Deanship of Graduate Studies

Al-Quds University

جامعــة القـدس

Evaluation of the Referral Health Care System between Primary Health Care Centers and Al- Ahli Arab Hospital

Haleema Ahmed Mousa El-Za'neen

MPH Thesis

Jerusalem – Palestine

1431/ 2010

Evaluation of the Referral Health Care System between Primary Health Care Centers and Al-Ahli Arab Hospital

Prepared By:

Haleema Ahmed Mousa El-Za'neen

BSN: Palestine College of Nursing

Supervisor:

Dr.P.H Yehia Abed
Associate Professor of Epidemiology

A Thesis Submitted in Partial Fulfillment of Requirement for the Degree of Master of Public Health School of Public Health – Al-Quds University

1431/2010

Al-Quds University
Deanship of Graduate Studies
School of Public Health

Thesis Approval

Evaluation of the Referral Health Care System between Primary Health Care Centers and Al- Ahli Arab Hospital

Prepared By: Haleema Ahmed Mousa El-Za'neen
Registration No.: 20612248

Supervisor: Dr. Yehia Abed

Master thesis submitted and accepted, Date: / / 2010
The name and signatures of the examining committee members as follows:

1. Head of Committee	**Dr. Yehia Abed**	**Signature**.....
2. Internal Examiner	**Dr. Bassam Abu Hamad**	**Signature**.....
3. External Examiner	**Dr. Ayoob El Alem**	**Signature**.....

Jerusalem – Palestine

1431/2010

Dedication

Lots of thanks and love to my Parents, who never stopped supporting and encouraging me

I would like to express my appreciation and gratitude to my brothers, sisters for their patients and support

To my love friends for endless, support , help and encouragement.

Declaration

I certify that this thesis submitted for the degree of Master is the result of my own research, except where otherwise acknowledged, and that this thesis (or any part of the same) has been submitted for a higher degree to any other university or institution.

Signed: _____

Haleema Ahmed Mousa El-Za'neen

Date: / /2010

Acknowledgement

My special appreciation with deep respect to Dr. Yehia Abed my academic supervisor for his patient, friendly and continuous support and great advices.

Special thanks to Dr. Bassam Abu Hamad the dean of the school of public health for his support and encouragement, provide great advice.

Thanks and deep respect to all teachers who taught me at the School of Public Health and provided me a new knowledge and skills.

Special thanks to Miss Suhaila Tarazy the general director of Al-Ahli Arab Hospital for her co-ordination, co-operation and agreement to conduct this study.

Special thanks and appreciation to Dr. Yousif El-Jesh, Dr. Ashraf El-Jedy, Dr. Rasmia El-Ghsoob, Dr. Ibraheem El-Borsh, Dr. Adnan Rady, Dr. Sa'eed Dalool, Dr. Younis Awadallah for their valuable advises in the construction of the questionnaire.

Special thanks and appreciation to Mr. Sa'di Abu Awad, Mr. Jameel El-Masry, Mr. Mo'een El-Kreery, Mr. Jehad Matter for their valuable advises in the construction of the questionnaire.

All thanks to the supervisors of Al-Ahli Arab Hospital who provided me with their perspective, kindly help and support in data collection, especially, Mr. Sa'ed Abu Shawesh, Mr. Isma'l Abu Etarabeesh, and Mr. Saed El-Frangy.

All thanks for all doctors and all nurses who working at Al-Ahli Arab Hospital and provided me with their perspective during data collection.

My special thanks to the nice group with whom I spent the best days in my education years, my colleagues at the School of Public Health, also for the team who are working there for their endless help.

My deep thanks to my classmate the MPH program, Mrs. Intisar El-Far, and Mrs. Arwa Shalabi for their endless support and help.

My deep thanks to all my colleague and friends Specially Mrs. Maysoun Turban, Mrs. Hussnia Hijazi and Mrs. Ra'eda Badah at the Palestine Collage of Nursing for their endless support.

Special thanks to Mrs. Fairouz El-Far whom printing my papers for her support and endless help.

My deep thanks to my all love friends for their endless support.

Finally, I would like to thank all people and patients who participated in this study and gave it a meaning.

بسم الله الرحمن الرحيم

قَالُوا سُبْحَانَكَ لَا عِلْمَ لَنَا إِلَّا مَا عَلَّمْتَنَا إِنَّكَ
أَنْتَ الْعَلِيمُ الْحَكِيمُ

(صدق الله العظيم)

Abstract

Universally, referral services are very important for any health care system in order to ensure continuity and complementariness of health care services. Referral services are important for ensuring effectiveness, efficiency and quality of health services. The overall aim of this study is to evaluate the status of referral services at Al-Ahli Arab Hospital; a non-governmental hospital serving vulnerable populations in particularly refugee patients referred from UNRWA health centers. The study could help in improving health services for the benefits of the hospital and the public as well.

A cross-sectional study was conducted between the years 2009-2010. Two standard questionnaires were developed; one for referred patients and the other for the health care providers. The number of health care providers included was 60, among them 84% responded. A cluster sample of 200 referred patients was taken with a response rate of 100%.

The study results reflected both the perceptions of health care providers and the referred patients towards the in-use referral system. The study clarified that the health staff were lacking adequate knowledge and awareness about the in-use referral system. The level of communication, follow up and feedback exchange among the referring and the referral organizations were limited. Additionally, referred patients were not adequately informed about their referral as only 39% of female patients had received information about their referral while the percentage was less among males (29.9%). In particular, referred patients reported lack of satisfaction about waiting system at the referral site. Also, the attitudes of health staff at the referral site were negatively perceived by the referred patients. Generally, female patients were more satisfied about the registration system than males (70.7%; 59.2% respectively). Female and male patients' satisfaction about the medical team behaviors was low with little variations between the two categories (38.5% and 37.7 respectively). Older people (over 61 years) tend to be more satisfied than young people; less than 18 years with 73.1% versus 63.6%.

The study clarified the general features of referral services at the concerned hospital and highlighted the main gaps and challenges encountering the referral process. Health providers should be familiarized about the referral system. Active dialogue among the referral and referring bodies need to be initiated and maintained. Referral patients should be more informed and their concerns should be taken into account.

