determine one's disposition towards job satisfaction: self-esteem, general self-efficacy, locus of control, and neuroticism. This model states that higher levels of self-esteem (the value one places on his/her self) and general self-efficacy (the belief in one's own competence) lead to higher work satisfaction. Having an internal locus of control (believing one has control over her\his own life, as opposed to outside forces having control) leads to higher job satisfaction. Finally, lower levels of neuroticism lead to higher job satisfaction (Judge et al.,1997).

2.3.3.4 Job characteristics theory

Job characteristics are aspects of the individual employee's job and tasks that shape how the individual perceives his or her particular role in the organization. Hackman and Oldham's (1980) original formulation of job characteristics theory argued that the outcomes of job redesign were influenced by several moderators. These moderators include the differences to which various employees desire personal or psychological progress (Perry et al., 2006). The clarity of tasks leads to greater JS because greater

role clarity creates such workforce, which is more satisfied with, committed to, and involved in work (Moynihan & Pandey, 2007). The jobs that are rich in motivating characteristics trigger psychological states, which in turn increases the likelihood of desired outcomes. For example, the significance of a task can sparkle a sense of meaningfulness of work that leads to effective performance (Perry et al., 2006). According to Hackman and Oldham 1980, the job characteristics model states that there are five core job characteristics (skill variety, task identity, task significance, autonomy, and feedback) which impact three critical psychological states (experienced meaningfulness, experienced responsibility for outcomes, and knowledge of the actual results), in turn influencing work outcomes (job satisfaction, absenteeism, work motivation, etc.) (Saif et al., 2012S).

2.3.3.5 Summary

The concept of satisfaction is very important in the field of work as JS reflects attitudes that individuals maintain about their jobs, and this attitude developed from the perceptions about their jobs. Job satisfaction is described as a function of what one wants from a job and what one perceives oneself as receiving. There are different theories and models that explain JS, and in this part, the researcher explained four theories; affect theory, two-factor theory, dispositional theory, and job characteristics theory. According to Weiss and Cropanzano 1996, dispositions may influence the experienced emotional state at work (affective component of attitude), which in turn influences JS. Furthermore, Herzberg theory demonstrated two factors that explain satisfaction – dissatisfaction from job; motivating factors make people want to work, and provide employees with satisfaction, including achievement in work, recognition, promotion opportunities, and

these factors are considered to be intrinsic to the job. Dissatisfaction (hygiene factors) include aspects of the working environment such as pay, policies, supervision, and other working conditions, and the hygiene factors are considered extrinsic factors.

It is important to consider the nature of work itself, and how employees perceive their job and their attitudes toward their job. People with positive attitude experience positive affective states, and are more likely to experience higher levels of job satisfaction, while People with negative attitudes experience negative affective states and tend to be dissatisfied with their jobs (Judge et al., 2002).

2.4 Perceived organizational support (POS)

Midwifery is experiencing challenges to achieve high level of performance and effectiveness inorder to maintain its growing profession, and to achieve that, there is a need for adequate support from their organizations. Employees' perception is one of the most important determinants of the employees' attitudes and behavior. This is due to the assumption that employees use their perception as a tool to measure the balance in their relationship with organization (Ali et al., 2010).

Perceived organizational support (POS) refers to employees' perception concerning the extent to which the organization values their contribution, and cares about their well-being, furthermore, POS refers to the beliefs of the employees regarding to the level of organizations commitment, consideration and caring for their well-being (Eder & Eisenberg, 2008). Organizational support theory (Eisenberg, Huntington, Hutchinson, & Sowa, 1986; Shore & Shore, 1995; Rhoades & Eisenberger, 2002) holds that in order to meet socio-emotional needs and to assess the benefits of increased work effort,

employees form a general perception concerning the extent to which the organization values their contributions and cares about their well-being. Such POS would increase employees' felt obligation to help the organization reach its objectives, their affective commitment to the organization, and their expectation that improved performance would be rewarded.

Organizational support theory also addresses the psychological processes underlying consequences of POS. First, on the basis of the reciprocity norm, POS should produce a felt obligation to care about the organization's welfare and to help the organization reach its objectives. Second, the caring, approval, and respect connoted by POS should fulfil socioemotional needs, leading workers to incorporate organizational membership and role status into their social identity. Third, POS should strengthen employees' beliefs that the organization recognizes and rewards increased performance (i.e., performance-reward expectancies). These processes should have favourable outcomes both for employees (e.g., increased job satisfaction and heightened positive mood) and for the organization (e.g., increased affective commitment, performance, and reduced turnover) (Pathak, 2012).

Behavioral outcomes of POS would include increase in role and extra-role performance and decreases in withdrawal behaviors such as absenteeism and turnover (Eisenberg et al., 1986. Cited in (www.eisenberger.psych.udel.edu/pos.html). In addition, Eisenberger & Eder (2008) considered that employees who have a high level of POS demonstrate increased job satisfaction, positive mood and reduced stress, and are more invested in their work organization, increase their positive outputs, attendance, and punctuality, and that employees with high POS should avoid high levels of voluntary withdrawal

behaviors, such as unnecessary absenteeism, tardiness, and engaging in non-work-related conversations, which meet a variety of personal needs and well-being. Employees evidently believe that the organization has a general positive or negative orientation toward them that encompasses both their contributions and their welfare.

A meta-analysis of 85 studies comprising 72,507 employees, demonstrated that supervisor support and organization support are strongly related to work–family conflict (Kossek et al., 2011). A systematic review carried out by Hayes et al., (2012) aimed to investigate determinants of nurses' turn over; the results supported the importance of organizational climate and the psychosocial work environment in employees' choice to leave their work. Furthermore, Rhoades & Eisenberger (2002) reviewed more than 70 studies concerning employees' general belief that their work organization values their contribution and cares about their well-being (perceived organizational support). They reported that 3 major categories of beneficial treatment received by employees (fairness, supervisor support, and organizational rewards and favourable job conditions) were associated with POS. In turn, POS was related to outcomes favourable to employees as (job satisfaction, and positive mood), and to the organization as (affective commitment, performance, and lessened withdrawal behavior), also, desire to remain was associated with POS because it is expected to reduce stress among employees' so it increases job satisfaction, positive mood, affective commitment with the organization performance, and that POS lessened withdrawal behavior and desire to leave work. A qualitative study aimed to explain Iranian nurses' experiences of perceived support and their contributing factors, indicated that nurses described their work place as non-supportive

due to managers' ignorance to individual and professional values, poor organization climate, low social dignity, and poor working conditions (Sodeify et al., 2013).

2.5 The link between job satisfaction, perceived organizational support and retention

Literature emphasized the role of JS in enhancing employee retention and increase productivity. Also, the literature focused on the importance of organization and social support as determinants for employee retention, and that these determinants are going to encourage employees to stay at their work and decrease their intention to leave. Furthermore, they will also empower the quality of their work, which in turn will affect positively the clients' satisfaction (El-Jardali et al., 2009; Akuoko & Ansong, 2012).

JS among nurses and midwives is a common reason for leaving or staying in their organizations or professional field. There is empirical evidence by some studies which reveal a link between job satisfaction and turnover. Thus, high JS among nurses was associated with high retention desire. Therefore, employees who are not satisfied leave, while those who are satisfied remain (El-Jardali, et al., 2012; Omar, et al., 2012; McCarthy, 2002). In addition, the study conducted by Blaauw, et al., (2013) found that JS is statistically related to intention to leave among health workers. Another study demonstrated linkages between JS, intent to leave, and migration (Akuoko & Ansong, 2012). In addition, the study conducted by Omar, et al., (2012) aimed to explore the relationship between JS and intention to leave among 700 permanent nurses working in public hospitals in Malaysia, found that Malaysian nurses who intent to leave work in

public hospitals were less satisfied in their job but moral obligation to the organization decrease their intention to leave even among dissatisfied nurses.

POS has been found to have important consequences on employee performance and satisfaction. Rhoades & Eisenberger (2002) emphasized that POS should contribute to overall job satisfaction by meeting socio-emotional needs, increasing performance-reward expectancies, and signalling the availability of aid when needed.

A study conducted in Miami-Dade county found that organizational support was most strongly related to JS (AL-Hussami, 2008).

Another study found that POS was found to indirectly affecting JS (Pathak, 2012). In addition, a study conducted on Korean nurses found that dissatisfaction was positively correlated to lack of organizational support, and that job satisfaction was significantly associated with the amount of organizational support (Kwak et al., 2010).

2.6 Towards a strategy for retention of midwives

Recruitment and retention of employees are considered among the major challenges that face organizations, as a result, voices raised to develop strategies to hire and retain employees (Government of Yukon, 2010). Employee retention is defined as an organized attempt by employers to construct and promote an environment that support keeping current employees working in the organization that have been already hired (Government of Yukon, 2010; Akuoko & Ansong, 2012).

Although intention to leave is associated within turnover rate, but actually both are two different concepts. Turnover is the actual act when employee leaves an organization,

while intention to leave is the employee desire or probable plan to leave an organization in a time in the future. Therefore, it is sensible to consider intention to leave as a predictor for turnover (Barriball & Coomber, 2007; McCarthy, 2002).

Omar et al., (2012) reported that developing countries are considered as more vulnerable to nurses and midwives turnover and intent to leave work either to go to private health sector or to developed countries where better salaries and job conditions. Despite this trend of turnover in developing countries, still studies concerning that phenomenon under recognized at national level. In order to develop employee retention strategy we need to understand the characteristics of employee who plan to leave the organization and those who plan to continue working in the organization (McCarthy, 2002). Some countries such as Ireland had put efforts toward understanding of turnover rate, furthermore, determinants of nurses and midwives intent to leave or stay were considered as important and should be identified at the national level to strengthen the workforce planning functions of the Department of Health and Children (McCarthy, 2002).

In Palestine, there is no clear information about midwives' turnover rate or factors that enhance turnover or stay intentions. Retaining midwives who are working in hospitals and decreasing turnover must be a priority besides educating and preparing new midwives. Therefore, midwives' needs must be understood, and their job satisfaction level should be assessed in order to retain them in the hospitals and improve their performance (El-Jardali et al., 2009) especially there is lack of researches that aim to explore Palestinian midwives work conditions, job satisfaction and turnover (Hassan and Narrainen, 2009).

The Palestinian MOH report of mid 2012 revealed that 98.8% of deliveries took place in hospitals, and 50.6% of these deliveries took place in governmental hospitals (PHIC, 2012). To be more clear, more than half of deliveries in Palestine took place in one third of hospitals (that offer maternity services) and this reflects the heavy workload that midwives face in governmental hospitals in comparison with other hospitals in Palestine, and in consequence, turnover of Palestinian midwives will inflict negative impact on quality of maternal care. In addition, Palestinian governmental hospitals in WB get their main human resources of midwives from those who are graduated yearly from Ibn Sina College as the college offer free of charge study in the midwifery program and the graduates are committed to work for 4 years in a governmental hospital in WB before they can take graduation certificate and transcript, this deal aims at maintain midwifery workforce supply in governmental hospitals (Ibn Sina College for Health Sciences, 2013).

Turnover means loss of qualified, skilful employees, which is costly in terms of monetary and quality aspects. When a health care facility loses part of its qualified staff, it needs to replace them with new staff to maintain the service, but these newly employed staff will need time and effort to gain adequate skills that enable them to perform the required tasks in a safe and quality manner. Therefore it is vital for the organizations to identify employees who are intended to leave and determine underlying factors that contributed to this intention inorder to put action plan that secure organizations from costly turnover.

Chapter Three

Methodology

This chapter addresses issues related to methodologies used to answer the research questions. The chapter commences with study design, study population, study setting, and period of the study, sample size, sampling and method of the study. It presents construction of the questionnaire, piloting, ethical consideration and procedures, (data collection and data analysis). Furthermore, it illustrates the validity and reliability of the study instrument and eligibility criteria of the study.

3.1 Study design

The researcher used descriptive, cross sectional design. The cross-sectional design has been selected because it is useful for descriptive purposes and it measures the variables of the study. Cross-sectional studies are generally carried out on a population at a point of time or over a short period (Coggon, *et al*., 1993). Cross-sectional studies are usually quick and cheap.

3.2 Study population and sample

The study population consisted of all the qualified midwives who are working in governmental hospitals in WB (9 hospitals), their total number was 114 midwives. Actually, the sample of the study was purposeful, where the population of the study was targeted.

3.3 Setting of the study

The study was conducted in all the governmental hospitals that offer maternity services in WB (Ramallah, Nablus, Jericho, Jenin, Hebron, Tulkarm, Salfeet, Bethlehem , and Qalqilya).

Table (3.1): Distribution of study participants according to place of work

Place of work	Frequency	Percent
Ramallah	26	22.6
Nablus	15	13.0
Jericho	7	6.1
Jenin	13	11.3
Hebron	19	16.5
Tulkarm	13	11.3
Salfeet	8	7.0
Bethlehem	8	7.0
Qalqilya	5	4.3
Total	**114**	**100.0**

3.4 Period of the study

The study was conducted during the period from June 2013 to February 2015.

3.5 Eligibility criteria

3.5.1 Inclusion criteria

- Have a valid registration to practice midwifery services.

- Midwives who are currently working in governmental hospitals in WB, either in labor room or post-delivery department.

3.5.2 Exclusion criteria

Midwives who are working in Private sector or UNRWA clinics, or Primary health care centers.

3.6 Instruments of the study

The researcher reviewed relevant literature and previous studies, then developed study instruments that were suitable to investigate the problem under study. The study utilized four questionnaires and interviews; two questionnaires were totally adopted such as Job Satisfaction Survey, which was prepared by Spector on 1994 with some modification to suit for this study. The Anticipated Turnover Scale (ATS) of Hinshaw and Atwood (1984), the other two questionnaires, Perceived Organizational Support (POS) and Social Support (SS) were constructed and modified to meet the study objectives. The questionnaires were worded in simple, clear language so the participants will understand them easily. In addition, the questionnaires were modified by a panel of experts to check the appropriateness of the questionnaire contents for this study (annexes 1, 2, 3, 4).

3.6.1 Questionnaires

For the quantitative part, the researcher used three constructed, self-administered questionnaires. The questionnaires are: (annex)

3.6.1.1 Job Satisfaction Survey (JSS): prepared by Spector (1994). The questionnaire consists of 36 items distributed on 9 domains as follows;

Pay; consists of 4 items.

Promotion; consists of 4 items.

Supervision; consists of 4 items.

Finger benefit; consists of 4 items.

Contingent rewards; consists of 4 items.

Operation condition; consists of 4 items.

Coworkers; consists of 4 items.

Nature of work; consists of 4 items.

Communication; consists of 4 items.

Response on scale items used Likert scale (6 responses). Scoring value on items as the following:

Agree very much (6) - Agree moderately (5) - Agree slightly (4) - Disagree slightly (3) - Disagree moderately (2) - Disagree very much (1).

Interpreting satisfaction scores: Scores with a mean item response of 4 or more represents satisfaction, whereas mean responses of 3 or less represents dissatisfaction, and mean scores between 3 and 4 are ambivalence.

3.6.1.2 Perceived Organizational Support Questionnaire (POS): Adopted by the researcher. The questionnaire consists of 14 items. Scoring of items as follows:

Agree very much (5) - Agree moderately (4) - Agree slightly (3) - Disagree slightly (2) - Disagree moderately (1) - Disagree very much (0).

3.6.1.3 Social Support Questionnaire (SS): Prepared by the researcher. The questionnaire consists of 6 items. Scoring on items as follows:

Agree very much (5) - Agree moderately (4) - Agree slightly (3) - Disagree slightly (2) - Disagree moderately (1) - Disagree very much (0).

3.6.1.4 Anticipated Turnover Scale (ATS): Developed by Hinshaw and Atwood (1984), and modified by the researcher. The questionnaire consists of 8 items. Scoring on items as follows:

Agree very much (5) - Agree moderately (4) - Agree slightly (3) - Disagree slightly (2) - Disagree moderately (1) - Disagree very much (0).

3.6.2 Interviews

The researcher conducted constructed individualized interviews with 18 midwives. The interviews aimed at gaining deep information related to study concepts from their perception. In interviews, the midwives have more space to talk and discuss, so, indepth information will be obtained that will enrich the quantitative data. Each interview lasts between 15 – 20 minutes, pre-set open-ended questions related to study concepts were prepared on advance before starting the interviews.

3.7 Pilot study

A pilot study was conducted before the start of actual data collection (pre-test of instrument); it was conducted to test validity and reliability of the questionnaire. The pilot study was carried out on 20 midwives who are working in the Red Crescent Hospital in

Al Bireh. After the pilot study was completed, necessary modifications were applied to questionnaire.

3.7.1 Validity of the questionnaire

The questionnaire was submitted to expert professionals for judgment about content adequacy and clarity of questionnaire items (annex 5). Their suggestions were considered in the development of the final questionnaire.

3.7.2 Reliability of questionnaire

Reliability is an important character of an instrument. It is concerned with how consistently the measurement technique measures the concept of interest. A measure is considered reliable if it gives the same results each time (Polit, 2004).

The researcher used the SPSS analysis for identification of Cronbache alpha measures for each subcategory of the questionnaire as presented in table (3.2).

Table (3.2): Cronbache alpha coefficient

Dimension	No. of items	Alpha coefficient
Job Satisfaction (JS)	36	0.805
Perceived Organizational Support (POS)	14	0.769
Social Support (SS)	6	0.734
Anticipated Turnover Scale (ATS)	8	0.648
Overall	64	0.856

Split half method

The researcher calculated the correlation coefficient for validation between the total scores of odd statements and the total score of even statements, the correlation value was (R = 0.558), then the researcher used equal length Spearman-Brown equation, the correlation value was (R = 0.716).

After performing the validity and reliability measures, it is clear that the questionnaire is suitable to be used in this study as the correlation coefficients were high (above 0.7).

3.8 Ethical and administrative consideration

Before starting the study, the researcher obtained approval from Al-Quds University (annex No.6), and approval from MOH (annex 7) to conduct the study. Participants were asked for their agreement to be included in the study with assurance of confidentiality of obtained data.

3.9 Data collection and analysis

Data was collected by the researcher with assistance from 6 lecturers from Ibn Sina College for Health Sciences, the assistants were trained by the researcher on the data collection process to ensure that data were collected in the same manner. 114 questionnaires were distributed to study participants. Then the researcher followed the following steps:

The researcher entered the data of 114 questionnaires using the Statistical Package for Social Sciences (SPSS version 20) with assistance of statistician, and the steps was as follows:

- Over viewing the filled questionnaires.

- Coding of questionnaires.

- Designing data entry model.

- Defining variables.

- Coding variables.

- Data cleaning.

- Frequency table for the study variables.

- Cross tabulation of results.

- Conducting statistical procedures like(*t)* test and Pearson correlation test.

3.10 Limitation of the study

- Difficulty accessing identified midwives in different provinces because many of them work evening and night shifts.

- Refusal of some midwives to be interviewed.

- To overcome these limitations, the researcher got assistance from the in-charge midwives in the maternity department in each hospital to facilitate the process of filling the questionnaires, in addition, six lecturers from Ibn Sina College were well trained for the collection of data, and they helped in filling the questionnaires.

Chapter Four

Results and Discussion

This chapter presents the findings of statistical analysis of data. Descriptive analysis of socio-demographic characteristics of participants is illustrated. In addition results of different variables and dimensions were identified, moreover, the differences between selected variables and correlations were explored. Statistical analysis included frequencies, means, percentage, t test, One way ANOVA, and Pearson correlation test.

4.1 Sociodemographic and work related characteristics of study participants

Table (4.1): Distribution of study participants by sociodemographic characteristics

Variable	Frequency	Percent
Age		
Less than 25 years	35	30.5
25 – 30 years	47	40.9
31 – 40 years	22	19.1
More than 40 years	10	8.7
Total	114	100.0
Academic qualification		
Diploma 3 years	8	7.0
High diploma	5	4.3
Bachelor in midwifery	94	81.7
Master degree	7	6.1
Total	114	100.0
Monthly income		
Less than 2000 NIS	7	6.1
2000 – 3000 NIS	74	65.0
3001- 4000 NIS	33	28.9
Total	114	100.0

Table (4.1) showed that the majority of study participants were young age as 71.4% of them aged 30 years and less (30.5% less than 25 years old and 40.9% were between 25 – 30 years old), while those who were aged between 31 – 40 years represented 19%, and those who were above 40 years old represented 8.7% of study participants. The researcher attributed the young age of midwives to the fact that midwifery education is relatively a new specialty in the Palestinian universities compared to nursing and allied health professionals, adding to that, the need to have qualified midwives in the hospitals to compromise the shortage of professional midwives in the hospitals, so graduated midwives usually find a job easier than other professions, which attract more young girls to study midwifery.

In addition, the majority of study participants hold bachelor degree in midwifery (81.7%), while 7% had three years diploma, 4.3% had high diploma, and 6.1% had master degree. Concerning monthly income, the results showed that more than two-thirds (65%) of study participants earn 2000 – 3000 NIS monthly, 6.1% earn less than 2000 NIS monthly, and 28.9% earn 3001 - 4000 NIS monthly. According to PCBS (Palestine in figures, 2013), hard core poverty line in Palestine was determined at NIS 1832 and poverty line at NIS 2293. Based on these numbers, these results of this study reflected that the majority of midwives were categorized as low income class.

Table (4.2): Distribution of midwives' according to family related data

Variable	Frequency	Percent
Marital status		
Single	29	25.4
Married	85	74.6
Total	114	100.0
Number of children		
No children	46	40.4
1 – 4 children	59	51.8
5 children and more	9	7.9
Total	114	100.0
Age of children		
Less than 3 years	49	72.0
3 – 8 years	14	20.5
9 – 12 years	1	1.5
13 – 18 years	2	3.0
More than 18 years	2	3.0
Total	68	100.0

Table (4.2) showed that the majority of study participants (74.6%) were married, and 25.4% were single. Furthermore, 51.8% have 1 – 4 children, and 7.9% have 5 children and more, in addition, out of those who have children, 72.0% of children were less than 3 years old, and 20.5% were between 3 – 8 years old.

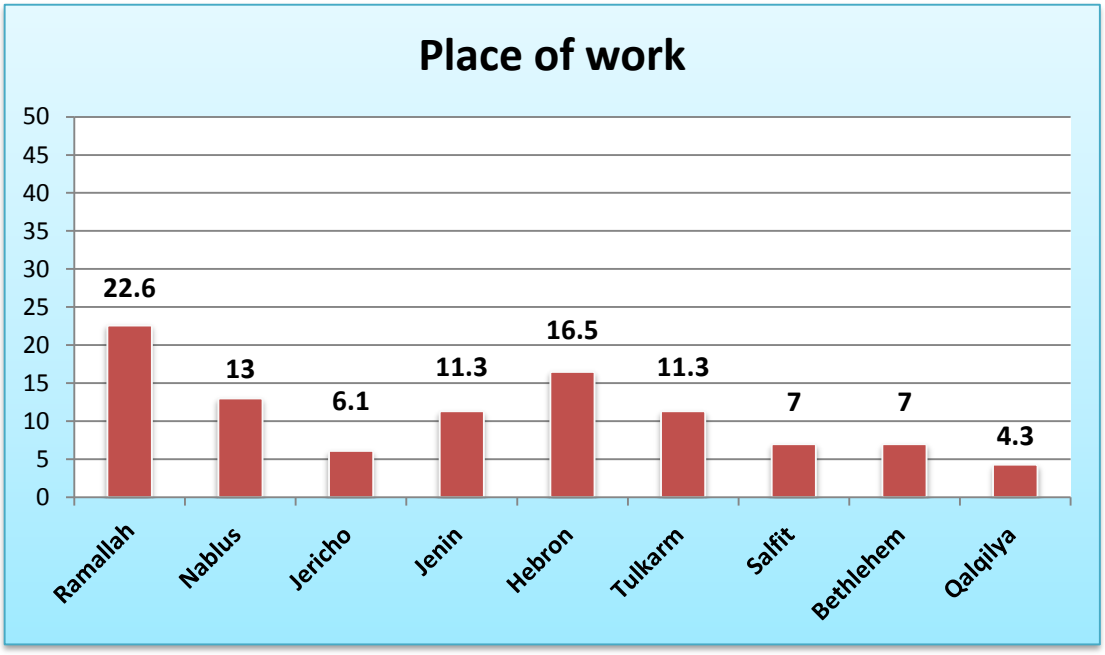

Figure (4.1): Distribution of study participants according to place of work

The study participants are working in 9 governmental hospitals in WB distributed as the following: 22.6% work in Ramallah, 16.5% work in Hebron, 13% work in Nablus, 11.3% work in Jenin, 11.3% work in Tulkarm, 7% work in Salfit, 7% work in Bethlehem, 6.1% work in Jericho, and 4.3% work in Qalqilya. These results reflected that the study participants are distributed in all the governmental hospitals that offer maternity services in the WB, which would increase the strength and representation of the sample.

Table (4.3): Distribution of participants according to work conditions

Variable	Frequency	Percent
No. of years working as midwife		
Less than 5 years	61	53.5
5 – 10 years	32	28.1
More than 10 years	21	18.4
Total	114	100.0
Current job position		
Midwife	100	87.7
Head of department	10	8.8
Assistant head nurse	4	3.5
Total	114	100.0
Type of working shifts		
Morning shift	16	14.1
Night shift	2	1.7
Morning and evening	3	2.6
Evening and night	4	3.5
Morning, evening and night	89	78.1
Total	114	100.0

Table (4.3) showed that 53.5% of study participants were working for less than 5 years, 28.1% were working for 5 – 10 years, and 18.4% were working for more than 10 years. These results revealed that more than half of study participants were newly employed and have low experience in midwifery. Also, 87.7% working as regular midwife, 8.8% were head of department, and 3.5 were assistant head nurses. The majority of study participants (78.1%) were working morning, evening and night shifts, 14.1% work

morning shifts only, and the rest were working all different shifts (morning, evening, and night).

Table (4.4): Distribution of participants according to work history

Variable	Frequency	Percent
Previous work		
Private hospital	38	33.3
Other governmental hospital	14	12.3
None	56	49.2
In the same hospital where I am now	2	1.7
In different area	4	3.5
Total	114	100.0
Position in previous work		
Midwife	55	95.0
Head of department	2	3.0
Assistant head nurse	1	2.0
Total	58	100.0
Cause of leaving previous work		
Family causes	5	8.6
Financial cause	4	7.0
Job security	29	50.0
No specific cause	20	34.0
Total	58	100.0

Table (4.4) showed that almost half of study participants (49.2%) did not have previous work, 33.3% worked in private hospital, 12.3% worked in another governmental hospital, 1.7% work in the same hospital, and 3.5% worked in another area. Out of those who had

previous work, only 3.0% were head of department, 2.0% were assistant head nurse, and 95.0% were midwives.

Concerning causes for leaving previous work, 50.0% attributed that to job security, 8.6% due to family causes, 7.0% due to financial causes, and 34.0% left their previous work without specific cause.

Table (4.5): Exposure to accidents during work

Variable	Frequency	Percent
You have been exposed to an accident during work		
Yes	48	42.1
No	66	57.9
Total	114	100.0
Type of accident		
Physical abuse	2	4.1
Emotional abuse	38	79.2
Physical, chemical, biological harm	2	4.1
Physical abuse & physical harm	3	6.3
Emotional abuse & physical harm	3	6.3
Total	48	100.0

Table (4.5) showed that 42.1% of study participants had been exposed to an accident during their work, of them, 79.2% exposed to emotional abuse, 4.1% exposed to physical abuse, 6.3% exposed to emotional abuse and physical harm, and 6.3% exposed to physical abuse and harm. Exposure to emotional and physical abuse and violence in governmental hospitals is increasing worldwide, and Uzune (2003) reported that the

prevalence of workplace violence against nurses in the hospital setting varied from 10% to 50% and even up to 87%.

4.1.2 Availability and use of protocols

When the participant midwives were asked about availability and usage of protocols at workplace, their responses were as presented in table (4.7).

Table (4.6): Availability and use of protocols at workplace

Variable	Frequency	Percent
Protocols are available at workplace		
Yes	93	81.5
No	21	18.5
Total	114	100.0
You had adequate training on protocols		
Yes	68	59.6
No	46	40.4
Total	114	100.0
Do you apply these protocols during work?		
Yes	90	79.0
No	24	21.0
Total	114	100.0

Table (4.6) showed that 81.5% of study participants reported that there are protocols available in their workplace, 59.6% reported that they had adequate training on those protocols, and 79% reported that they apply these protocols during work. Having written, clear protocols at workplace would standardize the tasks performed by midwives and ensuring that all the midwives do the same procedures in the same manner, adding to that

written protocols will clarify the role of midwives and decrease the chance of having undesired mistakes, and in consequence will improve the end result and productivity of the hospital.

In addition, among those who apply the protocols during work, 29% attributed that to ambition toward success and recognition, 22.6% attributed that to personal protection, and 16% reported that they apply protocols for the safety of mothers. On the other hand, among those who don't apply the protocols, 19% reported that the protocols were not clear, 6.5% attributed that to work overload, 3.2% attributed that to lack of resources, and 3.2% reported that the protocols were of no benefit to mothers.

4.2 Job satisfaction

4.2.1 Midwives satisfaction from the academic education / curriculum

The results showed that 103(90.4%) of midwives were satisfied, and 11 (9.6%) were dissatisfied. Among those who were dissatisfied, 3(27.3%) reported that the program was overcrowded and focus on quantity rather than quality, 3(27.3%) reported that the program was incomprehensive and don't cover all theoretical and clinical areas, 1(9.0%) reported that the clinical training sites were far away from place of residency, and 1(9.0%) reported that the clinical trainers were not qualified enough to train the students, while 3(27.3%) did not mention specific reason. On the other hand, those who were satisfied from the program attributed their satisfaction to the reasons presented in table 4.7.

Table (4.7): Causes of satisfaction from academic education program (N = 103)

Cause	Frequency	Percent
Flexible and easy applicable program	42	41.0
Comprehensive, well covered program	41	39.8
Appreciation and recognition of the profession	8	7.8
Qualified lecturers and trainers	6	5.7
Independency and self-confidence in providing care to clients	6	5.7
Total	103	100.0

Table (4.7) showed that 41% of study participants reported that the training program was flexible and applicable, 39.8% reported that the program was comprehensive and cover all the theoretical and clinical aspects, 7.8% contributed that to recognition of midwifery profession, 5.7% reported that lecturers and clinical trainers were qualified to teach and train, and 5.7% reported that the program enhanced independency and self-confidence of midwives.

4.2.3 Improvement opportunities at workplace

When participant midwives were asked if they were satisfied from the improvement opportunities at work, 52 (45.6%) reported that they were satisfied, and 62(54.4%) reported that they were not satisfied. Among those who were satisfied, 19.5% attributed their satisfaction to recognition and staff development, while those who were not satisfied attributed that to lack of opportunities for development (39%), inequity (19%), administrators and managers bias (14%), and shortage of midwives (11%).

4.2.4 Job satisfaction among midwives

To find out the level of job satisfaction among midwives, the researcher calculated their responses on the JSS items, mean score, and percentage. The results are presented in table (4.8).

Scoring of responses for each item is presented below:

Strongly disagree	Moderately disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree
1	2	3	4	5	6

According to Spector (1994), interpretation of scores will be as the following:

Mean score 4 and above	Mean score above 3 and less than 4	Mean score 3 or less
Satisfied	Ambivalent	Dissatisfied

Table (4.8): Participants' response on job satisfaction items

No.	Item		Strongly disagree (1)	Moderately disagree (2)	Slightly disagree (3)	Slightly agree (4)	Moderately agree (5)	Strongly agree (6)	Total	Mean	Percent %
	Pay										
1	I feel I am being paid a fair amount for the work I do	N	54	16	16	14	11	3	114	2.307	38.45
		%	47.0	14.0	14.0	12.3	9.6	2.6	100.0		
2	In fact, there are too few opportunities for promotion in my workplace	N	9	4	4	14	11	72	114	1.982	33.03
		%	7.9	3.5	3.5	12.3	9.6	63.2	100.0		
3	I feel unappreciated by the organization when I think about what they pay me	N	7	12	19	22	24	30	114	2.824	47.06
		%	6.1	10.5	16.7	19.3	21.1	26.3	100.0		
4	I feel satisfied with my chances for salary increases	N	48	19	13	14	10	10	114	2.552	42.53
		%	42.1	16.7	11.4	12.3	8.8	8.8	100.0		
	Promotion										
1	There is really too little chance for promotion on my job	N	8	10	8	8	25	55	114	2.271	37.85
		%	7.0	8.8	7.0	7.0	21.9	48.2	100.0		
2	Those who do well on the job stand a fair chance of being promoted	N	45	19	18	21	5	6	114	2.473	41.21
		%	39.5	16.7	15.8	18.4	4.4	5.3	100.0		
3	People get ahead as fast here as they do in other places	N	11	13	18	22	17	33	114	4.052	67.53
		%	9.6	11.4	15.8	19.3	14.9	28.9	100.0		
4	I am satisfied with my chances for promotion	N	50	19	24	14	5	2	114	2.219	36.98
		%	43.9	16.7	21.1	12.3	4.4	1.8	100.0		
	Supervision										
1	My supervisor is quite competent in doing his/her job	N	7	10	9	9	47	32	114	4.535	75.58
		%	6.1	8.8	7.9	7.9	41.2	28.1	100.0		
2	My supervisor is unfair to me	N	45	20	15	17	12	5	114	4.473	74.55
		%	39.5	17.5	13.2	14.9	10.5	4.4	100.0		
3	My supervisor shows too little interest in the	N	24	28	19	15	16	12	114	3.938	65.63

	feelings of subordinates	%	21.1	24.6	16.7	13.2	14.0	10.5	100.0		
4	I do like my supervisor	N	6	4	11	19	36	38	114	4.657	77.61
		%	5.3	3.5	9.6	16.7	31.6	33.3	100.0		
	Fringe Benefits										
1	I am not satisfied with the benefits I receive	N	8	3	12	28	30	33	114	2.526	42.10
		%	7.0	2.6	10.5	24.6	26.3	28.9	100.0		
2	The benefits we receive are as good as most other organizations offer	N	40	21	23	16	10	4	114	2.535	42.25
		%	35.1	18.4	20.2	14.0	8.8	3.5	100.0		
3	The benefit package we have is equitable	N	24	23	20	16	7	4	114	2.394	39.90
		%	38.6	20.2	17.5	14.0	6.1	3.5	100.0		
4	There are benefits we do not have which we should have	N	2	2	5	19	35	51	114	1.929	32.15
		%	1.8	1.8	4.4	16.7	30.7	44.7	100.0		
	Contingent rewards										
1	When I do a good job, I receive the recognition for it that I should receive	N	46	14	13	23	13	5	114	2.631	43.85
		%	40.4	12.3	11.4	20.2	11.4	4.4	100.0		
2	I do not feel that the work I do is appreciated	N	12	13	14	26	16	33	114	2.947	49.11
		%	10.5	11.4	12.3	22.8	14.0	28.9	100.0		
3	There are few rewards for those who work here	N	9	6	7	19	20	53	114	2.298	38.30
		%	7.9	5.3	6.1	16.7	17.5	46.5	100.0		
4	I don't feel my efforts are rewarded the way they should be	N	3	6	8	16	29	52	114	2.087	34.78
		%	2.6	5.3	7.0	14.0	25.4	45.6	100.0		
	Operating conditions										
1	Many of our rules and procedures make doing a good job difficult	N	6	9	23	32	16	28	114	2.886	48.10
		%	5.3	7.9	20.2	28.1	14.0	24.6	100.0		
2	My efforts to do a good job are seldom blocked by red tape	N	14	17	21	33	16	13	114	3.517	58.61
		%	12.3	14.9	18.4	28.9	14.0	11.4	100.0		
3	I have too much to do at work	N	2	1	5	17	22	67	114	1.745	29.08
		%	1.8	0.9	4.4	14.9	19.3	58.8	100.0		
4	I have too much paperwork	N	7	5	13	15	26	48	114	2.315	38.58
		%	6.1	4.4	11.4	13.2	22.8	42.1	100.0		
	Coworkers										