Table of Contents

List of Abbreviations

CMS	**Church Missionary Society**
GDN	**Gross National Product**
GDP	**Gross Domestic Product**
GS	**Gaza Strip**
MMS	**Medical Military Services**
MOH	**Ministry of Health**
MOHE	**Ministry of Higher Education**
NGOS	**Non-Governmental Organization**
OPT	**Occupied Palestinian Territories**
NIS	**New Israeli Shekel**
PCPs	**Primary Care Providers**
PHC	**Primary Health Care**
PNA	**Palestinian National Authority**
SPSS	**Statistical Package for Social Sciences**
UN	**United Nation**
UNICEF	**United Nations Children's Fund**
UNRWA	**United Nations Relief and Works Agency**
USD	**United State Dollar**
WA	**Welfare Association**
WB	**West Bank**
WHO	**World Health Organization**

Definitions of Terms

Referral Any process in which health care providers at lower levels of the health system, who lack the skills, the facilities, or both to manage a given clinical condition, seek the assistance of providers who are better equipped or specially trained to guide them in managing a clinical condition in a patient.

Primary Health Care Preventive, diagnostic, treatment, rehabilitative and support services are provided for individuals, it is the means through which many health services and interventions are provided for local communities.

Primary Health Care Center A center that provides services which are usually the first point of contact with a health professional.

A patient Any person who receives medical attention, care, or treatment. Although one who is visiting a physician for a routine check-up.

Communication It is the process of exchanging information and understanding from one to another.

Feedback The process in which part of the output of a system is returned in order to regulate its further output to its input response to an inquiry or experiment.

List of Tables

List of Annexes

Chapter 1: Introduction

1.1 Research Background

The referral process is an interesting and great subject to study for every institution. This study is very important for Ministry of Health, UNRWA, and other health organizations. Through the referral process each patient has the right to obtain a higher level of providing appropriate health services through a well referral process. So that, it is considered as a component of quality care. The referral process has two types: self-referral, which is by the person him/ herself, and referral by organizations through health providers responsible for referring the patients.

The referral starts from lower level of health services to higher level with adequate qualifications and specialized, skills and experts' people, more facilities and advanced equipments. The primary health care depend on the success of the referring process so that the referral system is consider as integral part of primary health care and secondary care. A functional referring process is a necessary part of primary health care to attain high levels of health services.

The proper and clear communication is the principle of the referral system to be effective, it have two directions: upward direction which is from the lower level prescribing all information related to the problem, and backward direction about the findings, actions were done and follow up. The design of referral for easy communication in both directions. In general, there is a weak part in the backward process from the higher level.

Distance and lack of transport are major obstacles and causes of delays for surgical and obstetric referrals, in spite of evident need to treat this problem, it still difficult to persuade

decision-makers in poor countries that it is execution and value to provide emergency evacuation as the researchers study which conducted in rural Niger (Bossyns, 2005).

Referring process between primary and secondary health care in a appropriate way is more accessible and affordable care provided for all. In addition, the patients access the right place with effective management and follow up provided a minimum cost. Because of more obstetric emergencies cannot be predicted a functional referral is a vital for health care during pregnancy and delivery. Families and health workers responsible for why, when, and how to referred the patient.

Maram project design a referral system from maternity home in PHC to secondary care in the hospital this design consists of three stage of referral: Stage1: rapid initial assessment.

Stage: 2 re-assess the pregnant prior to completing referral.

Stage: 3 follow up. This design includes two forms one for the pregnant or post partum, the other for the newborn; the form describes socio-demographic data of the woman, obstetric history. The literature focus on referral health care system shows great needs for it while there is still certain lake of its clarity (Maram protocol, 2005).

Palestinians are experiencing instable political status, as well there are many obstacles facing referral health care system. So the researcher conclude that there is more need to effective referral health as it help to offered quality of services.

Lack of awareness of guidelines and protocols, as well as inadequate training of health care providers, feedback is some of weakest point and constraints reported in the referral health.

This analytical cross sectional study is intended to evaluate the referral health care system at Al-Ahli Arab hospital to reflect awareness guidelines and protocols of referral health. The

study used two questionnaires to assess the awareness of health care providers, referred patients, and illustrates the client's perspectives about referral health care system guidelines and protocols.

With the best of researcher knowledge, this study is one of the first studies in Palestine, so it will be a basis for further researches regarding referral health system.

1.2 Research Problem

In Palestine, Despite of many workshops concern with this subject there is no research study shed the light on the referral system in Gaza Strip, only MARAM project survey of women and child health in the West Bank and Gaza Strip. It explained the problems of the pregnant woman that lead to refer her to the hospital. It considers that, Palestinian health facilities to develop and use the functional referral health system need to be supported by Ministry of Health. Challenges need further examination.

This study will evaluate the referral system, focus on guidelines, protocols, strong and weak points in the health referral system, area needs toe improved, as well as recommendation for future improvement from health care providers' point of views, and the researcher. Even the health care providers do not know about the referral health care system and its guidelines, it gives signal, which help encourage positive practicing and pointed the major obstacles facing by health directors.

1.3 Justification of the Study

The referral system is very important for all health organizations for continuous improvement of health. The referring process considered a basic principle between institutions, especially between all levels of health care system. The process must be a continuous and dynamic

process. The researcher believes that the health care system has problems with referral process, so the researcher studied and valuated the gaps in the referral system between the primary health care and secondary care in relation to referral process; in addition, she identified the weak aspects of this system. Despite of many workshops concern with this subject there is no research study shed the light on the referral system in Gaza Strip.

The researcher is interesting in conducting this study to shed the light about the gaps of the referral system among primary health centers and Al-Ahli Arab hospital.

This study was considered as the first and new one, which was conducted about referral health system in Gaza Strip. Also the study explores the weak points and the way to solve the problems. Furthermore this study contributes in health strategic planning for developing referral system.

1.4 Objectives of the Study

1.4.1 General Aim of the Study

The aim of this study to evaluate the referral system between primary health care centers and Al-Ahli Arab hospital in order to identify the gaps in the current system and to suggest corrective strategy for improving referral system.

1.4.2 Specific Objectives of the Study

1. To appraise the status of the referral system between PHC centers and Al-Ahli Arab hospital.
2. To identify strength and weakness aspects in the current referral system between PHC centers and Al-Ahli Arab hospital.

3. To illustrate health care providers and clients perspectives about the current referral system.
4. To assess health care provider concern with the guidelines or protocols concerned with managing referring patients from PHC centers to Al-Ahli Arab hospital.
5. To provide suggestions and recommendations for future possible interventions that may contribute and improve referral system.

1.5 Research Questions

1. What are the main causes of referring cases from PHC centers to Al-Ahli Arab hospital?
2. What is the status of current referral system of UNRWA?
3. What are the main strength and weak aspects in the current referral system between PHC centers and Al-Ahli Arab hospital?
4. What are the perspectives of health care providers and clients about the current referral system?
5. Are there a guidelines or protocols concerned with managing referring patients from PHC centers to Al-Ahli Arab hospital?
6. Are the guidelines and protocols applicable in proper way or not?
7. What are the suggestions and recommendations from this study for future possible interventions?