1	I like the people I work with	N	2	3	7	25	36	41	114	4.868	81.13
		%	1.8	2.6	6.1	21.9	31.6	36.0	100.0		
2	I find I have to work harder at my job because of the incompetence of people I work with	N	16	18	18	27	23	12	114	3.482	58.03
		%	14.0	15.8	15.8	23.7	20.2	10.5	100.0		
3	I enjoy my coworkers	N	3	5	7	23	42	34	114	4.736	78.93
		%	2.6	4.4	6.1	20.2	36.8	29.8	100.0		
4	There is too much bickering and fighting at work	N	21	18	23	22	11	19	114	3.640	60.66
		%	18.4	15.8	20.2	19.3	9.6	16.7	100.0		
	Nature of work										
1	I sometimes feel my job is meaningless	N	61	11	8	18	10	6	114	4.675	77.91
		%	53.5	9.6	7.0	15.8	8.8	5.3	100.0		
2	I like doing the things I do at work	N	3	0	4	16	36	55	114	5.166	86.10
		%	2.6	0	3.5	14.0	31.6	48.2	100.0		
3	I feel a sense of pride in doing my job	N	4	3	2	11	20	74	114	5.298	88.30
		%	3.5	2.6	1.8	9.6	17.5	64.9	100.0		
4	My job is enjoyable	N	7	3	11	21	27	45	114	4.693	78.21
		%	6.1	2.6	9.6	18.4	23.7	39.5	100.0		
	Communication										
1	Communications seem good within this organization	N	16	13	12	28	33	12	114	3.745	62.41
		%	14.0	11.4	10.5	24.6	28.9	10.5	100.0		
2	The goals of this organization are not clear to me	N	20	17	25	24	16	12	114	3.693	61.55
		%	17.5	14.9	21.9	21.1	14.0	10.5	100.0		
3	I often feel that I do not know what is going on with the organization	N	14	11	9	34	30	16	114	3.096	51.60
		%	12.3	9.6	7.9	29.8	26.3	14.0	100.0		
4	Work assignments are not fully explained	N	25	18	17	22	25	7	114	3.780	63.00
		%	21.9	15.8	14.9	19.3	21.9	6.1	100.0		

Table (4.9): Overall mean scores and percentage of job satisfaction

Domain	Number of items	Mean	Percent	Interpretation
Pay	4	2.416	40.28	Dissatisfied
Promotion	4	2.754	45.90	Dissatisfied
Supervision	4	4.401	73.35	Satisfied
Fringe Benefits	4	2.346	39.11	Dissatisfied
Contingent rewards	4	2.491	41.52	Dissatisfied
Operating conditions	4	2.616	43.60	Dissatisfied
Coworkers	4	4.182	69.70	Satisfied
Nature of work	4	4.958	82.64	Satisfied
Communication	4	3.578	59.65	Ambivalent
Overall average	**36**	**3.305**	**55.08**	**Ambivalent**

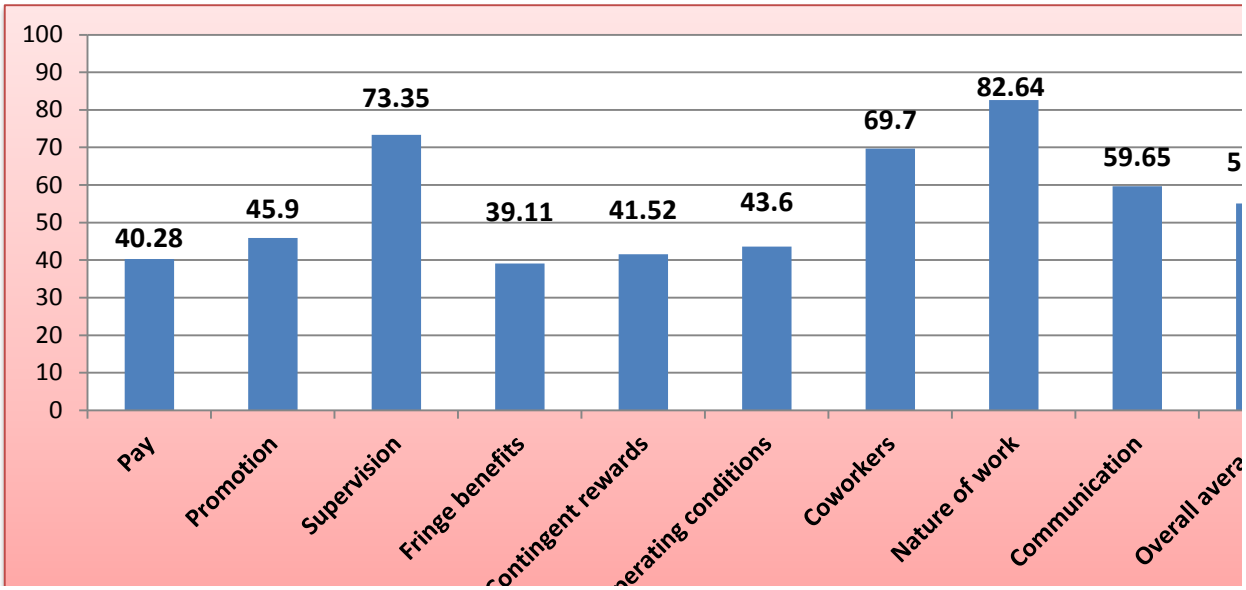

Figure (4.2): Overall midwives' job satisfaction

Table (4.9) showed that midwives were satisfied from the following domains: supervision with mean score 4.401 and weighted percentage 73.35, coworkers with mean score 4.182

and weighted percentage 69.70, and nature of work with mean score 4.958 and weighted percentage 82.64. On the other hand, midwives were dissatisfied from the following domains: pay with mean score 2.416 and weighted percentage 45.90, promotion with mean score 2.754 and weighted percentage 45.90, fringe benefits with mean score 2.346 and weighted percentage 39.11, contingent rewards with mean score 2.491 and weighted percentage 41.50, and operating conditions with mean score 2.616 and weighted percentage 43.60. The overall average mean score was 3.305 and weighted percentage 55.08 which reflected ambivalent job satisfaction among midwives working in governmental hospitals in WB.

4.2.5 Perceived organizational support (POS) among midwives

The researcher calculated participants' responses on the POS items, mean score, and percentage. The results are presented in table (4.10).

Satisfaction or dissatisfaction of respondents about organizational support will be interpreted as the following: (Spector, 1994).

Mean score 4 and above	Mean score above 3 and less than 4	Mean score 3 or less
Satisfied	Moderate satisfaction	Dissatisfied

Table (4.10): Participants' response on POS items

No.	Item		Strongly disagree (0)	Moderately disagree (1)	Slightly disagree (2)	Slightly agree (3)	Moderately agree (4)	Strongly agree (5)	Total	Mean	Percent %
1	I have a chance in making decisions related to problems I face in my profession	N	27	20	19	26	16	6	114	2.02	40.34
		%	23.7	17.5	16.7	22.8	14.0	5.3	100.0		
2	I have a contribution in discussing& analyzing of dying cases and giving a feedback as related to maternal mortality record	N	38	14	19	21	13	9	114	1.86	37.18
		%	33.3	12.3	16.7	18.4	11.4	7.9	100.0		
3	The hospital take into consideration my complains & suggestions seriously	N	29	12	22	22	19	10	114	2.18	43.50
		%	25.4	10.5	19.3	19.3	16.7	8.8	100.0		
4	The hospital has a plan for occupational hazards safety	N	18	21	13	20	19	23	114	2.61	52.28
		%	15.8	18.4	11.4	17.5	16.7	20.2	100.0		
5	The hospital has enough consumables that are needed for work accomplishment	N	7	14	15	27	28	23	114	3.09	61.74
		%	6.1	12.3	13.2	23.7	24.6	20.2	100.0		
6	Medications are always available in the ward	N	6	15	25	22	25	21	114	2.95	58.94
		%	5.3	13.2	21.9	19.3	21.9	18.4	100.0		
7	Blood transfusion is available whenever it is needed	N	1	8	14	28	28	35	114	3.57	71.40
		%	0.9	7.0	12.3	24.6	24.6	30.7	100.0		
8	Continuous education program that I received is suitable for my profession	N	26	8	22	16	26	16	114	2.49	49.82
		%	22.8	7.0	19.3	14.0	22.8	14.0	100.0		
9	Other departments like x-ray is very cooperative with my ward	N	11	11	19	31	30	12	114	2.82	56.48
		%	9.6	9.6	16.7	27.2	26.3	10.5	100.0		
10	My work environment is healthy in	N	11	10	23	27	29	14	114	2.83	56.66

	regard to space, ventilations & others	%	9.6	8.8	20.2	23.7	25.4	12.3	100.0		
11	I do face conflicts with doctors while performing my professional roles	N	20	14	33	20	16	11	114	2.27	45.42
		%	17.5	12.3	28.9	17.5	14.0	9.6	100.0		
12	Technical support (consultation& guidance) that I received from my supervisor is very beneficial to me	N	11	5	5	28	39	26	114	3.38	67.54
		%	9.6	4.4	4.4	24.6	34.2	22.8	100.0		
13	Inadequacy of equipment & devices limit my capabilities & abilities as a midwife	N	30	25	21	16	10	12	114	1.89	37.72
		%	26.3	21.9	18.4	14.0	8.8	10.5	100.0		
14	In general , I'm satisfied with the type of care that are provided to women& children in my unit	N	4	6	9	27	47	21	114	3.49	69.82
		%	3.5	5.3	7.9	23.7	41.2	18.4	100.0		
Overall average										**2.68**	**53.50**

Table (4.10) showed that midwives' perception about the support they received from their organizations was low in the majority of items. The lowest was in the item "I have a contribution in discussing and analyzing of dying cases and giving a feedback as related to maternal mortality record" with mean score 1.86 and weighted percentage 37.18. This result could be explained in the context that when maternal complications and mortality occur most of the inquiry committees are consisted of physicians, so the contribution of midwives in this issue is low. The results also showed that the item "Inadequacy of equipment and devices limit my capabilities and abilities as a midwife" with mean score 1.89, and "I have a chance in making decisions related to problems I face in my profession" with mean score 2.02. The overall average mean score 2.68 and weighted percentage 53.50, which means that the midwives were generally dissatisfied from the organizational support they received from their workplace. This result reflected the need of organizations to pay more attention to midwives, increase the midwives' contribution

and participation in planning and decision making for improving the functions and outcome of the organization.

4.2.6 Perceived social support (SS) among midwives

The researcher calculated participants' responses on the SS items, mean score, and percentage. The results are presented in table (4.11).

Satisfaction or dissatisfaction of respondents about social support will be interpreted as the following: (Spector, 1994).

Mean score 4 and above	Mean score above 3 and less than 4	Mean score 3 or less
Satisfied	Moderate satisfaction	Dissatisfied

Table (4.11): Participants' response on SS items

No.	Item		Strongly disagree	Moderately disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree	Total	Mean	Percent %
1	I receive help & emotional support from my family	N	2	2	5	14	27	64	114	4.23	84.60
		%	1.8	1.8	4.4	12.3	23.7	56.1	100.0		
2	I can talk frankly with my family about my work problems	N	4	1	19	12	27	51	114	3.84	76.80
		%	3.5	0.9	16.7	10.5	23.7	44.7	100.0		

3	I depend on my friends when I fall in troubles in my work	N	7	5	13	34	35	20	114	3.27	65.40
		%	6.1	4.4	11.4	29.8	30.7	17.5	100.0		
4	My family is always ready to help me in making decisions	N	6	2	7	19	29	51	114	3.89	77.80
		%	5.3	1.8	6.1	16.7	25.4	44.7	100.0		
5	I can depend on my family when I'm in need for support	N	6	1	10	13	29	55	114	3.96	79.20
		%	5.3	0.9	8.8	11.4	25.4	48.2	100.0		
6	I am satisfied about the reputation of midwifery in my community	N	21	12	19	29	17	16	114	2.50	50.00
		%	18.4	10.5	16.7	25.4	14.9	14.0	100.0		
	Overall average									**3.62**	**72.40**

Table (4.11) showed that the midwives satisfaction about the social support they receive was high in the item "I receive help & emotional support from my family" with mean score 4.23, but their perception about SS was low in the item "I am satisfied about the reputation of midwifery in my community" with mean score 2.50, while their satisfaction was moderate in the items "I can talk frankly with my family about my work problems" with mean score 3.84, "I depend on my friends when I fall in troubles in my work" with mean score 3.27, "My family is always ready to help me in making decisions" with mean score 3.89, and "I can depend on my family when I'm in need for support" with mean score 3.96. The overall average mean score was 3.62 and weighted percentage 72.40, which reflects that the midwives were moderately satisfied from the social support they receive from their family, relatives, and friends. This result revealed the growing interest and increasing awareness and understanding of people about the importance of midwifery and the need to have qualified midwives in all maternity settings.

4.2.7 Anticipated turnover (ATS) among midwives

The researcher calculated participants' responses on the ATS items, mean score, and percentage. The results are presented in table (4.12).

To indicate whether a midwife is experiencing the feeling of leaving her organization, the mean score was used to determine the existence of the intention to leave. Respondents with scores above the mean would be considered as having the intention to leave while those whose scores fall below the mean would not be considered as having the intention to leave (Anuar and Johari, 2012). So, according to the scale used in this study, mean score of (3) will be considered as neutral score, and scores above (3) will mean intention to leave, and scores below (3) will mean no intention to leave their current workplace.

Table (4.12): Participants' response on ATS items

No.	Item		Strongly disagree	Moderately disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree	Total	Mean
1	I am happy to stay working in this hospital regardless of current circumstances	N	20	11	13	16	25	29	114	2.89
		%	17.5	9.6	11.4	14.0	21.9	25.4	100.0	
2	I am obliged to stay at my current workplace regardless of all challenges	N	27	17	18	18	9	25	114	2.65
		%	23.7	14.9	15.8	15.8	7.9	21.9	100.0	
3	I'll stay working in this hospital if I received higher salary and incentives	N	21	10	12	12	23	36	114	3.00
		%	18.4	8.8	10.5	10.5	20.2	31.6	100.0	

4	I want to stay in this hospital regardless to the available opportunities	N	20	16	15	14	15	34	114	2.21
		%	17.5	14.0	13.2	12.3	13.2	29.8	100.0	
5	I will leave this hospital when there are better opportunities	N	40	11	15	8	8	32	114	2.25
		%	35.1	9.6	13.2	7.0	7.0	28.1	100.0	
6	I am planning to leave my current workplace next year	N	51	10	14	11	10	18	114	1.76
		%	44.7	8.8	12.3	9.6	8.8	15.8	100.0	
7	I am planning to change my career whenever it's possible	N	61	13	11	7	6	16	114	1.56
		%	53.5	11.4	9.6	6.1	5.3	14.0	100.0	
8	I intend to stay in current work if there's a possibility for working as part time	N	30	19	17	12	8	28	114	2.71
		%	26.3	16.7	14.9	10.5	7.0	24.6	100.0	
	Overall average									**2.37**

Table (4.12) showed that all the items had mean score less than (3), which indicated that the participants of the study do not have intentions to leave the current workplace as the overall average mean score of responses on ATS was 2.37.

4.3 Differential statistics results

4.3.1 Relationship between job satisfaction, perceived organizational support, social support, and anticipated turnover

To find the relationship between JS, POS, SS, and ATS, the researcher used Pearson correlation test. The results are presented in table 4.13.

Table (4.13): Relationship between JS, POS, SS, and ATS

Dimension		ATS	JSS	POS	SS
ATS	R	1	0.332 **	0.185 *	0.083 //
	S	.	0.000	0.049	
JSS	R		1	0.454**	0.133 //
	S		.	0.000	
POS	R			1	0.308 **
	S			.	0.001

** significant at 0.01 * significant at 0.05 // not significant

Table (4.13) shows that there was statistically significant relationship at 0.01 between anticipated turnover and job satisfaction (r= 0.332, P= 0.000). Also, there was statistically significant relationship at 0.05 between anticipated turnover and perceived organizational support (r= 0.185, P= 0.049), but the relationship was insignificant with social support (r= 0.083, P= 0.377). In addition, there was statistically significant relationship at 0.01 between job satisfaction and perceived organizational support (r= 0.454, P= 0.000), and there was statistically significant relationship at 0.01 between perceived organizational support and social support (r= 0.308, p= 0.001).

4.3.2 Job satisfaction, POS, SS, ATS and age

Table (4.14): Difference in JS, POS, SS, and ATS related to age

Variable	Category	N	Mean	F	P
Job Satisfaction	< 25 years	34	122.00	1.252	0.295
	25 – 30 years	48	116.68		
	31 – 40 years	22	115.81		
	>40 years	10	22.75		
Perceived Organizational Support	< 25 years	34	39.11	3.612	0.016 *
	25 – 30 years	48	37.95		
	31 – 40 years	22	31.40		
	>40 years	10	42.70		
Social Support	< 25 years	34	22.61	0.572	0.635
	25 – 30 years	48	21.45		
	31 – 40 years	22	21.36		
	>40 years	10	20.40		
Anticipated Turnover	< 25 years	34	23.38	1.214	0.308
	25 – 30 years	48	21.04		
	31 – 40 years	22	23.09		
	>40 years	10	25.80		

* significant at 0.05

Table (4.14) shows that there were statistically insignificant differences related to age of midwife and job satisfaction (F= 1.252, P= 0.295), social support (F= 0.572, P= 0.635), and anticipated turnover (F= 1.214, P= 0.308), but differences were significant in perceived organizational support (F= 3.612, P= 0.016), and to find the direction of these differences, Post hoc Scheffe test was performed and showed that midwives aged 40 years and above had higher perception of organizational support compared to other midwives.