1.6 Feasibility and Cost

This study was conducted at Al-Ahli hospital in Gaza Strip. As requirement for the MPH at the School of Public Health, Al-Quds University. Discussion and exchange of ideas with responsible persons from School of Public Health and different specialists made the implementation of this study feasible. This study was self funded; the researcher was

responsible for all needed costs. It supervised by the School of Public Health and PHC administration; they provided the researcher with the necessary research support such as access to study population, and ethical approval to conduct the study.

1.7 Context of the Study

The researcher provided some helpful background information about Al-Ahli Arab hospital, . in order to put some perspective to referral health care system. The information that describes the health care services and the population who received the care are considered important for proper planning and development of care services. This study conducted in the Gaza Strip which has unique culture, therefore in the following paragraph some information about Palestinian population and their health status, health care system and services delivery in Palestine are provided. So some of the demographic, socio-economical and political factors were important to the study as it affects on the referral health care system.

1.7.1 Demographic context:

Palestine considered an important geographical and strategic location. It is located on the eastern of Mediterranean Sea. The people who lived in Palestine are Muslims and Christians. The generation of all races and nations were come from Canaanites to British occupation of Palestine since 1918. Palestine formed the southwestern part of large geographical unity in the eastern part of the Arab world. Lebanon boundaries from the north, Syria and Jordan from the east in a addition to Egypt and Mediterranean Sea from the west (annex 1). Palestine extent from Ras-AL-Nakoura in the north to Rafah in the south. Palestine has 27,000 sq. Km, including Tabariya, El-Hoola lakes and half of the area of Dead Sea. The total area is about 6,020 square kilometers. (MOH, 2005).

Geographically the Palestine Territories have two areas separated, the West Bank and Gaza Strip, West Bank is located on the west of Jordan River with area of 5,655 square kilometers. It has been under Israeli Military Occupation, together with East Jerusalem and Gaza strip since June 1967 (MOH, 2006). It is divided into four regions. The north region involves Nablus, Jenin, and Tulkarem district, the central region includes the district of Ramalla, and Jerusalem, the south region includes the districts of Bethlehem, an Al-khalil districts and sparsely populated Jordan valley includes Jericho (MOH, 2006).

Gaza Strip is a narrow piece of land lying on the coast of the Mediterranean Sea. Egypt bounders from south, and Mediterranean Sea from the west, in addition to Israel boundaries from east and north. It's long about 46 kilometers, and the width 5-12 kilometers (MOH, 2005). Gaza Strip administratively divided into five governorates Gaza city, North, Mid-Zone, Khan-Younis, Rafah (MOH, 2006).

It is a very crowded place with area 365 square kilometers and constitutes 6.1% percent of total area of Palestinian territory land (MOH, 2005). Population is mainly concentrated in the cities, small village, and eight refugee camps that contain two thirds of the population of Gaza Strip. The population density is 3,808 inhabitants/ km 2 (PCBS, 2007).

The estimated population in Palestine is 3.761,646 million, in West Bank the population is 2,345,107 million with average 62.3% while Gaza Strip represents 37.7% about 1,416,539 million from total number (PCBC, 2007).

According to UNRWA records Palestinian registered refugees totaled to 4.7 million at end of 2008, of whom 41.8% in Jordan, 23.0% in Gaza Strip, 16.3% in the West Bank, 9.9% in Syria and 9.0% in Lebanon.

The percentage of Palestinian refugees in the Palestinian Territory 2009, represents 44.1% of the total Palestinian Territory population, of which 30.2% in the West Bank and 69.2 % in Gaza Strip.

The annual growth rate of Palestinian population reported as 2.6% (MOH, 2005). According to The Demographic Health Survey (DHS), conducted by (PCBS) in 2004 the trend of fertility rate is 5.6 % births per woman, 5.2 % in the West Bank and 6.6 % in Gaza (PCBS, 2004). The sex ratio which is Males to female ratio about 102.7 in WB to 102.5 in Gaza (MOH, 2005). The female age group from (15-49) is estimated 43 percent in Gaza Strip while West Bank 46.4 percent (MOH, 2005).

In Palestine the first leading causes of death among general population was cardiac diseases, accidents the second cause. Also the heart diseases are the leading cause of death among people aged 60 years and over. Despite of the leading cause of death for children were accident

1.7.2 Socio-economic Context:

The majority of Palestinians are considered as a poor people with low income especially in this period due to siege and closures from Israel army.

Population density rate in the Gaza Strip is about 3,808 inhabitants per one square kilometer (PCBC, 2007). The actual density rate is higher than the estimated due to the presence of Israeli settlements (MOH, 2003). In 2004 dependency ratio for Palestinian is about 0.91 it was decreased in 2005 to 0.90, 1.07 for Gaza Strip to 1.14 in West Bank (MOH, 2006).

Gross National Product (GNP) in Palestine per-capita decreased from 1,806 United States Dollar (USD) in 1999 was decreased to 1,039 million in year 2005, gross national product (GNP) in 1999 was 5,454 million USD was decline to 4,169 million in year 2005 while Gross Domestic Product (GDP) in year 1999 was 4,517 million USD in 2005 were decreased to 3,832 USD.

GDP per-capita in 1999 was 1,496 USD was decreased to 955 USD in year 2005 (MOH, 2005). The unemployment rate in Palestine is 32% 46.6% in Gaza Strip and 30.3% in West Bank, with poverty rate 44% in year 2005 this rate is unstable due to political situation and closure of the Palestinian regions, cities and other constrains (MOH, 2005).

1.7.3 Health Care Context:

The Palestinian health care system is a mixture of governmental, UNRWA non governmental (NGOs), private sector, and Medical Military health services (MMS), which are provided all health services for all people (MOH, 2005). Ministry of Health is the health authority who is responsible for supervision, regulations, licensure and control of all health services including primary, secondary, and tertiary care (National Strategic Health Plan, 2003).

The secondary healthcare is provided by the governmental, non-governmental, UNRWA and private sectors. The MOH is responsible for a significant portion of the secondary healthcare delivery system (60-70% of general and specialized hospital beds) and more than this proportion in hospital services (about 70% of hospital services).

There are 76 hospitals, 54 of them in WB and 22 in Gaza Strip. MOH responsible and owns 22 hospitals 10 in Gaza Strip, and there are 12 hospitals in West Bank (MOH, 2005).

UNRWA owns one hospital in Qqlqelia. NGOs operate 31 hospitals, 10 hospitals in Gaza Strip and 31 hospitals in West Bank (MOH, 2005).