4.3.3 Job satisfaction, POS, SS, ATS and marital status

Table (4.15): Difference in JS, POS, SS, and ATS related to marital status

Variable	Category	N	Mean	t	P value
Job Satisfaction	Single	29	116.68	0.742	0.459
	Married	85	119.76		
Perceived Organizational Support	Single	29	36.75	0.401	0.689
	Married	85	37.69		
Social Support	Single	29	23.00	1.515	0.133
	Married	85	21.24		
Anticipated Turnover	Single	29	22.10	0.339	0.735
	Married	85	22.70		

Table (4.15) shows that there were statistically insignificant differences in job satisfaction between midwives who are single and those who are married (t= 0.742, P= 0.459), in perceived organizational support (t= 0.401, P= 0.689), in social support (t= 1.515, P= 0.133), and in anticipated turnover (t= 0.339, P= 0.7350.

4.3.4 Job satisfaction, POS, SS, ATS and number of children

Table (4.16): Difference in JS, POS, SS, and ATS related to number of children

Variable	Category	N	Mean	F	P
Job Satisfaction	No children	46	114.67	2.611	0.078
	1 – 4 children	59	120.89		
	< 4 children	9	128.44		
Perceived Organizational Support	No children	46	37.84	0.176	0.839
	1 – 4 children	59	36.93		
	< 4 children	9	38.88		
Social Support	No children	46	22.82	1.755	0.178
	1 – 4 children	59	21.00		
	< 4 children	9	20.44		
Anticipated Turnover	No children	46	20.76	2.307	0.104
	1 – 4 children	59	23.40		
	< 4 children	9	26.11		

Table (4.16) shows that there were statistically insignificant differences related to number of children and job satisfaction (F= 2.611, P= 0.078), perceived organizational support (F= 0.176, P= 0.839), social support (F= 1.755, P= 0.178), and anticipated turnover (F= 2.307, P= 0.104). These results reflected that the number of children did not make significant differences in midwives' intention to stay or leave their organization.

4.3.5 Job satisfaction, POS, SS, ATS and qualification

Table (4.17): Difference in JS, POS, SS, and ATS related to qualification

Variable	Category	N	Mean	F	P
Job Satisfaction	3 years diploma	8	126.87	0.750	0.524
	High diploma	5	114.80		
	Bachelor	94	118.14		
	Master degree	7	124.14		
Perceived Organizational Support	3 years diploma	8	37.75	0.126	0.944
	High diploma	5	37.60		
	Bachelor	94	37.24		
	Master degree	7	39.85		
Social Support	3 years diploma	8	19.12	1.574	0.200
	High diploma	5	22.80		
	Bachelor	94	21.60		
	Master degree	7	25.00		
Anticipated Turnover	3 years diploma	8	24.12	0.396	0.756
	High diploma	5	25.60		
	Bachelor	94	22.20		
	Master degree	7	23.28		

* significant at 0.05

Table (4.17) shows that there were statistically insignificant differences related to qualification of midwife and job satisfaction (F= 0.750, P= 0.524), perceived organizational support (F= 0.126, P= 0.944), social support (F= 1.574, P= 0.200), and anticipated turnover (F= 0.396, P= 0.576). These results reflected that there were insignificant differences in intention to stay or leave the organization between midwives who have three years diploma, high diploma or master degree.

4.3.6 Job satisfaction, POS, SS, ATS and monthly income

Table (4.18): Difference in JS, POS, SS, and ATS related to monthly income

Variable	Category	N	Mean	F	P
Job Satisfaction	< 2000 NIS	7	123.42	0.197	0.821
	2000 – 3000 NIS	74	118.72		
	> 3000 NIS	33	118.60		
Perceived Organizational Support	< 2000 NIS	7	45.57	2.148	0.122
	2000 – 3000 NIS	74	37.00		
	> 3000 NIS	33	36.75		
Social Support	< 2000 NIS	7	24.85	1.480	0.232
	2000 – 3000 NIS	74	21.70		
	> 3000 NIS	33	21.00		
Anticipated Turnover	< 2000 NIS	7	24.14	2.060	0.132
	2000 – 3000 NIS	74	21.41		
	> 3000 NIS	33	24.75		

Table (4.18) shows that there were statistically insignificant differences related to monthly income of midwife and job satisfaction (F= 0.197, P= 0.821), perceived organizational support (F= 2.148, P= 0.122), social support (F= 1.480, P= 0.232), and anticipated turnover (F= 2.060, P= 0.132). These results indicated that differences in monthly salary did not make significant differences in intention to stay or leave the organization.

4.3.7 Job satisfaction, POS, SS, ATS and years of experience

Table (4.19): Difference in JS, POS, SS, and ATS related to years of experience

Variable	Category	N	Mean	F	P
Job Satisfaction	<5years	61	121.14	2.448	0.091
	5 – 10 years	32	112.71		
	>10 years	21	122.23		
Perceived Organizational Support	<5years	61	38.63	1.578	0.211
	5 – 10 years	32	34.593		
	>10 years	21	38.38		
Social Support	<5years	61	22.45	1.411	0.248
	5 – 10 years	32	20.56		
	>10 years	21	21.19		
Anticipated Turnover	<5years	61	21.93	1.434	0.243
	5 – 10 years	32	21.93		
	>10 years	21	25.28		

Table (4.19) shows that there were statistically insignificant differences related to years of experience among midwives and job satisfaction (F= 2.448, P= 0.091), perceived organizational support (F= 1.578, P= 0.211), social support (F= 1.411, P= 0.248), and anticipated turnover (F= 1.434, P= 0.243). These results revealed that there were insignificant differences in intention to stay or leave the organization related to midwives' years of experience.

4.3.8 Job satisfaction, POS, SS, ATS and job position

Table (4.20): Difference in JS, POS, SS, and ATS related to job position

Variable	Category	N	Mean	F	P
Job Satisfaction	Midwife	100	118.51	0.304	0.738
	Head of department	10	123.50		
	Assistant head nurse	4	119.50		
Perceived Organizational Support	Midwife	100	37.30	0.894	0.412
	Head of department	10	40.90		
	Assistant head nurse	4	32.75		
Social Support	Midwife	100	21.74	0.451	0.638
	Head of department	10	22.20		
	Assistant head nurse	4	19.25		
Anticipated Turnover	Midwife	100	22.32	0.334	0.717
	Head of department	10	24.00		
	Assistant head nurse	4	24.75		

Table (4.20) shows that there were statistically insignificant differences related to job position of midwife and job satisfaction (F= 0.304, P= 0.738), perceived organizational support (F= 0.894, P= 0.412), social support (F= 0.451, P= 0.638), and anticipated turnover (F= 0.334, P= 0.717). These results reflected that there were insignificant differences in intention to stay or leave the organization between midwives who have administrative position and regular midwives.

4.3.9 Job satisfaction, POS, SS, ATS and working shifts

Table (4.21): Difference in JS, POS, SS, and ATS related to working shifts

Variable	Category	N	Mean	F	P
Job Satisfaction	Straight morning	16	121.00	1.478	0.214
	Straight night	2	133.00		
	Morning & evening	3	117.66		
	Evening & night	4	98.50		
	Morning, evening & night	89	119.26		
Perceived Organizational Support	Straight morning	16	39.00	0.202	0.937
	Straight night	2	36.00		
	Morning & evening	3	35.33		
	Evening & night	4	34.25		
	Morning, evening & night	89	37.42		
Social Support	Straight morning	16	20.87	0.722	0.579
	Straight night	2	18.50		
	Morning & evening	3	25.66		
	Evening & night	4	23.00		
	Morning, evening & night	89	21.71		
Anticipated Turnover	Straight morning	16	24.43	1.171	0.328
	Straight night	2	21.00		
	Morning & evening	3	16.66		
	Evening & night	4	16.50		
	Morning, evening & night	89	22.71		

Table (4.21) shows that there were statistically insignificant differences related to working shifts among midwives and job satisfaction (F= 1.478, P= 0.214), perceived organizational support (F= 0.202, P= 0.937), social support (F= 0.722, P= 0.579), and anticipated turnover (F= 1.171, P= 0.328). These results indicated that there were

insignificant differences in intention to stay or leave the organization between midwives who are working straight morning shifts and those who are working combination of morning, evening and night shifts.

4.3.10 Job satisfaction, POS, SS, ATS and place of work

Table (4.22): Difference in JS, POS, SS, and ATS related to place of work

Variable	Category	N	Mean	F	P
Job Satisfaction	Ramallah	26	123.73	1.400	0.205
	Nablus	15	120.86		
	Jericho	7	125.14		
	Jenin	13	107.46		
	Hebron	19	117.52		
	Tulkarm	13	120.92		
	Salfeet	8	126.62		
	Bethlehem	8	110.37		
	Qalqilya	5	112.00		
Perceived Organizational Support	Ramallah	26	37.96	3.642	0.001 *
	Nablus	15	38.20		
	Jericho	7	34.57		
	Jenin	13	41.46		
	Hebron	19	33.73		
	Tulkarm	13	47.00		
	Salfeet	8	38.50		
	Bethlehem	8	26.62		
	Qalqilya	5	31.20		
Social Support	Ramallah	26	21.07	0.505	0.850
	Nablus	15	22.26		
	Jericho	7	21.14		
	Jenin	13	22.38		
	Hebron	19	21.42		
	Tulkarm	13	22.84		
	Salfeet	8	23.75		
	Bethlehem	8	19.50		
	Qalqilya	5	20.40		

Anticipated Turnover	Ramallah	26	22.07	1.708	0.105
	Nablus	15	21.73		
	Jericho	7	20.42		
	Jenin	13	17.07		
	Hebron	19	22.68		
	Tulkarm	13	26.53		
	Salfeet	8	27.75		
	Bethlehem	8	24.00		
	Qalqilya	5	23.20		

Table (4.22) shows that there were statistically insignificant differences related to place of work and job satisfaction (F= 1.400, P= 0.205), social support (F= 0.505, P= 0.850), and anticipated turnover (F= 1.708, P= 0.105), but there were statistically significant differences in perceived organizational support related to place of work, to find the direction of these differences, Post hoc Scheffe test was performed and it showed that differences were in favour of midwives working in Tulkarm compared to other places (P= 0.012).

4.4 Suggested strategies to develop midwifery profession and midwives

When the participants were asked about their suggestions to develop the midwifery profession, the participant midwives responses were as presented in table 4.23.

Table (4.23): Suggestions to develop midwifery profession

Suggestion	Frequency	Percent
Provide in-service training programs	60	70.9
Motivations & incentives	21	24.7
Employ adequate qualified midwives	19	22.4
Availability of clear protocols	18	21.2
Participate in decision-making	17	20.0
Clear job description	17	20.0
Support & safeguard from harm and assault	12	14.1
Active Midwifery union accredited by MOH	11	13.0
Community awareness about the role of midwife	10	11.8
Exchange experiences with other health facilities	10	11.8
Equity in distribution of daily scheduled duty	9	10.6
Job security	9	10.6
Offer upgrading programs, master degree, and PhD scholarships	9	10.6
Engagement in recreational activities	7	8.2
Fairness and equity in dealing with midwives by supervisors	7	8.2
Financial support	6	7.0
Establish a research centre	5	5.9

Table (4.23) showed that 60 (70.9%) of midwives reported that providing in-service training programs was the highest suggestion to improve midwifery profession, followed by 21 (24.7%) reported that offering motivators and incentives will improve midwifery profession, 19 (22.4%) suggested employing adequate qualified midwives, 18 (21.2%) suggested available clear protocols, 17 (20%) suggested giving opportunities to

participate in decision-making, 17 (20%) suggested affording clear job description, while the lowest suggestions were establishing research centre (5.9%) and financial support (7%).

4.5 Qualitative part - interview results

The researcher carried out 18 individualized interviews with midwives from different hospitals in the north, middle, and south of West Bank. The midwives were randomly selected. Interviews were taped using Mp3 recorder and transcribed for coding. The interviewing, transcribing, and coding continued until data saturation occurred (interviews did not generate new additional data). Then generated data were categorized and ranked in order of most to least frequency. Summary of data collected by the interviews are presented in table 4.24.

Table (4.24): Summary of interview analysis

Statement	Frequency
Causes of job satisfaction:	
Independency in work.	11 (61%)
I like to work as a midwife.	10 (55.5%)
Job security and stability.	6 (33.3%)
The NORWAC project empowered and improved midwifery in Palestine.	5 (27.7%)
Cooperation between the teamwork members.	5 (27.7%)
Good communication with people.	5 (27.7%)
Capability to take decisions.	5 (27.7%)
The salary which I receive.	3 (16.6%)

Monetary motives and incentives.	2 (11.1%)
Causes of dissatisfaction:	
Work overload (number of deliveries compared to number of midwives).	8 (44.4%)
Conflict between the role of midwife and the role of physician (working under responsibility of physicians).	6 (33.3%)
Working night shifts which affect me socially (my home, children and my husband).	5 (27.7%)
Unfair promotions.	4 (22.2%)
Unfair distribution of schedules and assignments which lead to psychological and physical pressure.	3 (16.6%)
Shortage of supplies and consumables such as (latex gloves).	3 (16.6%)
Negative attitudes and poor awareness of some people about the role of midwife.	3 (16.6%)
Some decisions from the decision makers in the Ministry of Health which are mostly in favour of physicians.	2 (11.1%)
Do you think about leaving your work?	
No. I do not think to leave my work.	14 (77.7%)
Yes, social / personal causes (home and children).	3 (16.6%)
Yes, to get a higher qualification	1 (5.5%)
Causes that keep you in current workplace:	
Advancements in midwifery profession.	9 (50.0%)
I like working as a midwife.	6 (33.3%)
Feeling safe and secured in my current job.	5 (27.7%)
Feeling independent and able to take decisions.	4 (22.2%)
The climate in the hospital and in my department we work as a teamwork with good relations and cooperation.	3 (16.6%)

I have a good position in my department.	2 (11.1%)
I would have a retirement salary when I retired.	1 (5.5%)
Fair distribution of tasks and assignments.	1 (5.5%)
Strategies and policies to develop midwifery profession:	
Participation in workshops, and training programs specialized in midwifery through continuous education and in-service training programs.	11 (61.1%)
Prepare and implement working protocols to ensure that all midwives perform procedures in the same way.	9 (50.0%)
Increase the number of midwives in maternity departments to meet the high number of deliveries.	8 (44.4%)
Focusing on improving the community attitudes toward midwives.	4 (22.2%)
Exchange of experience between different hospitals in Palestine and abroad.	3 (16.6%)
To make all needed equipment and monitoring systems available (e.g. CTG).	2 (11.1%)
To conduct research studies aiming to improve midwives' practices.	2 (11.1%)
To establish an independent midwifery association to empower the midwives and struggle to obtain their rights.	2 (11.1%)
To conduct personal interviews with midwives in different hospitals to know their needs, strong points, and weak points.	1 (5.5%)
Cooperation and coordination between different institutions that support midwifery development projects.	1 (5.5%)
To give license to midwives to deliver at home.	1 (5.5%)
How we can improve the midwifery education program?	
I think that the education program is suitable and cover most of the subjects that are needed for midwives.	8 (44.4%)
Increase the time allocated for clinical practice.	6 (33.3%)
To decrease the gap between theory and practice.	6 (33.3%)
Proper selection of students enrolled in midwifery colleges (open minded,	6 (33.3%)

smart, initiative students who are willing to work as a midwife).	
Focusing on scientific research (evidence-based) to improve and update practice.	4 (22.2%)
Coordination between all colleges to unify the education program for midwifery.	3 (16.6%)
Stop the 2 years diploma program and upgrade all diploma midwives to bachelor degree.	1 (5.5%)
To afford master degree (postgraduate) programs specialized in midwifery	1 (5.5%)
Coordination between maternity hospitals and colleges to improve the quality of midwives skills.	1 (5.5%)

Interview questions focused on four major themes;

a. Job satisfaction with two outlier themes; causes of job satisfaction, and causes of dissatisfaction.
b. Intentions to leave current workplace with two outlier themes; thoughts about leaving current work, and causes that keep the midwife stay in current work.
c. Strategies and policies to develop midwifery profession.
d. Suggestions to improve the midwifery education program.

Each interview started by asking the midwife to describe her experience from the first day of employment till now. The first category that was emerged is the gap between what they learned in the college and the actual work in the field. Too much deliveries compared to the number of midwives do not give the midwife time to set with the women to give her instructions and health education about care of the woman and her baby. Six midwives said that "*only two midwives take care of 15 – 20 deliveries during the night shift, they have to monitor the woman during the stages of labor, identify and refer high*

risk cases to the obstetrician, they have to deliver the women, perform episiotomies, take care of the newborn, give medication as prescribed, and talk to family members about each case".

The second category that emerged was the influence of work on social life of married midwives. Midwives mentioned the need for adaptation and compromise between the work requirements and the home requirements. Eight midwives said "*It is not easy to go to work and leave the home especially in the night shifts…. The children need care that the father cannot do it at home…. It is much easier if married midwives work morning shifts only*"

The third category that emerged was the nature of midwifery profession. Working as a midwife need special knowledge and skills to deliver the woman safely. The majority of midwives said "*Working as a midwife is not simple …. It is not a state of pulling the head of the baby…. It needs knowledge and skills because it is concerned of two lives …. The mother and her baby…. You need to be familiar with the work protocols…. It is interesting to help women during delivery because it is stressful event for the woman and her family*".

The first question asked the midwives to identify causes of job satisfaction and causes of dissatisfaction. The interviews generated nine causes of satisfaction; independency in work was the most frequent cause (61.1%), followed by like to work as a midwife (55.5%), job security and stability (33.3%), the NORWAC project that empowered and improved midwifery in Palestine (27.7%), cooperation between the teamwork members (27.7%), good communication with people (27.7%), ability to take decisions (27.7%), the

salary which I receive (16.6%), and monetary motives and incentives (11.1%). In addition eight causes of job dissatisfaction were generated; work overload (44.4%), conflict between the role of midwife and the role of physician (33.3%), working night shifts (27.7%), unfair promotions (22.2%), unfair distribution of schedules and assignments (16.6%), shortage of supplies and consumables (16.6%), negative attitudes of some people about the role of midwife (16.6%), and decisions from the MOH are mostly in favor of physicians (11.1%).