The non-MOH hospitals constitute 71.1% of the total hospitals in Palestine (about 63.6% of the total hospitals in the WB and 54.5% of the total hospitals in GS).

The NGOs hospitals constitute about 39.5% of the total hospitals. They constitute about 37.1% of the total hospitals in the WB. In the GS, they constitute about 45.5% of the total hospitals.

The NGOs have not existed at the secondary healthcare services in Jericho, Qalqilia, Salfiet, Mid-Zone, and Rafah.

Private sector operates 19 hospitals in West Bank including Jerusalem and two hospitals in Gaza Strip (MOH, 2005).

The estimated national health expenditures per capita in West Bank and Gaza Strip at 122 USD in 1996, which means 8.6% of GDP. The national health expenditures ranged between 6.6% and 8.2%.

In 2002 MOH expenditures as percent of GDN was 3.2% about one third of all health care expenditures are directed to MOH, health facilities (including capital expenditures), while NGOs and UNRWA making up the rest (MOH, 2003). MOH coordinated with UNRWA and NGOs are health care providers for Palestinian women health especially for pregnant woman and her baby during antenatal period which is need more attentions.

1.7.4 Primary Health Care Services (PHC):

Primary health care is the basic level of care provided equally to everyone by providing preventive, curative and rehabilitative services to maximize health and well being (MOH, 2005). PHC centers try to offer accessible and affordable health services for all Palestinians regardless the geographical locations (MOH, 2006). Palestinian PHC is the major component of health care system; this system has provided health care to all Palestinian people especially for children and other vulnerable groups (MOH, 2006).

PHC centers in Palestine provide primary and secondary health care services as well as tertiary services. In the last five years and after the uprising of second Intifada, PHC centers in Palestine have been developed in a dynamic way (MOH, 2006), but the management system

still not develop. As a result of the needs assessment carried out by the MOH-Department of Planning, both at the district and national level, it was determined that Palestinian society looks for more PHC interventions at community level with greater emphasis on health promotion, education and prevention (MOH, 1999). Therefore, the national strategy adopted objectives for health tackles specifically the utilization of the full potential of PHC services while improving secondary and tertiary care. The two focus of concern for the MOH with respect to public health as a whole and PHC in particular, have been health and education and environmental health, food safety, water quality and vector control (MOH, 1999). According to MOH policy, PHC centers classified into four levels offering different health services according to clinic level, these services include maternal and child health, family planning, care of chronic diseases, daily care, dental, mental services and other services. The MOH is working with other health sectors in providing the primary health services, as MOH is considered the main provider with 63.65% from the total PHC centers, followed by the NGOs with 28.3%, then UNRWA with 8.1% (MOH, 2006).

At the end of 2005, there are 654 PHC centers in Palestine(annex 2), the total number of PHC was increased compared with 595 in years 2000, these centers are cared for about 3.7 million people, 129 of these centers are in Gaza Strip, 56 of them were managed by MOH (MOH, 2005; MOH, 2006). Despite increasing the number of PHC centers since the establishment of the PNA, Palestinian health services have been developed much closer to a hospital- based model, with a concentration on a few key public hospitals (MOH, January 2005). The average ratio of person per center was 12,774 in Gaza Strip; this ratio is high reflecting the density in Gaza Stripe. PHC system in Gaza Stripe is well established and functioning despite the high population density and the over crowded of population, but these changes doesn't accompanied by progress in the referral health care system (MOH, 2006).

Despite the patients fact Palestinian MOH has developed advanced diagnosis and treatment facilities in Gaza Strip and West Bank, it is necessary to refer patients who are need special diagnosis, care and managed through special treatment which are not available in MOH institutions to other institutions outside the Palestinian MOH. These patients are referred for consultations or hospitalization at NGO, private health providers in Gaza Strip, West Bank and East Jerusalem or to public health providers in Egypt, Jordan, and Israel (MOH, 2006).

It is important to stress that the treatment abroad embraces all patients who receive treatment consultation (out-patient) or hospitalization (in-patient) outside the Palestinian MOH institutions, either in health facilities in Gaza Strip, West Bank, East Jerusalem, or in Egypt, Jordan and Israel.

In Palestine, the total number of patients referred for hospitalization and consultation increased from 6,200 in year 2000 to 31,744 in year 2004 and 31,721 in year 2005 with an increasing percentage of 41.2% in comparison with the year 2000 (MOH, 2006). For 2004 the total cost of treatment abroad was 261,356,601 NIS (58,079,245 USD), which represented 46 % of the actual expenditure for 2004. For 2005 the total cost of treatment abroad was 268,044,025 NIS (59,565,339 USD), the running cost MOH budget in 2005 was 139,584,400 USD. The treatment abroad represented 42.7% of actual running expenditure for 2005 (MOH, 2006).

It is imperative, therefore, for healthcare providers to focus on and deliver quality services to regain patient confidence. It should be to introduce patient-driven quality standards to enable

service providers to better address patients' needs. In turn, such measures should bring patients back to a system that designed to serve their needs as well or better than the services abroad. When the quality of the services improves, patients will feel reassured to seek curative services within the country. An indirect benefit to the country would be preserve its foreign exchange that be deployed in other sectors (El-Haj,2008).

1.7.5 Al-Ahli Arab Hospital

Ahli Arab Hospital is non governmental hospital; it is located in the Gaza Strip area of Palestine. Gaza lies on one of the oldest high-ways in the world, on the Mediterranean coast. It has been a cross-road of the Middle East for centuries, well before the arrival of Christianity or Islam. The hospital is a remarkable place, and was originally built in the 1882 by the Church Missionary Society (CMS), in the center of Gaza City. It became a service ministry of the Episcopal Diocese of Jerusalem in 1982. During the first Intifada it was the only non-Israeli hospital run by Palestinians in Gaza, working with the community. The work of healing continues to the present day (http://www.lynda. Us/content-Ahli.shtml).

Residents of Gaza Strip including fewer than twenty–five hundred are Christian get benefit of the hospital services. Ahli Hospital is still known and respected as a provider of the highest quality health care for all the women, children and men of Gaza. A significant portion of their care is charitable, as they minister to many of the poorest, in a community where over 60% of the residents live in refugee camps. During recent years Ahli Arab Hospital has responded to the needs of the people as they occur, in particular during the times of crises that related to the Palestinian Israeli conflict. Throughout its emergency program the hospital has continued to provide medical treatment to victims of the current crisis. The emergency team has been deployed to several heavily shelled sites to treat the injured, and help transport the wounded to medical

facilities. Al-Ahli Arab hospital also tailors its services to those vulnerable women, children and elderly who lack the basic necessities of life.