The second question asked about intentions to leave the current work place and causes of staying. More than three-quarters (77.7%) of midwives do not think of leaving their work, while (16.6%) of midwives will leave their work because they want to take care of their home and children, and (5.5%) will enrol in postgraduate studies. Regarding intentions to stay in current workplace, eight causes were emerged; advancements in midwifery profession (50.0%), I like working as a midwife (33.3%), feeling safe and secured in current job (27.7%), feeling independent and able to take decisions (22.2%), the climate of teamwork (16.6%), having a good position in my department (11.1%), having retirement salary when I retired (5.5%), and fair distribution of tasks and assignments (5.5%).

The third question asked about strategies and policies to develop midwifery profession. Eleven suggestions were generated; participation in workshops and training programs through continuous education and in-service training programs (61.1%), prepare and implement working protocols to ensure that all midwives perform procedures in the same way (50.0%), increase the number of midwives in maternity departments to meet the high number of deliveries (44.4%), focus on improving the community attitudes toward

midwives (22.2%), exchange of experience between different hospitals in Palestine and abroad (16.6%), to make all needed equipment and monitoring systems available, to conduct research studies aiming to improve midwives' practices, and to establish an independent midwifery association to empower the midwives and struggle to obtain their rights (11.1% for each. Other suggestions included conducting personal interviews with midwives in different hospitals to know their needs, strong points, and weak points, and cooperation and coordination between different institutions that support midwifery development projects, and to give license to midwives to deliver at home (5.5% for each).

The fourth question asked about ways of improving the midwifery education programs. First of all 44.4% of midwives who have been interviewed thought that the education program is suitable and cover most of the subjects. The interviews generated nine suggestions to improve the midwifery education program including: Increase the time allocated for clinical practice (33.3%), decrease the gap between theory and practice (33.3%), proper selection of students enrolled in midwifery colleges (33.3%), focusing on scientific research (evidence-based) to improve and update practice (22.2%), coordination between all colleges to unify the education program for midwifery (16.6%), stop the 2 years diploma program and upgrade all diploma midwives to bachelor degree, and to afford master degree (postgraduate) programs specialized in midwifery, and coordination between maternity hospitals and colleges to improve the quality of midwives skills (5.5% for each).

4.6 Discussion of results

In this part, triangulation method was used in which quantitative data with integration of qualitative data were discussed and tackled to gain indepth detailed information and comprehensive understanding of the results of the study.

The study included 114 midwives from 9 hospitals which covers the north, middle and south areas in the West Bank, furthermore, 18 midwives were interviewed. More than two-thirds of the study participants were young (30 years old and less), and the majority of them had bachelor degree in midwifery. The vast majority of midwives (90.4%) were satisfied from the educational midwifery program, they attributed their satisfaction mainly to flexibility of the program, and that the program was comprehensive, the program covers all the subjects that the midwife need to learn, and the presence of qualified lecturers and trainers, which was reflected in midwives' feelings of independency and self-confidence in providing care to clients. Data generated from interviews reflected that about half of midwives being interviewed were satisfied from the midwifery education program. They said "*I think that the midwifery education program was suitable …. The program covers all the subjects needed for the student midwife …. We get good knowledge in the lectures but we need more hours of clinical training to capture the skills that enable the midwife to work safely*".

Similar results were obtained from a qualitative study included respondent midwives described overall satisfaction with the quality of their education. Strengths of training program included evidence-based content, standardized materials, clinical training, and supportive learning environment. Turkmani et al., (2013) found that self-reported aspects

of the quality education in respect to midwives empowerment included feeling competent and confident as demonstrated by respect shown by co-workers, while weaknesses of the programme included perceived low educational requirement to enter the programme and readiness of programmes to commence education.

Midwifery is a unique profession that started to occupy an essential role in the health system, midwifery educational programs started to gain interest from both students and universities, and we see that many colleges and universities in Palestine started midwifery programs (either bachelor or diploma). It is important that these programs are designed to meet the needs of graduating qualified, competent midwives who are able to work in maternity departments safely and efficiently. These programs need to be flexible, cover all theoretical and clinical aspects, updated, and challenging. I believe that different midwifery faculties in different colleges should meet and set a program that would be applicable in all the colleges so that graduates from different colleges would gain the similar knowledge and skills that would be reflected in their career performance and decrease discrepancy in practice between different hospitals and health centers.

The results also showed that the majority (81.5%) of midwives mentioned availability of protocols in workplace, more than half of them had adequate training on those protocols, and 79% implement the protocols during work. Those who implement the protocols do that for ambition toward success and recognition, for personal protection, and safety of mothers. Data generated from interviews indicated the importance of protocols in the workplace "*Written, clear protocols will raise the standards of care …. Every midwife will perform the same procedure or task in the same manner …. Protocols will decrease the conflicts with physicians and will decrease the chance for making mistakes*". It is

obvious that having clear, standardized protocols at workplace will be a guide for all the midwifery team members to ensure that tasks and procedures done in the right way by all the team members all the time. It is important to have these protocols and to be periodically evaluated and revised to keep team members updated and offer quality care to clients.

Regarding improvement opportunities, about 45% of midwives were satisfied from the improvement opportunities at work, improvements mainly included recognition and staff development. Data emerged from interviews reflected that half of the midwives talked about improvement in midwifery profession "*There are many improvements in the profession …. Nowadays, the situation is better because we have more number of qualified midwives …. Expanded role of midwife, and we can perform episiotomies …. The community perception toward midwifery is improving and I feel that people have positive attitudes toward midwifery*". A qualitative assessment study found that factors that affect retention of midwives include professional development opportunities and inefficient human resources planning (Wood et al., 2013).

To retain and keep qualified midwives, it is important for the administration to afford equal opportunities for growth and advancement in career for team members, and to avoid bias that will inflict negative feelings and attitudes of team members toward the workplace. In-service training departments play a main role in designing and implementing educational and training programs that would contribute to improve midwives' skills that will be reflected in their performance and productivity.

On assessing job satisfaction among midwives, the results showed that the overall satisfaction was ambivalent with mean score 3.305 and weighted percentage 55.08. The factors that attributed to satisfaction were supervision, coworkers, and nature of work, while dissatisfaction was related to promotion opportunities, fringe benefits, contingent rewards, and operating conditions. This result was higher than that obtained by Zaghloul, et al., (2008) which showed that mean general job satisfaction score was 2.2, and that nurses were least satisfied with the hospital's benefits, hospital policies, bonuses, fairness of the performance appraisal system, paid time off, and recognition of achievements. Other studies found that 52.1% of health workers in South Africa were satisfied with their jobs compared to 71% from Malawi and 82.6% from Tanzania (Blaauw, et al., 2013). Another study found that 96% of Australian nurses and midwives were moderately or highly satisfied with their work (Skinner et al., 2007). Another study among Palestinian nurses reported moderate levels of job satisfaction and moderate burnout. Furthermore, the results indicated that Palestinian nurses face many challenges in their work due to decreased chances of job advancement and emotional exhaustion which may lead to job dissatisfaction (Abu Shaikha & Saca-Hazboun, 2009). Data generated from the interviews reflected some factors that contribute to satisfaction / dissatisfaction of the midwives. Regarding satisfaction, midwives said "*I feel confident and independent in my work …. It is very interesting work and I like being a midwife …. I feel secured in my job and I do not think that the director will fire me from my job …. Money is not the major factor, but cooperation and respect between team members is more important*". On the other hand factors that may contribute to dissatisfaction were mentioned "*The workload is too much that we can't tolerate sometimes …. In one night I*

delivered 23 cases and prepared two women for CS …. Working night shifts and being away from home for long hours affect my social life and all the night I feel worry about my children …. Sometimes we get in conflict with some physicians because they talk in a superior way and they do not understand the role of the midwife".

Regarding midwives' perception about the support they received from their organizations, the results indicated that it was low with overall mean score 2.68 and weighted percentage 53.50. Similar results were obtained from a study conducted in Iran which indicated that nurses described their work place as non-supportive due to managers' ignorance to individual and professional values, poor organization climate, low social dignity, and poor working conditions (Sodeify et al., 2013). In addition, Rude (2004) suggests that POS is strongly related to leadership behavior, hence insufficient support from leader is an important factor to employees' dissatisfaction and burnout. On the other hand, the results showed that perception about social support was moderate with overall average mean score 3.62, which revealed that midwives were moderately satisfied from the social support they receive from their families, relatives, and friends.

Concerning thoughts of leaving or staying in the current workplace, the results reflected that in general, midwives do not have intensions to leave their current workplace (m= 2.37). Data generated from the interviews indicated also low intention to leave and that 77.7% of midwives will stay in their current workplace. Intentions to stay were reflected in "*I feel safe and secured in my current workplace …. There are advancements and improvements in the maternity department in structure of the building, equipment and supplies …. I feel like being with my family as good cooperation exists between team members …. My supervisor have confidence in my work and I can take decisions*

independently …. The clients respect me and are aware of my role". In this regard, it is important to say that over the recent decades, recruitment and retention of qualified nurses and midwives have been challenging. The shortage problem has been addressed especially in regard to increased cost and patient care quality (Hayes et al., 2012). Available literature indicated limitation of data availability for actual nurse turnover, and many turnover studies use intent to leave or stay as a proxy measure of turnover (Loyce, 2013). Davidson et al., (1997) reported that intent to leave was predicted by the perception of little promotional opportunity, high routinization, low decision latitude, and poor communication. Another study aimed to investigate to what extent the registered nurses at a university hospital intend to quit their present jobs found that about 54% of nurses intended to quit and 35% had already taken steps to do so. Main reasons were dissatisfaction with the salary (65%), psychologically strenuous and stressful work (32%), a wish to try something new (28%) and limited opportunities to make a professional career (19%). Nurses who intended to quit rated a higher work tempo, experienced an increased work-related exhaustion and a lower quality of patient care. They also perceived to a lower degree that their competence was made good use of and that they had fewer opportunities of developing their own competence and making a professional career. They were less satisfied with the support from their superiors for participating in nursing research and developing projects (Gardulf et al., 2005). This result raised the need to motivate midwives and to take actions that will improve their intention to stay in their work.

In addition, the results indicated significant relationship between anticipated turnover and job satisfaction and perceived organizational support (P= 0.049, and 0.000 respectively),

but the relationship was insignificant with social support (P= 0.377). Also, significant relationship existed between job satisfaction and perceived organizational support (P= 0.000), and between perceived organizational support and social support (p= 0.001). Previous studies have shown that POS was positively associated with levels of job satisfaction, and that high level of POS caused higher level of job satisfaction (Burke & Greenglass, 2001; Burke, 2003; Stamper & Johlke, 2003; Armstrong et al., 1996). In addition the study conducted by Boyle et al., (1999) found that high job satisfaction was the most significant contributor to high intent to stay at one's position. Furthermore, Gregory et al., (2007) found that job satisfaction was positively associated with intent to stay. Also, Applebaum et al., (2010) reported that there is a direct relationship between job satisfaction and turnover intention, adding to that, McCarthy et al., (2007) identified job satisfaction to be the most accurate predictor of intent to stay. Another study found that as overall job satisfaction increased, intent to stay also increased (Tourangeau & Cranley, 2006), while Aydogdu & Asikgil, (2011) reported that there was significant negative relationship between turnover intention and job satisfaction. Furthermore, Kalliath & Morris, (2002) found that job satisfaction has both direct and indirect effects on burnout.

Regarding POS and turnover it was reported that perceived supervisor support is a predictor of POS and that POS is a predictor of turnover intention (Dawley et al., 2010). Another study showed that supervisor support and organizational support act differently as moderators of the care adequacy-job satisfaction-turnover intention relationship, and job satisfaction was a mediating variable between care adequacy and turnover intention (Galletta et al., 2011). Another study found that several factors affect retention of

midwives including support of family and community, and workplace support (Wood et al., 2013). These results revealed that ATS was positively related to job satisfaction and POS, so, we can argue that midwives who perceive a high level of support from their organization and satisfied from their job, are more likely to feel an obligation to repay their organizations in terms of commitment to stay and increase their productivity in terms of quantity and quality.

The results also did not indicate significant differences in job satisfaction related to age of midwife, social support, and anticipated turnover (P= 0.295, 0.635, 0.308), but midwives aged 40 years and above had higher perception of organizational support compared to other midwives. Previous studies showed variable results; Clark et al., (1996) reported that significant variations across age are commonly found, with older employees tending to report higher satisfaction than younger ones. Another study indicated that there was significant positive relationship between age and job satisfaction (Gesinde & Adejumo, 2012). Also, midwives who are single and those who are married did not convey significant differences in job satisfaction, perceived organizational support, social support, and anticipated turnover (P= 0.459, 0.689, 0.133, 0.7350 respectively). These results revealed that intention to stay or leave the organization was not related to marital status of midwives, but different results obtained by Gomez (2010) who found that single teachers are more satisfied compared to married teachers.

Also, different qualifications of midwives did not convey significant differences in job satisfaction, perceived organizational support, social support, and anticipated turnover (P= 0.524, 0.944, 0.200, and 0.576), which reflected that intention to stay or leave the

organization is concerned with other factors rather than qualification. Different results were obtained by Shields and Wards (2001) who found that nurses with higher level of education were less likely to remain employed at their current institution. Kovner et al., (2009) reported that newly licensed nurses with bachelor degree were found to be less likely to stay at their current position compared to those with lower levels of education. Loyce (2013) found negative association between intent to stay and level of education, and that bachelor prepared nurses were less likely to report that they would stay employed in their current position.

Furthermore, monthly income did not cause significant differences in job satisfaction, perceived organizational support, social support, and anticipated turnover (P= 0.821, 0.122, 0.232, 0.132). Data emerged from the interviews reflected similar results as only 16.6% of midwives who were interviewed connected their job satisfaction with monthly salary and 11% said that monetary incentives led to satisfaction.

Different results were found by Aydogdu and Asikgil, (2011) who performed s study on 2000 managers and reported that the amount of wages received was very positively related to satisfaction. Another study conducted in Afghanistan found that salary levels was among the factors that affect retention of midwives (Wood et al., 2013). It is worth to say that wages and salaries are important factors in life; money not only helps individuals attain their basic needs, but also instrumental in providing upper-level needs satisfaction (Luthans, 1992).

Furthermore, different years of experience did not impose significant differences in job satisfaction, perceived organizational support, social support, and anticipated turnover

among midwives (P= 0.091, 0.211, 0.248, 0.243 respectively), which means that intention to stay or leave the organization was not related to midwives' years of experience. Different results were reported by Tourangeau and Cranley, (2006) who found that the more years nurses reported being employed in their position, the more likely they were to remain employed in that position until retirement, while Loyce (2013) found positive association between intent to stay and length of years working in the organization. Another study indicated that there was significant positive relationship between work experience and job satisfaction, and that significant difference existed between employees with less and above five years of working experience (Gesinde & Adejumo, 2012). In addition, intention to stay or leave the organization was not related to the position status of midwives, nor the type of duty shifts (morning, evening, and night), and place of work, but midwives who are working in Tulkarm reported higher organizational support (P= 0.012).

On tackling their suggestions to develop the midwifery profession, 70.9% of midwives reported that providing in-service training programs was the most important factor, followed by offering motivators and incentives (24.7%), employing adequate qualified midwives (22.4%), available clear written protocols (21.2%), opportunities to participate in decision-making (20%), adopting clear job description (20%), while the lowest factor was financial support (7%). These results revealed that midwives reflected high concern about their profession and suggested strategies that focus mainly on improving the health services provided by midwives while monetary and financial aspect was among the least suggestions.

One of the most damaging effects of severely weakened and under-resourced health systems is the difficulty they face in producing, recruiting and retaining health professionals both in the health sector. Low wages, poor working conditions, lack of supervision, lack of equipment and infrastructure all contribute to the flight of health care personnel (Lehmann et al., 2008). The discussion of attraction and retention factors and strategies falls within the broad scope Human Resource Management (HRM) as a strategic and coherent approach to managing staff of an organization (Armstrong, 2007). HRM covers all aspects of staff management, including the resourcing of staff through attraction and retention strategies. Ensuring coherence of these HRM strategies is complex, as illustrated by Buchan with reference to nurses: "The complex interaction of pay, job satisfaction, career prospects and non-work issues mean that there is no single solution to retaining and motivating nursing staff" (Buchan, 2002). The success of strategies within a health sector will also depend on the socio-economic, political and institutional context and on the health labour market: availability of resources, management skills, influences exercised by key stakeholders, political will or even sabotage by dissatisfied stakeholders can play decisive roles in the success or failure of strategies (Buchan, 2004).

Further information were generated from the interviews, which increased the validity and credibility of the study results. This information are presented below.

Concerning job satisfaction, the interviewed midwives related their satisfaction to many causes. What was encouraging is that 55% of the midwives said that they like being a midwife. If the midwife like her profession, she would work hard to offer quality care to her clients, and put extra efforts to develop herself and to develop the profession.

In addition, 61% of midwives attributed their satisfaction to feeling of independency in work and ability to take decisions. Feeling independent in the work increase the midwife's confidence in herself and her ability to perform the required tasks in a good manner.

Furthermore, 33.3% attributed that to job security and stability, which is important for both the midwife and the hospital. When the midwife feels secured and not threatened of losing her job, this will lead to performance in a relaxed psychological condition, and that will be reflected in her performance of tasks and work related activities. On the other hand, the hospital got benefit, as keeping midwives who are skilled and have good experience will lead to improve the outcome and productivity.

Also, 27.7% of midwives related their satisfaction to the advancement and empowerment of midwifery profession and the role of NGOs especially the NORWAK project to develop the midwifery in Palestine. The researcher believes that development and advancement of midwifery will attract more females to engage in the profession. Recruiting new midwives is essential to face the shortage of midwives in maternity departments, and will enable the midwives to handle the increased number of deliveries.

Another factor was the climate of teamwork, which was mentioned by 27.7% of midwives. It is believed that working as a team will increase cooperation between the team members and working as one unit to accomplish the goals of the team members and the goals of the hospital.

Adding to that 27.7% of midwives said that good communication with clients and their relatives, which reflected awareness and respect to the midwife and her role in caring for the mother in this special event.

What was surprising in this part is the wages and money as only 16% of midwives attributed their job satisfaction to the salary they receive and only 11% said that monetary motives and incentives attributed to their satisfaction. Money is important for everyone, especially for employees as their income is mainly from their salary. Thinking of money as the least factor of satisfaction means that other factors of psychosocial base are important besides the work climate and culture of support in the work setting.