Ahli Arab Hospital is a profound illustration of the mission of the Anglican Church, and a visible expression of our concern for the community in our daily lives. The hospital plays an enormous role in the provision of general medical and surgical care and in the prevention of illness and disability to all people of the Gaza Strip, both residents and refugees, regardless of race, gender, ethnic background or political affiliation. The hospital is involved in organizing medical out-reach clinics to the most needed areas to bring primary care and home care services to villages and individuals who can't access health services from any other source. These villages are primarily located near the Israeli settlements and have been under a total siege for months. Residents are required to obtain a permit from the Israeli military offices in order to leave their villages. The hospital coordinates with the community leaders to host the free medical missions or help to evacuate patients who are in need for further medical treatment. The hospital provides free health care, including out-patient, diagnostic and in-patient services, transportation and food parcels for each family attending this out-reach program (http://www.lynda. Us/content-Ahli.shtml).

Al-Ahli Arab hospital is considered one of the medical health institutions in Gaza strip. It plays a role in providing primary, secondary and tertiary medical and surgical health services except vaccination program. All services is providing for people from Gaza provinces, in-spite of some patients may referred from primary centers to Al-Ahli Arab hospital to receive a medical and surgical care that don’t provided in there hospitals. Also Al-Ahli Arab hospital is considered as a referral hospital for a medical and surgical service to other hospital.

This study was conducted at this hospital which consists of 8 departments. The out patient clinic provided all services to all cases with average 2200 to 2500 cases monthly. There is also at average referred patients from primary health care centers about 400 to 450 monthly. Al-Ahli Arab hospital provides a major portion of services for Palestinians through a full range of diagnostic and management facilities for patients ranging in age from the neonate to elderly, and for both in-patients, and out-patients care. Al-Ahli Arab hospital consist of many departments, it includes reception department provided all services for all people; female medical surgical department; male medical surgical department; operation department; physiotherapy department, in addition to maternity wards with neonatal care. As well as maternity wards are providing an obstetric and gynecological services. The hospital working time is three shifts, for all workers from 7 in the morning to 2 in the evening except the administrative director and the medical director who attend the morning shift.

The health care providers in hospital are 57 nurses, 13 doctors, and 5 assistant anaesthetize doctor who are caring and providing services for all patients. Al-Ahli hospital have 81 beds are distributed for all departments. In spite of paying for the hospital the population visit it for accessible and utilized the services, and consultations. Any patient needs health services from general doctor must pay about 15 shekels and 25 shekels for specialist doctor. There is agreement between UNRWA and Ahli Arab Hospital for providing health services to referral cases. UNRWA covers the referring patient by paying about seventy to eighty dollars per day where the referred patient paid about 40 shekels about every admission day. The admission days vary from one day to five days for operation, and for medical patients the admission extends more than months for chronic patients, as the health condition need.

In summary, this chapter includes the general explanation of study which aimed to evaluate the referral health care system at Al-Ahli Arab hospital in Gaza Strip, to identify the gaps in the current system and suggest corrective strategy for improving referral system. Justifications of doing this study were mention above. Brief discussion about context of the study including demographic, socio-economic and health context all were mentioned.

1.8 Definitions

What is evaluation?

American Evaluation Association defined evaluation as: assessing the strengths and weaknesses of programs, policies, personals, product, and organizations to improve their effectiveness. It is the systematic collection and analysis of data needed to make decisions, a process in which most well-run programs engage from the outset (AEA web site, 2008).

It may be defined as a systemic determination of merit, wroth, and significance of something or someone. also used to valued subject of interest in a wide range of human effort, including the health care, foundations, government, and human services (AEA web site, 2008).

Referral

Can be defined as any process in which health care providers at lower levels of the health system, who lack the skills, the facilities, or both to manage a given clinical condition, seek the assistance of providers who are better equipped or specially trained to guide them in managing or to take over responsibility for a particular episode of a clinical condition in a patient. Furthermore, higher-level hospitals in developing countries do not treat only referred

patients; tertiary hospitals are frequently the first point of contact with health services for many patients. The functions of referral hospitals may broadly be categorized into:

a. The direct clinical services provided to individual patients within the hospital and the community.
b. A set of broader functions only indirectly related to patient care (Jamison, Breman, Measham, Alleyne, Claeson, Evans, Jha, Mills, Musgrove, 2006).

Primary Health Care

Is a vital means through which not only many preventive, diagnostic, treatment, rehabilitative and support services are provided for individuals, but importantly the means through which many health services and interventions are provided for local communities (WHO, 2005).

Primary Health Care Center

A center that provides services which are usually the first point of contact with a health professional. They include services provided by general practitioners, dentists, community nurses, pharmacists and midwives among others, (wikipedia, 2009)

A patient

Is any person who receives medical attention, care, or treatment. The person is most often ill or injured and in need of treatment by a physician or other health care professional, although one who is visiting a physician for a routine check-up may also be viewed as a patient. The word patient originally meant 'one who suffers'. This English noun comes from the Latin word patiens, the present participle of the deponent verb, patior, meaning I am suffering (wikipedia.org/wiki/Patient, 2008).

Communication

It is the process of exchanging information and understanding from one to another (Haimann, 1991).

Feedback

The process in which part of the output of a system is returned in order to regulate its further output to its input response to an inquiry or experiment (wordnetweb, 2009).

Chapter 2: Literature Review

This chapter discusses the literature review about what was written on referral health system and the studies conducted from different places and authors. The researcher tried to cover the major factors that affect on the referral health system which may help the policy-makers to recognize the most important aspect of this system. I hope to cover the points.

2.1 Definition and Concept

The term "**referral**" can refer both to the act of sending you to another doctor or therapist, and to the actual paper authorizing your visit. Also it is known as, the recommendation of a medical or paramedical professional. A referral is usually necessary to see any practitioner or specialist other than your primary care physician (PCP), if you want the service to be covered. The referral is obtained from your PCP, who may require first a telephone or office consultation (Kelly Montgomery, former About.com, 2009).

Referral is dynamic processes which we need it. The people are searching for obtaining a quality services especially in the health system, so the referral system is considered as a component of quality care. There are two types of referral: self-referral who decides to refer alone and referral by organization the health providers responsible for referral.

Referral is a special kind of pre approval that health plan members primarily those with Health Maintenance Organization must obtain from their primary care physician before seeing a specialist. Some plans require the referral to be in writing, while others will accept a phone call from your primary care physician. Be proactive, and make sure that your insurer has

received a referral before you make an appointment with your specialist (Kelly Montgomery, former About.com, 2009).

2.2 Literature Studies

Researchers carried out study in rural Mali (Sub-Sahran Africa); they evaluated the effect of national referral system to reduce maternal mortality rates through improving access to the quality of emergency obstetric care. The method was maternity referral system that included basic and comprehensive emergency obstetric care; transportation to obstetric health services and community cost-sharing schemes was implemented in six rural health districts in Kaye's region between December 2002 and November 2005. In an uncontrolled “before and after” study, the authors recorded all obstetric emergencies, major obstetric interventions and maternal deaths during a 4-year observation period (2003 to 2006). The primary outcome was the risk of death among obstetric emergency patients, calculated with crude case fatality rates and crude odds ratios. Analyses were adjusted for confounding variables using logistic regression. The number of women receiving emergency obstetric care doubled, maternal mortality rates decreased more among women referred for emergency obstetric care than among those who presented to the district health centre without referral also the reduction in deaths was attributable to fewer deaths from hemorrhage. The intervention showed rapid effects due to the availability of major obstetric interventions in district health centers, reduced transport time to such centers for treatment, and reduced financial barriers to care. Results showed that national programmes can be implemented in low-income countries without major external funding and that they can rapidly improve the coverage of obstetric services and significantly reduce the risk of death associated with obstetric complications (Fournier, Dumont, Tourigny, Dunkley, Drame, 2009).

United Kingdom is the area of authors study; they evaluated professional educational interventions; comparisons between ineffective strategies of passive dissemination of local referral guidelines; feedback of referral rates and discussion with an independent medical adviser. They conducted electronic searches of the Cochrane Effective Practice and Organization of Care group specialized register and the National Research Register. Randomized controlled trials, controlled clinical trials, controlled before and after studies and interrupted time series of interventions to change or improve outpatient referrals. Participants were primary care physicians. The outcomes were objectively measured provider performance or health outcomes. Authors concluded that a limited number of evaluations to base policy, active local educational interventions, secondary care specialists and structured referral sheets are shown to impact on referral rates, the effects of second opinion and other intermediate primary care (Akbari, Mayhew, Al-Alawi, Grimshaw, Winkens, Glidewell, Pritchard, Thomas, Fraser, 2008).

A study conducted by Kongnyuy, Mlava, van den Broek(2008) to study the feasibility of using criteria-based audit to improve a district referral system. The researchers used A criteria-based audit to assess the Salima District referral system in Malawi. A retrospective review of 60 obstetric emergencies referred from 12 health centers was conducted and compared with prior established standards for optimal referral of emergencies. Recommendations were made and implemented. Three months later, a re-audit was conducted (62 cases).

There were significant improvements in 4 out of 7 standards: adequate resuscitation before referral (33.3% vs. 88.7%; p = 0.001); delay of less than 2 hours from the time the ambulance is called to when the ambulance brought the patient to the hospital (42.8% vs. 88.3%; p = 0.014); clinician attends to patient within 30 minutes of arrival to hospital (30.8% vs. 92.6%; p

= 0.001) and feedback given to the referring health centers (1.7% vs. 91.9%; p <0.001). The rest of the three standards showed a high level of attainment (>95%) in both the initial audit and the re-audit: referred patients accompanied by a referral form; ambulances are available at all times and the district hospital is informed through short-wave radio by the health centre when a patient is referred. The researchers conclusions: Criteria-based audit can improve the ability of a district referral system to handle obstetric emergencies in countries with limited resources (Kongnyuy, Mlava, van den Broek, 2008)

A study described the referral completion from the perspectives of patients and primary care physicians and was identified predictors of adherence to the referral recommendation. The researchers were observed a cohort of 776 referred patients from the offices of 133 physicians in 81 practices and 30 states. Referring physicians and patients completed self-administered questionnaires at the time of the referral decision and 3 months later. Physicians reported that 79.2% of patients referred had a specialist visit, and 83.0% of patients indicated they completed the referral. The most common reasons for not completing the referral were lack of time. A longer duration of the patient relationship with the primary care physician and physician/staff scheduling of the specialty appointment were both positive predictors of referral completion. Finding from the study about 8 in 10 patients referred from primary care complete a specialty referral within 3 months. Researcher's suggestions that referral completion rates may be increased by assisting patients with scheduling their specialty appointments and promoting continuity of care (Forrest, Shadmi, Nutting, Starfield, 2007).

Rural Niger is area of researchers study; they established a benchmark for referral rate with interpretation of routine referral data to assess the performance of referral health system. Strict

and controlled implicated of existing clinical decision trees in a sample of rural health centers allowed the estimation of the corresponding need for and characteristics of curative referrals in rural Niger. Compliance of referral was monitored as well. Need was matched against actual referral in 11 rural districts. The referral patterns were registered so as to get an idea on the types of pathology referred. The referral rate benchmark was set at 2.5 % of patients consulting at the health centre for curative reasons. Niger's rural districts have a referral rate of less than half this benchmark. Acceptability of referrals is low for the population and is adding to the deficient referral system in Niger. Mortality because of under-referral is highest among young children. The study concluded that the referral programme approach deliver a health care leaves a large amount of unmet need for which only comprehensive, the benchmark suggested that well functioning health centers take care of the majority of present problems with patients, establishing a referral benchmark allowed evaluating routine referral rates in rural health centers for their curative services, health centers under routine conditions are seriously under referring, which lead to avoidable deaths, the exercise proposes a low-cost tool for other districts in the world to evaluate their referral system for curative services, the proposed benchmark is context specific and can not be used by simple extrapolation, Bossyns, Abache, Abdoulaye, Miye,. Depoorter, Van Lerberghe, 2006).

Maram is a project carried out in Palestine; the objective was to provide the appropriate referral practices as the maternity home needs. Referral in these protocols explained an appropriate service provided for mother and her baby and the process of referral from maternity home to the hospital. The design included the information concern with socio demographic data of the woman, obstetric history and vital assessment. It's consisted from two referral forms, one for the pregnant and the other for the baby. For effective management,

services providers must be commitment and applicants protocols. All referral cases need to follow the appropriate referral services (Maram protocol, 2005).

A study was carried out in a central Spain at a major outpatient surgery unit of the hospital clinic San-Carlos and health centers serving health area 7 in Madrid. The Prospective, descriptive, longitudinal study was analyzed the results obtained with a "one-stop" specialty service designed as a part of a collaborative program involving primary and specialized care in order to improve communication between levels of care and reduce the delay in referral and surgical treatment for patients eligible for outpatient surgery. Researchers sample was all Patients more than 14 years of age with a surgical condition involving the abdominal wall, palatial sinus, soft-tissue tumor, or proctologic disease. 188 patients were referred, more than two thirds (68.7%) had an abdominal wall condition eligible for direct referral, for diagnostic appointments was 96%. The delay from referral until surgery was reduced by 60%, The overall referral rate was 12.6%. the researchers concluded that the feasibility, acceptability, and cost-efficiency, the direct referral system has the potential to improve relations between primary and specialized care and enhance the quality of care by shortening the delay to treatment (Cerdan Carbonero, Sanz Lopez, Martinez Ramos, 2005).