In contrary, some factors were mentioned as causing dissatisfaction; 44.4% of midwives mentioned that work overload was the leading cause of dissatisfaction. Most of the midwives said that the number of midwives is inadequate compared to the number of deliveries. In most of maternity departments only two midwives are assigned to take care of all the deliveries that coming during the night shift, which is stressful to the midwives physically and psychologically and may affect the quality of care and increase the chance of making undesired mistakes. Adding to work overload, 33.3% of midwives said that they were in conflict with the doctors. The midwives said that the doctors talk in a superior way and they said that they are the leaders and midwives are working under the doctors umbrella. This way of thinking would impose negative feelings upon midwives and decrease their self-confidence, which will diminish their potentials and reduce their interest in their work.

Also working for many years without being promoted was another factor that caused dissatisfaction as 22% of midwives said that promotion for some midwives was unfair and not based on qualification of the midwife, additionally unfair distribution of schedules and assignments was mentioned by 16.6% of midwives. Some midwives said that the head of department assign some midwives on easy tasks while heavy tasks are given to other midwives, and that was not based on skills and abilities, but it was a bias from the head of department because she like some midwives and give them easy tasks.

Shortage of supplies and consumables was another cause of dissatisfaction but to a low degree as only 16.6% of midwives complained of shortage of supplies especially latex gloves. It is important to ensure availability of adequate amounts of supplies that enable midwives to perform their tasks in a proper way without causing harm to the mother, the baby, and the midwife herself.

Paying attention to midwifery is needed from the decision-makers. In this regard, 11% of midwives said that most of decisions from MOH are in favour of physicians.

Working for long hours (12 hours) in the night shift was a cause for leaving the current work especially for those midwives who are married and having children. In this regard, 27.7% of midwives said that working long hours in the night shift was dissatisfying, and 16.6% of midwives said that they think to leave their work because of being away from home and children for long hours especially during the night. I think that this problem should be solved by decreasing the hours of night shift, and decrease the number of night duties for those who are married and have children and replace them with young, single midwives.

More than two-thirds of midwives (66.6%) said that they like their workplace and will stay in their work. If the midwife likes her workplace and do not think of quitting, this would be reflected in her performance and will seek to give her best to the clients. This is of value to the hospital and the profession as well, so, steps to enforce the staff retention should be taken to encourage other midwives to stay in work to enlarge the work-force of midwives in the health system.

Among those who are willing to stay in their work, 50% of them attributed that to the advancement and progress of midwifery as a profession, and 33.3% said that they like working as a midwife. In addition, 27.7% said that feeling safe and secured in their job was important to keep them in their current work and 22% attributed that to their feeling of independency and ability to take decisions, while 11% said that they want to stay because they have a good position in their current workplace. These factors are of interest because some of these factors indicated concerns about the midwifery in general, and other factors were personal, which reflect midwives' interest in personal issues as well as professional issues.

Concerning strategies and policies to develop midwifery profession, 50% of midwives emphasized the need to have written clear protocols in every maternity department. It is important to have written protocols and guidelines with specific actions that will make all the midwives perform the tasks in the same way. Presence of protocols will standardize the plan of care and decrease the occurrence of mistakes during the treatment process. In addition, 44.4% of midwives raised the need to increase the number of qualified midwives in accordance with the increasing number of deliveries. In this regard, one midwife said that during the night, there are two midwives who take care of 20 – 30

deliveries; this is a big load that cannot be tolerated and it is unsafe for the mother and her baby.

In addition, 22% of midwives said that efforts should be directed toward improving the community awareness about the importance of the role of midwife in the entire journey from the beginning of pregnancy to the end of delivery, as the midwife is present in antenatal clinics, during delivery, and after delivery. To keep updated, some midwives raised the need to conduct scientific research and participation in workshops and study days that aims to exchange experiences between different work settings and will result in development of the midwives' knowledge and skills.

In the last part, the midwives were asked about methods that will help in improving the education programs at the colleges. About 44.4% of midwives thought that the education program was suitable and cover most of the required materials and knowledge needed for the midwife, while 33.3% emphasized the need to decrease the gap between theory and practice and the need to increase time allocated for clinical training during the study program. In addition, 33.3% focused on the process of choosing students in the midwifery program and emphasized the need to recruit intelligent, smart students with special personal characters. Other suggestions included stopping the 2-years diploma program and to have postgraduate programs.

In conclusion, it was clear that the interviews added extra information that would be helpful in putting strategies to retain and support midwives in their work. Any strategy to be succeeded should include personal interests as well as organization interests. Factors

that increase midwives' satisfaction and decrease dissatisfaction, advancement and progress of the midwifery services should be emphasized.

- Increase the number of qualified midwives in maternity departments by employing more midwives based on the number of deliveries and other maternal health services.
- Widening the mother and child health services to include all the clinics to empower community health services and decrease the load on the hospitals.
- Attract smart secondary school students to enrol in the midwifery programs by decreasing the fees of study and guarantee for being employed after graduation.
- Establish a union body for midwives and exchange experience with other unions in other countries.

To activate the role of in-service training to increase the knowledge and skills of midwives and keep them updated.

Chapter 5

Conclusion and Recommendations

This chapter presents the conclusion of the study tackling the main results of the study, besides the suggested recommendations toward building a strategy to enhance midwives retention and decrease turnover.

5.1 Conclusion

This study aimed to identify level of job satisfaction, perceived organizational support, social support, and anticipated intention to stay or turnover among midwives working in governmental hospitals in West Bank. Identifying these variables would be a guide to set a strategy to enhance midwives retention and increase their productivity.

The study explored these variables among midwives in relation to demographical characteristics including (age, qualification, and marital status, place of work, years of experience, job position, and working shifts).

The target population consisted of 114 midwives, with different qualifications and the majority of them 81.7% had bachelor degree in midwifery, more than two-thirds are young (less than 30 years old), and 53.5% of them are working in maternity departments for less than 5 years.

The overall level of job satisfaction among participants was ambivalent with mean score 3.305 and weighted percentage 55.08%, the highest was in nature of work domain with mean score 4.958 and the lowest was in fringe benefits with mean score 2.346. The mean

score for perceived organizational support was 2.68 social support 3.62, and anticipated turnover 2.37 which reflected low intention to leave.

The results also found that there was statistically significant positive relationship between anticipated turnover and job satisfaction (P= 0.000) and perceived organizational support (P= 0.049), but the relationship was insignificant with social support (P= 0.377). Job satisfaction is among the determinants of staying in or leaving the place of work, and it is evident that midwives who are satisfied with their work conditions would probably stay in their work. In addition, when the employees feel gaining support from their organization, including supervisors respect, availability of equipment and materials needed to accomplish their tasks, harmony and cooperation between different departments, these issues most probably will decrease the midwives' intention to leave. Being satisfied from the work and being supported by the organization will have synergistic effect and increase the chance of staying in the same workplace.

The study results also indicated that generally there were statistically insignificant differences in anticipated turnover, job satisfaction, perceived organizational support and social support in relation to age of midwife, marital status, number of children, qualification, income, experience, position, working shifts, and place of work.

Suggestions to develop midwifery profession included providing in-service training programs, offer motivators and incentives, employing adequate midwives, having clear work protocols, participation in decision-making, having clear job description, safe guard from harm and assault, having a union body for midwives, community awareness about

the role of midwives, exchange experience with other facilities, job security, upgrading programs, and financial support.

The findings of the study raise the need to increase midwives' level of job satisfaction by taking some actions from the side of MOH and work organization to avoid losing their qualified midwives which would inflict negative impact on the safety and quality of maternal care.

5.2 Recommendations

Based on the study results, the researcher recommend the following to develop a strategy aiming at retaining and empowering midwifery in Palestine. The strategy will be developed under five strategies:

1. **Patient safety / quality**

   Through applying the scope of midwifery practice framework to assure and sustain the provision of safe, quality patient care. This can be attained through:

   - Increase the number of employed qualified midwives to meet the increasing number of deliveries in Palestine, and compromise for the increased work overload.
   - Developing written work protocols to guide work activities and ensure that everyone do the same procedures in the same way.

2. **Support learning and development**

   Through supporting the development of competent, capable and confident staff who will meet the needs of service for today and tomorrow. This can be attained through:

- Affording in-service training programs to develop and update the midwives knowledge and skills that enable them to perform their tasks in a quality manner.
- Establish a research center that will enhance evidence based practices.
- Unify the midwifery-learning program in all the colleges that run midwifery courses.

3. Efficient and effective care

This can be attained through:

- Expanding the role of midwives and adopting the midwife led model of care.
- Implement appropriate skills and qualification mix in maternity departments.
- Increase the focus on clinical training for midwifery students to integrate knowledge and skills.
- To employ adequate number of midwives in proportion to number of deliveries in each hospital.

4. Management and technology

Through the use of technology to assist in managing the midwifery workforce including rostering, absenteeism, and workforce planning. Optimise the use of quality management information system for policies, procedures, protocols, and guideline documentation. This can be attained through:

- The need to have clear, written job description for different levels of midwives to clarify the role of each level and avoid the occurrence of conflicts between the midwives.
- To develop a clear system of rewards and promotions that gives every midwife a fair chance for promotion.

- To perform periodical evaluation / audit about the quality of care at maternity departments in governmental hospitals.

5. Employing qualified midwives

Through good preparation and training of midwives who are capable to work in maternity departments safely and effectively. This could be achieved through:

- Unifying the midwifery educational program at all the colleges in Palestine, with periodic evaluation and reform as necessary.
- Allocate qualified, expert midwives in the clinical training settings to train students' midwives.
- Increase the time allocated for clinical training during the education program.
- Offer continuous in-service training programs for newly employed midwives to increase their skills and capabilities.

5.3 Suggestions for further studies

- To conduct a study focusing on evaluating the adequacy of maternity departments to offer safe maternal services.
- To carry out need assessment of midwives regarding numbers and qualifications of present and future midwives.
- To conduct a study aiming to compare the roles and number of midwives between those who are working in governmental, UNRWA, and private sectors.

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Annexes

Annex (1) Questionnaire after modification (English version)

Study Title:

Toward Development of Human Resource Strategy: The Case of Midwives in Palestine.

Dear midwife: You are requested to participate in a research study that aims at exploring midwives job satisfaction and organization and social support in order to develop retention strategies for midwives working in Governmental Hospitals in the West Bank.

The expected duration of your participation is 20 minutes. The procedures of the research will be as follows: a quantitative approach will be selected applying a survey questionnaire. The questionnaire will be divided into 4 parts. The first one consists of the demographic variables. The second part aim to assess level of job satisfaction and perceived organizational support. The third part are questions to assess social support .The fourth part are questions to assess midwives intention to leave or to stay direct questions of their intent to leave hospital. If the answer is yes, where she plan to go. There will not be certain risks or discomforts associated with this research. The information you provide for purposes of this research is anonymous. Participation in this study is voluntary. You may discontinue participation at any time without penalty or the loss of benefits to which you are otherwise entitled.

For more information, please contact Samar Mghari at **0599878357.**

Signature of participant ---------- Date:----------

Part I: Socio-demographic data and workplace characteristics

1	Age	☐ less than 25 ☐ 25 - 30 ☐ 31 – 40 ☐ more than 40 years
2	Academic qualification	☐ diploma 3 years ☐ high diploma ☐ bachelor ☐ master degree
3	Monthly income	☐ Less than 2000 NIS ☐ 2000 – 3000 NIS ☐ 3001- 4000 NIS
4	Marital status	☐ Single ☐ Married ☐ divorced ☐ widow
5	Number of children	☐ No children ☐ 1 – 4 children ☐ 5 children and more
6	Age of children	☐ No children ☐ Less than 3 years ☐ 3 – 8 years ☐ 9 – 12 years ☐ 13–18 years ☐ More than 18 years
7	Place of residence	☐ Tulkarm ☐ Qalqilya ☐ Nablus ☐ Salfeet ☐ Jenin ☐ Jericho ☐ Ramallah ☐ Bethlehem ☐ Hebron ☐ Yatah
8	No. of years working as midwife	☐ Less than 5 years ☐ 5 – 10 years ☐ More than 10 years
9	Current job position	☐ Midwife ☐ Head of department ☐ Assistant head nurse
10	Type of working shifts	☐ Morning shift ☐ Night shift ☐ Morning and evening ☐ Evening and night ☐ Morning, evening and night
11	Previous work	☐ Private hospital ☐ Other governmental hospital ☐ None ☐ In same hospital where I am ☐ In different area
12	Position in previous work	☐ None ☐ Midwife ☐ Head of department ☐ Assistant head nurse
13	Cause of leaving previous work	☐ None ☐ Family causes ☐ Financial cause ☐ Job security ☐ No specific cause
14	You have been exposed to an accident during work	☐ Yes ☐ No
15	Type of accident	☐ None ☐ Physical abuse ☐ Emotional abuse ☐ Physical, chemical, biological harm ☐ Physical abuse & physical harm ☐ Emotional abuse & physical harm
16	Midwifery protocols are available at workplace	☐ Yes ☐ No
17	You had adequate training on midwifery protocols	☐ Yes ☐ No
18	Do you apply these protocols during work?	☐ Yes ☐ No

Please choose causes of satisfaction from the education program while you were student (you can choose more than one answer)

Cause	
Flexible and easy applicable program	
Comprehensive, well covered program	
Appreciation and recognition of the profession	
Qualified lecturers and trainers	
Independency and self-confidence in providing care to clients	

Part II: Job Satisfaction Survey (JSS)

Please answer all the following questions by putting (√) in front of each question in the appropriate column. Your answer reflects your feeling toward the questions.

No.	**Item**	**Strongly disagree**	**Moderately disagree**	**Slightly disagree**	**Slightly agree**	**Moderately agree**	**Strongly agree**
	Pay						
1	I feel I am being paid a fair amount for the work I do						
2	Raises are too few and far between						
3	I feel unappreciated by the organization when I think about what they pay me						
4	I feel satisfied with my chances for salary increases						
	Promotion						
1	There is really too little chance for promotion on my job						
2	Those who do well on the job stand a fair chance of being promoted						

3	People get ahead as fast here as they do in other places						
4	I am satisfied with my chances for promotion						
	Supervision						
1	My supervisor is quite competent in doing his/her job						
2	My supervisor is unfair to me						
3	My supervisor shows too little interest in the feelings of subordinates						
4	I do like my supervisor						
	Fringe Benefits						
1	I am not satisfied with the benefits I receive						
2	The benefits we receive are as good as most other organizations offer						
3	The benefit package we have is equitable						
4	There are benefits we do not have which we should have						
	Contingent rewards						
1	When I do a good job, I receive the recognition for it that I should receive						
2	I do not feel that the work I do is appreciated						
3	There are few rewards for those who work here						
4	I don't feel my efforts are rewarded the way they should be						
	Operating conditions						
1	Many of our rules and procedures make doing a good job difficult						
2	My efforts to do a good job are seldom blocked by red tape						
3	I have too much to do at work						

4	I have too much paperwork						
	Coworkers						
1	I like the people I work with						
2	I find I have to work harder at my job because of the incompetence of people I work with						
3	I enjoy my coworkers						
4	There is too much bickering and fighting at work						
	Nature of work						
1	I sometimes feel my job is meaningless						
2	I like doing the things I do at work						
3	I feel a sense of pride in doing my job						
4	My job is enjoyable						
	Communication						
1	Communications seem good within this organization						
2	The goals of this organization are not clear to me						
3	I often feel that I do not know what is going on with the organization						
4	Work assignments are not fully explained						

Part III: Perceived organizational support (POS)

No.	Item	Strongly disagree	Moderately disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree
1	I receive help & emotional support from my family						
2	I can talk frankly with my family about my work problems						
3	I depend on my friends when I fall in troubles in my work						
4	My family is always ready to help me in making decisions						
5	I can depend on my family when I'm in need for support						
6	I am satisfied about the reputation of midwifery in my community						

Part IV: Anticipated turnover scale (ATS)

No.	Item	Strongly disagree	Moderately disagree	Slightly disagree	Slightly agree	Moderately agree	Strongly agree
1	I am happy to stay working in this hospital regardless of current circumstances						
2	I am obliged to stay at my current workplace regardless of all challenges						
3	I'll stay working in this hospital if I received higher salary and incentives						
4	I want to stay in this hospital regardless to the available opportunities						

5	I will leave this hospital when there are better opportunities						
6	I am planning to leave my current workplace next year						
7	I am planning to change my career whenever it's possible						
8	I intend to stay in current work if there's a possibility for working as part time						

Please what your suggestions to develop midwifery profession?

Part V: Interview format

1	Describe your experience from the first day of employment till now	
2	Job satisfaction a. Causes of job satisfaction b. Causes of dissatisfaction c. Intentions to stay or leave your current work d. Causes of staying e. Causes of leaving	
3	From your opinion, what are the strategies and policies that can be adopted to develop the midwifery profession?	
4	How can we improve the midwifery educational programs in the colleges?	

Annex (2): Questionnaire (Arabic version)

البيانات الشخصية العامه:

I. **العمر:**
1. أقل من 25سنة 2. من 25 إلى 30 سنة 3. من 31 إلى 40 سنة 4. أكثر من 40 سنة

II. **الحالة الاجتماعية:**
1. عزباء 2. متزوجه 3. منفصلة 4. مطلقة 5. أرمله

III. **عدد الأطفال:**
1. لا يوجد أطفال ب. من (1 – 4) أطفال ج. أكثر من 4 أطفال

IV. **عمر أصغر أطفالك:**
1. أقل من 3 سنوات 2. من 3 إلى 8 سنوات 3. من 9 ألى 12 سنة 4. من 13 إلى 18 سنة 5. أكثر من 18 سنة

V. **مكان إقامتك (المحافظة):**
1. رام الله 2. نابلس 3. أريحا 4. جنين 5. الخليل 6. طولكرم 7. سلفيت 8. بيت لحم 9. قلقيلية

10. غير ذلك / حددي _____.

VI. **مكان عملك (المحافظة):**
1.رام الله 2. نابلس 3. أريحا 4. جنين 5. الخليل 6. طولكرم 7. سلفيت 8. بيت لحم 9. قلقيلية

10. غير ذلك / حددي _____.

VII. **آخر درجه علمية حصلت عليها:**
1. دبلوم ثلاث سنوات 2. دبلوم عالي في القبالة 3. بكالوريوس في القبالة 4. ماجستير 5. غير ذلك/وضحي _____.

VIII. **منذ متى وأنت قابلة؟**
1. أقل من 5 سنوات 2, من 5سنوات إلى 10 سنوات 3. أكثر من 10 سنوات

IX. **المسمى الوظيفى الحالي:**
1. قابلة 2. رئيسة قسم 3. مساعدة رئيسة قسم 4, مسمى آخر/ وضحي _____.

X. **دوامك في وظيفتك الحالية:**
1. صباحي 2. مسائي 3. ليلي 4. صباحي ومسائي 5. مسائي وليلي 6. صباحي وليلي 7. صباحي ومسائي وليلي

XI. **مقدار راتبك الشهري الاجمالي الحالي:**
1. أقل من 2000 شيكل 2. من 2000 إلى 3000 شيكل 3. من 3001 إلى 4000 شيكل 4. أكثر من 4000 شيكل

XII. **هل تعرضت لحادث أثناء عملك كقابلة؟ (عنف / عدوى / ...)**
1. نعم 2. لا

XIII. **إذا كان الجواب نعم ... حددي نوعية الاصابة من فضلك:**
1. عنف جسدي
2. عنف نفسي
3. ضرر جسدي (فيزيائي / كيميائي / بيولوجي)

XIV. **أين كنت تعملين قبل عملك الحالي؟**
1. مستشفى خاص 2.مستشفى حكومي 3. عياده 4. لم أكن أعمل 5. في نفس المستشفى الحالي 6. في مجال مختلف / حددي_____.

XV. **كانت وظيفتي في عملي السابق هي:**
1. قابلة 2. رئيسة قسم 3. مساعدة رئيسة قسم 4. مسمى آخر / وضحي _____.

XVI. **السبب الرئيسي لترك وظيفتي السابقة هي:**
1. أمور عائلية 2. أمور مالية 3. الحصول على أمن وظيفي 4. لا يوجد أسباب 5. أسباب أخرى / حددي _____.

XVII. **هل أنت راضية عن برنامج تدريبك أثناء دراستك القبالة (النظري والعلمي)؟**
1. نعم 2. لا
لماذا نعم ولماذا لا؟
_____
_____
.___

XVIII. **هل يوجد في قسمك البروتوكولات الخاصة بعملك كقابلة؟ 1. نعم 2. لا**

XIX. **هل تم تدريبك على هذه البروتوكولات الخاصة بعملك كقابلة خلال فترة توظيفك؟ 1. نعم 2. لا**

XX. **هل تطبقين هذه البروتوكولات في عملك كقابلة؟ 1. نعم 2. لا 3.**
لماذا؟_____.

XXI. **هل أنت راضيه عن فرص التقدم التي تحصلين عليها في مهنتك؟ 1. نعم 2. لا 3.**
لماذا؟_____.

XXII. **أنت كقابلة وحسب رأيك ... ما هي الاستراتيجيات والسياسات التي يجب وضعها والعمل بها لتطوير مهنة القبالة وتطوير القابلات؟**

ضعي دائرة حول الإجابة الأقرب للصحيح لك!

#	أسئلة الرضا الوظيفي	أختلف بشده	أختلف باعتدال	أختلف قليلاً	أوافق قليلاً	أوافق باعتدال	أوافق بشده
1	أشعر أنني أتقاضى أجرا عادلا على العمل الذي أقوم به	1	2	3	4	5	6
2	الحقيقة أن هناك فرص قليله جدا للترقية في عملي	1	2	3	4	5	6
3	إن مسؤولي المباشر كفؤ جدا في أدائه / أدائها للعمل	1	2	3	4	5	6
4	أنا غير راضٍ عن الامتيازات التي أحصل عليها	1	2	3	4	5	6
5	عندما أقوم بعمل جيد أحصل على التقدير الذي يجب أن أحصل عليه عن ذلك العمل	1	2	3	4	5	6
6	هناك عدة أنظمة وإجراءات تجعل القيام بالعمل الجيد أمراً صعباً	1	2	3	4	5	6
7	أحب الاشخاص الذين اعمل معهم	1	2	3	4	5	6
8	أشعر أحيانا أن عملي بلا معنى	1	2	3	4	5	6
9	الاتصال والتواصل تبدو جيدة ضمن إطار هذه المؤسسة	1	2	3	4	5	6
10	العلاوات قليلة جداً ومتباعدة زمنيا	1	2	3	4	5	6
11	لذين يؤدون عملهم بصورة جيدة يحظون بفرص جيدة للترقية	1	2	3	4	5	6
12	مسؤولي المباشر في العمل غير عادل معي	1	2	3	4	5	6
13	الامتيازات التي نحصل عليها هي نفس الامتيازات في المؤسسات الأخرى	1	2	3	4	5	6
14	لا اشعر بأن العمل الذي أقوم به يلقى التقدير	1	2	3	4	5	6
15	جهودي المبذولة لكي أقوم بعمل جيد نادرا ما تكون دون جدوى أو (تذهب سدىً)	1	2	3	4	5	6
16	وجدت بأنه على أن اعمل بجد اكبر في عملي و ذلك لعدم كفاءة الأشخاص الذين اعمل معهم	1	2	3	4	5	6
17	أحب الأعمال التي أقوم بها في عملي	1	2	3	4	5	6
18	غايات هذه المؤسسة غير واضحة بالنسبة لي	1	2	3	4	5	6
19	أشعر بعدم التقدير في المؤسسه عندما أفكر بالأجر الذي أتقاضاه منها	1	2	3	4	5	6
20	يتقدم الناس وظيفيا في هذه المؤسسه بالسرعة التي يتقدمون بها في الأماكن أو المؤسسات الأخرى	1	2	3	4	5	6
21	المشرف علي في العمل يعطي اهتماما قليلا لمشاعر العاملين المشرف عليهم	1	2	3	4	5	6
22	إن حزمة الامتيازات التي نحصل عليها عادله	1	2	3	4	5	6
23	المكافأة قليله للعاملين هنا	1	2	3	4	5	6
24	هناك واجبات كثيرة في العمل	1	2	3	4	5	6
25	أنا مستمتع بعملي مع الزملاء	1	2	3	4	5	6
26	غالبا ما اشعر بأني لا اعرف ماذا يحدث في المستشفى	1	2	3	4	5	6

27	أنا اشعر بالفخر عندما أؤدي عملي	1	2	3	4	5	6
28	اشعر بالرضى عن الفرص المتاحة في زيادة الأجور	1	2	3	4	5	6
29	هنالك فوائد من المفترض أن نحصل عليها ولكنها غير موجودة	1	2	3	4	5	6
30	أنا أحب مشرفي في العمل	1	2	3	4	5	6
31	لدي الكثير من الأعمال الكتابية في العمل	1	2	3	4	5	6
32	أنا أشعر بأن جهودي لا تكافئ بالطريقة الصحيحة التي يجب أن تكافئ بها	1	2	3	4	5	6
33	أنا راض عن فرصي في الترقيه في العمل	1	2	3	4	5	6
34	هناك الكثير من المشاحنات والشجار في العمل	1	2	3	4	5	6
35	عملي ممتع	1	2	3	4	5	6
36	لواجبات في العمل غير موضحة بصورة مفصله	1	2	3	4	5	6

#	الدعم الملتقى من المؤسسة وزملاء العمل	أختلف بشده	أختلف باعتدال	أختلف قليلاً	أوافق قليلاً	أوافق باعتدال	أوافق بشده
37	لدي فرص المشاركة فيصنع القرار من أجل حل المشاكل المتعلقة بعملي كقابلة	0	1	2	3	4	5
38	أشارك في مناقشة وتحليل الحالات القريبة من الفقدان ومراجعة وفيات الأمهات والسجلات الطبية والتقارير	0	1	2	3	4	5
39	يتم التعامل مع شكاواي واقتراحاتي على محمل الجد من خلال المستشفى	0	1	2	3	4	5
40	لدينا تدابير للحماية ضد الأخطار المهنية (مثل التعرض لفيروس نقص المناعة، ومخاطر أخرى)	0	1	2	3	4	5
41	لدينا ما يكفي من المواد الاستهلاكية (مثلا لقطن والكحول والماء الساخن...) للقيام بعملنا	0	1	2	3	4	5
42	الأدوية دائماً متوفرة في القسم	0	1	2	3	4	5
43	الدم للنقل متاح عن الحاجة	0	1	2	3	4	5
44	التعليم المستمر الذي أتلقاه مناسب لمتطلبات وظيفتي	0	1	2	3	4	5
45	الأقسام الأخرى مثلا لمختبر، الأشعة السينية. الخ متعاونون للغاية مع قسمنا	0	1	2	3	4	5
46	مكان عملي الحالي في المستشفى صحي (مثل المساحة، والنظافة والتهوية والضوء والهدوء، الراحة...)	0	1	2	3	4	5
47	أنا أواجه مصادمات مع الأطباء بخصوص أداء دوري المهني	5	4	3	2	1	0
48	الدعم الفني مثل (المشورة والتوجيه)، الذي أتلقاه من مشرفي المباشر في	0	1	2	3	4	5

	قسمي مفيد جداً						
49	قلة الأجهزة والمعدات تمنعني وتحد من إمكانياتي كقابله	5	4	3	2	1	0
50	على العموم، أنا راضيه عن نوعية الرعاية المقدمة للنساء والأطفال في وحدتي	0	1	2	3	4	5
	الدعم الملتقى اجتماعياً ومعنوياً						
51	أتلقى المساعدة والدعم المعنوي من عائلتي	0	1	2	3	4	5
52	يمكنني التحدث بصراحة مع عائلتي عن مشاكل العمل	0	1	2	3	4	5
53	يمكنني الاعتماد على الأصدقاء عندما تسير الأمور بشكل سيء	0	1	2	3	4	5
54	عائلتي على استعداد لمساعدتي في اتخاذ قراراتي	0	1	2	3	4	5
55	يمكنني الاعتماد على عائلتي حين أكون بحاجه للدعم	0	1	2	3	4	5
56	أنا راضيه عن سمعة/صورة القبالة في أوساط مجتمعنا	0	1	2	3	4	5
57	يسعدني البقاء في هذا المستشفى والعمل به رغم الظروف الحالية	0	1	2	3	4	5
58	أنا مضطر للبقاء والعمل في هذا المستشفى بغض النظر عن كل التحديات	5	4	3	2	1	0
59	سأبقى أعمل في هذا المستشفى إذا حصلت على راتب أعلى وحوافز أكثر	5	4	3	2	1	0
60	اريد البقاء هنا بغض النظر عن الفرص البديلة المتوفرة	0	1	2	3	4	5
61	سوف أترك المستشفى في حال توفرت فرص أفضل	5	4	3	2	1	0
62	هناك خطة لترك الوظيفة الحالية في العام المقبل	5	4	3	2	1	0
63	أخطط لتغيير مهنتي متى ما أمكن	5	4	3	2	1	0
64	عندي النية للبقاء إذا توفر لدينا نظام الدوام الجزئي كالبلدان الأخرى	5	4	3	2	1	0

Anticipated Turnover Scale (ATS) which was developed by Hinshaw and Atwood (1984)

نشكر لك وقتك ونقدر شفافيتك في جميع إجاباتك

Annex (3): Expertise opinions for questionnaire modification

From: **Mohanad Mahmoud Ahmad Khader** (mohannad.khader@aauj.edu)
I reviewed the your sent questionnaire, I have no comments on the existing questions or items, but suggest to add some questions on previous works places and job positions of your subjects, in order to know more information about their profile and maybe the reasons of their previous attritions and similar job changes (financial, social, or any other)
Before my current job i worked in:
1-Nothing
2- Private hospital
3- Public Hospital
4-Clinic

I left my previous work due to :
1-Family causes
2-Financial causes
3-More job security
4-Others : .....

From:AMAL Abu Awad (ibnsina99@yahoo.com).

1- It is better to use positive statements for all the items and avoid negatives, so that the scale will be answered in the same way on a scale from 0 to 5. This is because the participants might not pay attention to the change in the scale or the change in the language, or it might get them confused during the answering.
2- It is better to categorize the items into components and my suggestions are the following :
a. Organizational climate
b. Colleagues
c. Administrative policies
d. Managers
e. Payment/ salary

From: Aidah Alkaissi
Dear Samar,
Thank you for sending your questionnaire,

Unfortunately, It is spread, not organized, jumping back and forth, not sequential. It does not answer adequately the objectives of your research. it does not contain any item related to midwives. I advise you to seek vigorously a valid and reliable questionnaire in previous studies. This should be directed to midwives.

Best regards

Annex (4): Questionnaire (before modification)

Demographic data:

1. **Age:**

a. Less than 25Y/O b. From 25 to 30 Y/O c. From 31 to 40 Y/O d. More than 41**(40)**Y/O

2. Marital status:

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

3. Number of children:

No children ☐ 1-4 child ☐ more than four ☐

Age of youngest child:

Less than 3years ☐ 3- 8yrs ☐ 9-12ys ☐ 12-18yrs **(> 12 yrs)** ☐

4. Place of residence:

Tulkarem ☐ Qalqelia ☐ Nablus ☐ Salfeet ☐

Jenin ☐ Jericho ☐ Ramallah ☐ Bethlehem ☐

Hebron ☐ Yatah ☐ Other Specify_____

5. Last Academic degree:

Bachelors in Midwifery ☐ Post-graduate midwifery ☐ Master Degree ☐

6. Place of work now:

Tulkarem (Thabet Thabet) ☐ Qalqelia (Darwesh Nzal) ☐

Nablus (Rafedia) ☐ Salfeet (Yaser Arfat) ☐

Jenin (Khalel Sluiman) ☐ Jericho ☐

☐

Palestinian Medical Complex Ramallah Wing

Beet Jallah (Al-Hussen) ☐ Hebron (Alia) ☐

Yatah (Abu Al-Hassan Qasem ☐

7. How long have you been in the field of midwifery?

less than 5 years ☐ 5 -9 years ☐ More than 9 years ☐

8. Type of job:

a. Midwife ☐

b. Head of Department ☐

c. Assistant head nurse ☐

9. You are working: You can check more than one answer

a. Stright **Mo**rning shifts b. Straight **E**vening shifts c. Straight Night shifts

d. Morning Evening shifts e. Morning, Evening & Night shifts

f. Evening & Nightshifts. g. Morning & nightshifts.

Please put a circle around each appropriate choice for you:

	JOB SATISFACTION SURVEY	Strongly Disagree	Disagreemoderately	Disagree slightly	Agree slightly	Agree moderately	Agree very much
1	I feel I am being paid a fair amount for the work I do.	1	2	3	4	5	6
2	There is really too little chance for promotion **in** my job.	1	2	3	4	5	6
3	My supervisor is quite competent in doing his/her job.	1	2	3	4	5	6
4	I am not satisfied with the benefits I receive.	1	2	3	4	5	6
5	When I do a good job, I receive adequate recognition for my work.	1	2	3	4	5	6
6	Many of our rules and procedures make doing a good job difficult.	1	2	3	4	5	6
7	I like the people I work with.	1	2	3	4	5	6
8	I sometimes feel my job is meaningless.	1	2	3	4	5	6
9	Communications seem good within this organization.	1	2	3	4	5	6
10	Raises are too few and far between.	1	2	3	4	5	6
11	Those who do well on the job stand a fair chance of being promoted.	1	2	3	4	5	6
12	My supervisor is unfair to me.	1	2	3	4	5	6
13	The benefits we receive are as good as most other organizations offer.	1	2	3	4	5	6
14	I do not feel that the work I do is appreciated.	1	2	3	4	5	6
15	My efforts to do a good job are seldom blocked by red tape (or by administrative obstacles).	1	2	3	4	5	6
16	I find I have to work harder at my job because of the incompetence of people I work with.	1	2	3	4	5	6
17	I like doing the things I do at work.	1	2	3	4	5	6
18	The goals of this organization are not clear to me.	1	2	3	4	5	6

		Disagree very much	Disagree moderately	Disagree slightly	Agree slightly	Agree moderately	Agree very much
19	I feel unappreciated by the organization when I think about what they pay me.	1	2	3	4	5	6
20	People get ahead as fast here as they do in other places.	1	2	3	4	5	6
21	My supervisor shows too little interest in the feelings of subordinates.	1	2	3	4	5	6
22	The benefit package we have is equitable.	1	2	3	4	5	6
23	There are few rewards for those who work here.	1	2	3	4	5	6
24	I have too much to do at work.	1	2	3	4	5	6
25	I enjoy my coworkers.	1	2	3	4	5	6
26	I often feel that I do not know what is going on with the organization.	1	2	3	4	5	6
27	I feel a sense of pride in doing my job.	1	2	3	4	5	6
28	I feel satisfied with my chances for salary increases.	1	2	3	4	5	6
29	There are benefits we do not have which we should have.	1	2	3	4	5	6
30	I like my supervisor.	1	2	3	4	5	6
31	I have too much paperwork.	1	2	3	4	5	6
32	I do not feel my efforts are rewarded the way they should be.	1	2	3	4	5	6
33	I am satisfied with my chances for promotion.	1	2	3	4	5	6
34	There is too much bickering and fighting at work.	1	2	3	4	5	6
35	My job is enjoyable.	1	2	3	4	5	6
36	Work assignments are not fully explained.	1	2	3	4	5	6

		Disagree very much	Disagree moderately	Disagree slightly	Agree slightly	Agree moderately	Agree very much
1.	**Perceived Organizational Support:**						
1	The hospital values my contribution to its well-being.	0	1	2	3	4	5
2	The hospital fails to appreciate any extra effort from me	5	4	3	2	1	0
3	The hospital would ignore any complaint from me	5	4	3	2	1	0
4	The hospital really cares about my well-being	0	1	2	3	4	5
5	Even if I did the best job possible, the hospital would fail to notice.	5	4	3	2	1	0
6	The hospital cares about my general satisfaction at work	0	1	2	3	4	5
7	The hospital shows very little concern for me	5	4	3	2	1	0
8	The hospital takes pride in my accomplishments at work	0	1	2	3	4	5
2	Perceived social support:						
1.	I trust my union(?) in defending me.	0	1	2	3	4	5
2.	I have conflict relationship with the doctors regarding my roles.	5	4	3	2	1	0
3.	It is so easy that doctor accusing me in any mistake.	5	4	3	2	1	0
4.	My manager is flexible in arranging my schedule according to any emergent personal life challenges.	0	1	2	3	4	5
5.	My manager trying to be fair with all employees.	0	1	2	3	4	5
6.	My manager is a good listener.	0	1	2	3	4	5

7.	My manager respects all sub-ordinates	0 1 2 3 4 5
8.	My manager is empowering me.	0 1 2 3 4 5
9.	The night duty is one of my challenges.	5 4 3 2 1 0
10.	I wish that I had straight day duty work.	5 4 3 2 1 0
11.	I want to keep on the relationship with my colleague that has developed while working in the hospital.	0 1 2 3 4 5
12.	I get the emotional help and support I need from my family	0 1 2 3 4 5
13.	I can talk about my work problems frankly with my family.	0 1 2 3 4 5
14.	My family is supporting my work decision.	0 1 2 3 4 5
15.	Life management support**(?)** that I **get** from my family helps me to go through my work events.	0 1 2 3 4 5
16.	I have friends with whom I can share my joys and sorrows.	0 1 2 3 4 5
17.	I can count on my friends when things go wrong.	0 1 2 3 4 5

		Disagree very much	Disagree moderately	Disagree slightly	Agree slightly	Agree moderately	Agree very much
3	**Intention to stay working in the hospital:**						
1.	I would be happy to stay in this hospital in the current situation.	0	1	2	3	4	5
2.	I am obligated to stay in the hospital regardless of all challenges.	0	1	2	3	4	5
3.	I will stay in the hospital if I have more salary and more incentives.	0	1	2	3	4	5
4.	I want to stay regardless of the alternative opportunities available to me.	0	1	2	3	4	5
5.	I will leave the hospital **if** another work opportunity becomes available.	5	4	3	2	1	0
6.	I have a plan to leave the hospital next year.	5	4	3	2	1	0
7.	I am planning to change my profession whenever it is possible.	5	4	3	2	1	0
8.	I have intention to stay if we have system of part time duty as other countries.	5	4	3	2	1	0

THANK YOU!