Other study conducted in Madrid. It was observational, descriptive and cross-sectional study. The researchers studied the process of referral from primary care in a health area and evaluated the trends in the referral process. The researchers sample was all referrals, 13 doctors during three consecutive weeks, they were from three urban health centers in the area 2. The total number of visits attended was 6012. Measurements for patient, doctor and referral characteristics on every referral. The result was 349 referrals were studied. The rate of referral

5.8%. The referred patients, 65.5% women. 89.7% not urgent. The reason for referral was to accede to the patient's request in 18.3% of the referrals. The study conclusions: People are more participative, more information and the defensive medicine is increasing, the process of referral have not changed (DePrado-Ptieto, Garcia-Olmos, Rodriguez-Salvanes, Otero-Puime, 2005).

Group specialized register conducted electronic searches of the Cochrane Effective Practice and Organization of Care. They estimated the effectiveness and efficiency of interventions to change outpatient referral rates and improved outpatient referral appropriateness. Randomized controlled trials, controlled clinical trials, controlled before and after studies and interrupted time series of interventions changed or improved outpatient referrals. Participants were primary care physicians; a minimum of two reviewers independently extracted data and assessed study quality. The outcomes were objectively measured provider performance or health outcome. There are a limited number of strict evaluations to base policy. Active local educational interventions involving secondary care specialist and structured referral sheets are the only interventions shown to impact on referral rates based on current evidence. The effects of other immediate primary care based alternatives to outpatients' referral appear promising. (Grimshaw, Winkens, Shirran, Cunningham, Mayhew, Thomas, Fraser, 2005).

The three levels of health care delivery in Nigeria should caring clients with a good referral health system in these levels. The primary health centers are supposed to be the point of first contact of patients. Then Patients referred from health centers to other levels of health care. Survey examined referral system in Nigeria with a study on new patients seen in a tertiary health facility. This cross-sectional survey was conducted with 1416 new patients seen at University of Ilorin Teaching Hospital, Ilorin interviewed over a period of 4 weeks to examine

the referral system in Nigeria. Only 100 (7.1%) of them were referred to the hospital, the rest (92.9%) reported to the hospital directly without referral. The new patients (87.1%) were generally resident in Ilorin. The proportion of those referred is higher among patients from outside Ilorin. Most of the patients referred were from doctors from private clinics. Both the educated and non-educated bypass the primary and secondary levels of health care. A high proportion of patients seen in this tertiary health facility were not referred. The result was over crowding of the tertiary health facilities with problems that can be managed at the lower levels. Highly skilled manpower and equipments wasted on health problems requiring lesser resources to solve. Necessary steps to make clients utilize primary and secondary health facilities need a create disincentives for patients to passing levels (Akande, 2004**).**

In 2004 a study was conducted in Ouallam and Tahoua. These two districts are the poorest in one of the poorest countries of the world. The population in the 2 districts (approximately 270.000 and 350.000 inhabitants) is scattered in a huge territory with 25 rural health centers at an average of 60 km from the district hospital. Only 29 % and 42 % of the respective populations live within 5 km from a health centre. Going to the district hospital is quite an undertaking: there is almost no transport and there are no tarmac roads. Traveling to the hospital costs a lot of money, often the equivalent of several times a household's monthly income. The study shown what extent the behavior of the health care providers with interaction with the patient can be a barrier of its own. Information was collected from three sources in two rural districts in Niger: first, 46 semi-structured interviews with health centre nurses; second, 42 focus group discussions with an average of 12 participants – patients, relatives of patients and others; third, 231 semi-structured interviews with referred patients. The researchers found that the staff communication was poorly and shown little wish to

convince reluctant patients and families to accept referral suggestion. The conclusion from study indicates that the failure of referral systems in sub-Saharan rural Africa is often attributed to transport problems and financial barriers. In Niger these problems are real and important. The diminishing referral costs and distance barriers was not enough to correct failing referral systems. Nurses find themselves in the ambiguous situation where the population is reluctant to be referred because of transport and costs barriers. There is a clear case for investment in the district hospitals, and particularly in their human resources. Policy makers and specialist doctors are reluctant to invest in further training of general practitioners. There was also a need for investment in district hospitals to make referrals visibly worthwhile and for professional upgrading of the human resources at the first contact level, so as to allow for more effective referral patterns (Bossyns, Lerberghe, 2004).

Lusaka, Zambia is the cities which a study was conducted there; the study was about tools for monitoring the effectiveness of referral system, in relation to maternity. The researcher was described some tools used to review pregnancy related to referrals, the data was collected from health facilities statistics, registers and medical notes. The researchers find some tools not work in other places, the level of needs were different. Poor quality of routine recording and inadequate storage of information was remained a major potential obstacles to collecting reliable data for auditing. Researchers were suggested to the managers and decision makers of district services for more training staff and resource allocation to improve the quality of recording (Murray, Davies, Phiri, Ahmed, 2001).

Four public agencies participated in this study, the Lakewood Division of Aging, the Lakewood Division of Health, the Cuyahoga County (services the greater Cleveland area)

Department of Senior and Adult Services, and the Cuyahoga County Department of Health. Older Emergency Department patients have complex medical, social, and physical problems. We established a program at four emergency department sites to improve case finding of at-risk older adults and provide comprehensive assessment in the emergency department setting with formal linkage to community agencies. The objectives of the program are to improve case finding of at-risk older patients, improve care planning and referral for those returning home, and create a coordinated network of existing medical and community service. The four sites are a 1,000-bed teaching center, a 700 bed county teaching hospital, a 400 bed community hospital, and a health maintenance organization emergency department site. Ten community agencies also participated in the study four agencies associated with the hospital health maintenance organization sites, two nonprofit private agencies, and four public agencies. Case finding is done using a simple screening assessment completed by the primary or triage nurse. A geriatric clinical nurse specialist further assesses those considered at risk. Patients with unmet medical, social, or health needs are referred to their primary physicians or to outpatient geriatric evaluation and management centers and to community agencies. After 18 months, the program has been successfully implemented at all four sites. Primary nurses screened over 70% (n = 28,437) of all older emergency department patients, a geriatric clinical nurse specialist conducted 3,757 comprehensive assessments, participating agency referrals increased six-fold, and few patients refused the geriatric clinical nurse specialist assessment or subsequent referral services. Thus, case finding and community linkage programs for at risk older adults are feasible in the setting (Mion, Palmer, Anetzberger, and Meldon, 2001).