Annex (5): List of expertise

قائمة بأسماء محكمي الاستبانة

Name	Place of work
Mohanad Khader	**Arab American University**
Jamal Qadoumi	**Arab American University**
Aidah Alkaissi	**Al Najah University**
Amal Abu Awad	**Ibn Sina College / MoH**

Annex (6): Approval from Al-Quds University

بسم الله الرحمن الرحيم

معهد التنمية المستدامة

Institute of Sustainable Development

التاريخ: 1/12/2013

الى من يهمه الأمر،،

تحية طيبة وبعد،،

تقوم الطالبة سمر فاروق المغاري / تخصص بناء مؤسسات وتنمية بشرية ورقمها الجامعي (21110891) ببحث ما يتعلق نحو تطوير الموارد البشرية " دراسة حالة القابلات في وزارة الصحة" مما يستلزم من بحثها جمع المعلومات والاستبيان والمقابلات، فنرجو السماح لها بذلك، بما يخدم أغراض البحث العلمي.

مع جزيل الشكر،،

د. عزمي الاطرش

مدير معهد التنمية المستدامة

معهد التنمية المستدامة
Institute of Sustainable Development

1/12/2013

Jerusalem – Abu Deis
Tel / Fax: 009722790345
P.O.Box: 51000, 20002

القدس- أبوديس
تلفاكس 009722790345
ص.ب: 51000 او 20002

Annex (7): Agreement of MOH

State of Palestine
Ministry of Health - Nablus
General Directorate of Higher & Continuing Education

دولة فلسطين
وزارة الصحة- نابلس
الإدارة العامة للتعليم الصحي

Ref.: .....
Date:.....

الرقـــم: .....
التـاريخ: .....

الأخ مدير عام الادارة العامة للمستشفيات المحترم،،،
الأخ مدير مجمع فلسطين الطبي المحترم،،،

تحية واحترام،،،

الموضوع: تسهيل مهمة – جامعة القدس

تماشياً مع سياسة وزارة الصحة المتعلقة بتعزيز التعاون مع الجامعات والمؤسسات الأكاديمية بإتاحة فرص التدريب أمام الطلبة والخريجين والباحثين في المؤسسات الوطنية وإسهاماً في تنمية قدراتهم.

يرجى تسهيل مهمة **الطالبة سمر فاروق المغاري – تخصص بناء مؤسسات وتنمية بشرية –معهد التنمية المستدامة – جامعة القدس**، في عمل دراسة تتعلق بتطوير الموارد البشرية بعنوان " **دراسة حالة القابلات في وزارة الصحة**"، وذلك من خلال السماح للطالبة بتوزيع استبانة الدراسة على القابلات وعمل مقابلات بالتعاون مع الباحثة باسمة القواسمة في **مستشفيات وزارة الصحة في الضفة الغربية وفي المجمع الطبي**، للحصول على المعلومات التي يحتاجها البحث، وانه سيتم الالتزام بمعايير البحث العلمي والحفاظ على سرية المعلومات.

مع الاحترام،،،

د. أمل ابو عوض
ق. أ. مدير عام التعليم الصحي

نسخة: مدير معهد التنمية المستدامة المحترم/ جامعة القدس

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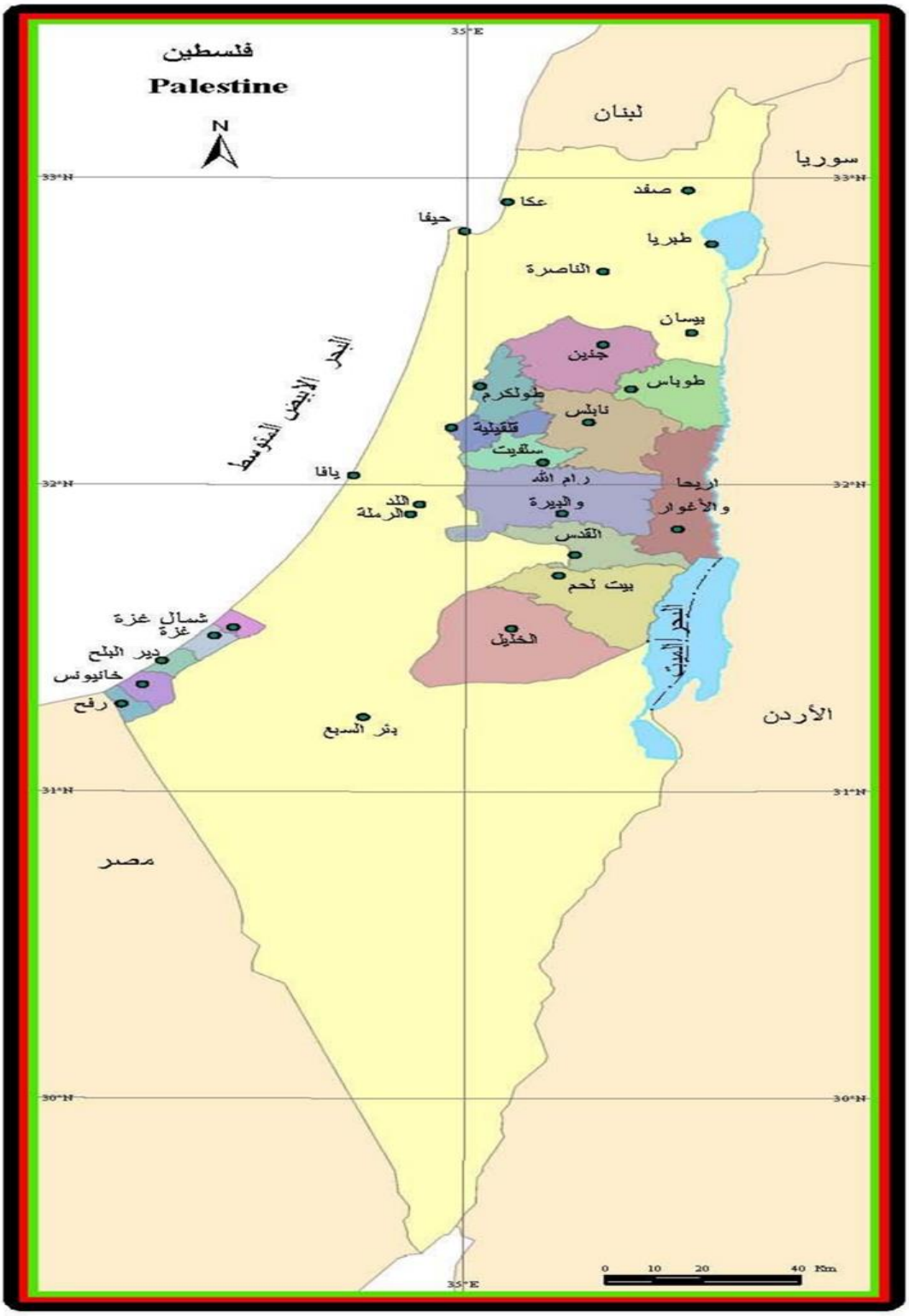
E-mail: pnamoh@palnet.com
ص.ب. 14
تلفاكس: 09-2333901

Annex (8): Map of Palestine



عنوان الدراسة: نحو وضع استراتيجية لتنمية المصادر البشرية: حالة القابلات في فلسطين.

إعداد: سمر المغاري

إشراف: د. أسماء الإمام

ملخص الدراسة

يعتبر النقص الحاد في أعداد الممرضات والقابلات مشكلة عالمية. هدفت الدراسة الحالية إلى معرفة مستوى كل من الرضى الوظيفي، مستوى الدعم الذي تتلقاه القابلات من المستشفى، الدعم الاجتماعي ورغبة القابلات في ترك أو البقاء في المستشفى الذي تعمل به القابلة، ولتحقيق أهداف الدراسة فقد استخدمت الباحثة المنهج الوصفي، وتكونت عينة الدراسة من جميع القابلات اللاتي يعملن في أقسام الولادة في المستشفيات الحكومية بالضفة الغربية والبالغ عددهن 114 قابلة موزعات على تسع مستشفيات في كل من رام الله، نابلس، أريحا، جنين، الخليل، طولكرم، سلفيت، بيت لحم، وقلقيلية.

لجمع البيانات فقد استخدمت الباحثة مقياس الرضى الوظيفي من إعداد (JSS - Spector, 1994)، استبانة لقياس الدعم المتلقى من المؤسسة، استبانة لقياس الدعم الاجتماعي وهما من إعداد الباحثة، ومقياس الرغبة في ترك العمل في المؤسسة (ATS - Hinshaw and Atwood, 1984) كما تم إجراء 18 مقابلة فردية مع عينة من القابلات من شمال ووسط وجنوب الضفة الغربية. لتحليل البيانات فقد استخدمت الباحثة برنامج الرزم الإحصائية للعلوم الاجتماعية (SPSS, version 20)، وقد تم استخدام التكرارات، المتوسط الحسابي، النسب المئوية، اختبار (ت)، واختبار تحليل التباين الأحادي.

بينت نتائج الدراسة أن 81.7% من القابلات المشاركات في الدراسة حاصلات على درجة البكالوريوس في القبالة، 65% يتراوح دخلهن الشهري بين 2000 – 3000 شيكل، 74.6% كن متزوجات، 53.5% يعملن لمدة تقل عن خمس سنوات. وأظهرت النتائج أن 90.4% من القابلات أبدين رضاهن عن برنامج تعليم القابلات، ويرجع ذلك إلى مرونة البرنامج وقابليته للتطبيق، شمولية البرنامج، الاعتراف بالبرنامج، كفاءة المحاضرين والمدربين، والثقة بالنفس. وأفاد 81.5% من المشاركات في الدراسة بوجود بروتوكولات عمل في الأقسام، 59.6% تلقوا تعليمات كافية حول تلك البروتوكولات، و 79% يطبقن البروتوكولات خلال عملهن، وتبين أن 45.6% أظهرن رضاهن من فرص التقدم والتطور المهني المتوفرة، بينما أظهر 54.4% عدم رضاهن من فرص التقدم المهني ويرجع ذلك إلى قلة الفرص المتوفرة، تحيز الإدارة لأشخاص معينين وعدم الحيادية، والنقص الحاد في أعداد القابلات.

بالنسبة لمستوى الرضى الوظيفي فقد تبين أن المتوسط العام على مقياس الرضى الوظيفي بلغ 3.305 وقد كانت أعلى المستويات في أبعاد الإشراف، زملاء العمل، وطبيعة العمل، في حين كانت أدنى المستويات في الترقيات، الراتب، وظروف العمل.

كما تبين أن مستوى الرضى عن الدعم المتلقى من المؤسسة كان متدني حيث بلغ المتوسط العام للدرجات 2.68 ، بينما كان الرضى عن الدعم الاجتماعي متوسط وبلغ المتوسط العام للدرجات على مقياس الدعم الاجتماعي 3.62، أما بالنسبة للرغبة في ترك المؤسسة فقد تبين أن المتوسط العام للدرجات بلغ 2.37 ويدل ذلك على عدم وجود رغبة لدى القابلات لترك مكان عملهن الحالي.

وأظهرت النتائج وجود علاقة إيجابية ذات دلالة إحصائية عند مستوى ≤ 0.01 بين الرغبة في ترك المؤسسة والرضى الوظيفي، كما كانت العلاقة دالة إحصائياً عند مستوى ≤ 0.05 بين الرغبة في ترك المؤسسة والدعم المتلقى من المؤسسة، في حين لم تكن العلاقة دالة إحصائياً بالنسبة للدعم الاجتماعي. وبينت النتائج عدم وجود فروق ذات دلالة إحصائية في كل من الرغبة في ترك المؤسسة، الرضا الوظيفي، الدعم المتلقى من المؤسسة والدعم الاجتماعي تعزى لكل من عمر القابلة، الدرجة العلمية، سنوات الخبرة، الحالة الاجتماعية، الدخل الشهري، مكان العمل، ونظام المناوبات.

بالنسبة للمقترحات لتطوير مهنة القبالة فقد أفادت 70.9% من المشاركات في الدراسة بضرورة توفر برامج التعليم المستمر، بالإضافة إلى الحوافز المادية (24.7%)، توظيف عدد كافي من القابلات (22.4%)، توفر بروتوكولات واضحة (21.2%)، المشاركة في اتخاذ القرار (20%)، الوصف الوظيفي (20%)، الحماية من الأضرار والمخاطر (14%)، إضافة إلى عوامل أخرى مثل وجود اتحاد أو جمعية خاصة بالقابلات، زيادة الوعي الجماهيري بأهمية القبالة، تبادل الخبرات مع مؤسسات صحية أخرى، العدالة في توزيع المهام، والأمن الوظيفي.

وأظهرت نتائج المقابلات الشخصية أن أكثر من نصف القابلات كن راضيات عن عملهن كقابلة وذلك بسبب حبهن لمهنة القبالة، كما أن 61.1% من القابلات كن راضيات عن عملهن بسبب الشعور بالاستقلالية في العمل والقدرة على اتخاذ القرارات، كما أن 33.3% كن راضيات عن عملهن بسبب الشعور بالثبات والأمان الوظيفي، في حين أن فقط 16% أرجعن سبب الرضا إلى الراتب والحوافز المادية، في المقابل تمثلت أسباب عدم الرضا الوظيفي في ضغط العمل الزائد لدى 44.4% من القابلات، كما أفادت 22% من القابلات إلى عدم وجود ترقيات مبنية على أساس مهني، كما أشارت 16.6% إلى عدم توزيع جدول المناوبات بشكل عادل، بالإضافة إلى ساعات العمل الطويلة خاصة في المناوبات الليلية.

بالنسبة للرغبة في البقاء في العمل الحالي أو تركه فقد تبين أن 77.7% من القابلات يرغبن في البقاء في عملهن الحالي بسبب حبهن لمكان عملهن، كما أن 50% من القابلات أبدين رغبتهن في البقاء في عملهن بسبب التطور الحاصل في مهنة القبالة، 27% يرجعن ذلك إلى الشعور بالأمان في مكان عملهن.

بالنسبة للاستراتيجيات المقترحة لتطوير مهنة القبالة فقد ذكرت 61.1% من القابلات أن تطوير مهنة القبالة يكمن في المشاركة في المؤتمرات العلمية وورش العمل الخاصة بالقبالة، كما أفادت 50% من القابلات بالحاجة إلى توفر بروتوكولات مكتوبة وواضحة مبنية على معايير محددة في جميع

أقسام الولادة، في حين أن 44% يرين ضرورة توفير أعداد كافية من القابلات تتناسب مع حجم العمل اليومي، 22% يرين بضرورة تغيير نظرة المجتمع نحو مهنة القبالة وزيادة مستوى الوعي حول الدور الهام للقابلة في النظام الصحي، بالإضافة إلى إجراء البحوث العلمية وتبادل الخبرات مع المستشفيات المختلفة.

بالنسبة لبرامج تعليم القبالة في الجامعات فقد أفادت 44% من القابلات بأن برامج تعليم القبالة مناسبة بدرجة كافية وتغطي غالبية المواضيع التي تحتاجها القابلة، كما أفادت 33.3% من القابلات بالحاجة إلى تقليل الفجوة بين الجانب النظري والجانب العملي وزيادة ساعات التدريب العملي خلال برنامج الدراسة، كما أفاد 33.3% بضرورة اختيار الطالبات المناسبات للالتحاق ببرنامج الدراسة في الكليات المختلفة.

وفي الإجمال فإن نتائج هذه الدراسة تظهر الحاجة إلى العمل على تعزيز مستوى الرضى الوظيفي وزيادة الدعم المتلقى من المؤسسة من أجل بقاء القابلات في مكان عملهن والعمل على توظيف أعداد جديدة من القابلات لمواجهة النقص في أعداد القابلات العاملات في المستشفيات الحكومية.