A large study was conducted in Pakistan despite an elaborate network of over 5000 basic health units and rural health centers, supported by higher-level facilities, primary health care

activities have not brought about expected improvements in health status, especially of rural population groups. A poorly functioning referral system may be partly to blame. System analysis of patient referral was conducted in Attock district in Punjab province. for the purpose of identifying major shortcomings. Attock district population about 1.2 million people. The respondents from 225 households were interviewed. Serious illness cases of the households taken the health care from the first nearest level of facility. Major reasons included dissatisfaction with quality of care offered, non-availability of physician, and patients being too ill to be taken to the nearest first-level care facility. Only 15% of patients were referred on the prescribed referral form. None of the higher-level facilities provided feedback to first-level care facility. Records of higher-level facilities revealed lack of information on either patient referrals or feedback. There were no surgical or emergency obstetric services available at any of the first-level referral facilities. Seventy five percent of the patients attending the first-level referral facilities and 44% of the patients attending higher level facilities had a problem of a primary nature that could well have been managed at the first-level care facility. As a result of the study findings, the researchers concluded: Every level of health service delivery has access to a higher level for patients whose condition can either not be satisfactorily diagnosed or managed at the referring level; the secondary referral level is better able to handle with health problems than the first level. Administrative rules and regulations governing referral have been worked out for all members of the health service facility, and follow up both the referring and referral facility. Every center that caries out referrals determines the material infrastructure minimally required to effect referral. Health personnel have been trained to recognize problems that cannot be satisfactorily handled at their level of care. Referral either up or back down the levels of health care can readily be demonstrated to occur on a regular

basis through random examination of treatment records. The community is a ware of referral system and readily follows its rules (Siddiqi, Kielmann, Khan, Ali, Ghaffar, Sheikh, 2001).

In china a study was carried out in four governments general out patient clinics in Hong Kong West and South were informed of the service by letter and about their free choice to arrange an upper endoscope directly with the medical endoscope unit. The prospective follow up was performed from June to September 1997 to evaluate the outcome and impact of open-access upper endoscope. In the management of dyspepsia, upper endoscope is an important component. In our locality, patients requiring upper endoscope are conventionally referred to specialist clinics by family physicians. We have introduced the first open-access upper endoscope service in Hong Kong, which has allowed family physicians to arrange endoscope without prior specialist consultation. A study on the outcome of open-access upper endoscope in contrast with the conventional referral system was conducted. The researchers' method for patients presenting with dyspepsia, family physicians in our region were given the option to arrange upper endoscope directly with our medical endoscope unit in addition to the conventional referral to specialist clinics. The results were compared with those from the specialist clinic. The service significantly reduced the waiting time for the procedure by 16 weeks. Open-access upper endoscope had similar detection rates for peptic ulcers and cancers compared with referrals from specialist clinics. Seventy-five percent of patients did not require further consultation with their family physicians within 2 months after endoscope. It is a safe and effective procedure in establishing a definitive diagnosis. All family physicians were satisfied with the open-access upper endoscope service. The study conclusions: Open-access upper endoscope reduced waiting time from the patient perspective, decreased subsequent consultations with family physicians and reduced referral to specialist clinics as well as

increased patient and doctor satisfaction. Both referral systems for endoscope were similar in terms of the diagnostic yield (Wong, Chan, Wong, Wong, Yuen, Lai, Hc Hu, Lau, Lai, and Lam, 2000).

Other study was performed at Brigham and Women's hospital, which is an academic tertiary care teaching and referral center to identify the major problems in the current referral process and evaluate the satisfaction and the communication between primary care and specialists physicians. The design of this study was surveys by mailed. The response rate for mail surveys for primary care physicians was 57% in addition to 51% for the specialists. There was 35% of specialists were dissatisfied with current referral process, in addition 63% of primary care physicians by mail survey. Respondents felt that major problems with the current referral system were lack of timeliness of information and in adequate content of referral letter.

In Brigham study the researchers' conclusions that the problems were present in the referred process physician dissatisfaction, lack of timeliness, in adequate content of physician communication, information obtained from the general survey and referral specific survey was congruent. The researchers' suggestions were to improve the referral system could improve the physician satisfaction and quality of patient care (Gandhi, Sitting, Franklin, Sussman, Fairchild, and Bates 2000).

A study was carried out in Sub-Saharan Africa, much of the current reform of urban health systems in sub-Saharan Africa focuses upon the referral system between different levels of care. It is often assumed that patients are by-passing primary facilities which lead to congestion at hospital out-patient departments. Zambia is well advanced in its health sector reform and this case study from the capital, Lusaka, explores the patterns of health seeking

behavior of the urban population, the reasons behind health care choices, the functioning of the referral system and the users' evaluations of the care received. Data were collected across three levels of the system: the community, local health centers and the main hospital (both in- and out-patients). Results showed those who by-passed health centers were doing so because they believed the hospital out-patient department to be cheaper and/or better supplied with drugs (not because they believed they would receive better technical care). Few users were given information about their diagnosis or reason for referral. The most striking result was the degree of unmet need for health services and the large number of individuals who were self-medicating due to lack of money rather than the minor nature of their illness. The upgrading of urban health centers into ‘reference centers' may provide a capacity for unmet need rather than de-congesting the hospital outpatient department as originally intended (Atkinson, Ngwengwe, Macwan'gi, Ngulube, Harpham, and O'Connell, 1999).

The researchers was conducted this study in California. Data derived from a cross sectional survey in 1997 of patients in managed care plans who received their care from 1 of several large medical groups in California. The study was conducted as part of a broader project investigating patient, physician, and organizational factors associated with specialty referrals for patients with 1 of 3 medical conditions (congestive heart failure, benign prostate hypertrophy, or peptic ulcer disease and related gastric conditions). The study objectives was to determine the extent to which patients value the role of their primary care physicians as first-contact care providers and coordinators of referrals, whether patients perceive that their primary care physicians impede access to specialists, and whether problems in gaining access to specialists are associated with a reduction in patients trust and confidence in their primary care physicians. The researcher used cross-sectional survey mailed in the fall of 1997 to 12707

adult patients who were members of managed care plans and received care from 10 large physician groups in California. The response rate among eligible patients was 71%. A total of 7718 patients were eligible for analysis.

The researchers used questionnaire in three main topics:

(1) Patient attitudes toward the first contact and coordinating role of their primary care physicians,

(2) Patients ratings of their primary care physicians (trust and confidence in and satisfaction),

(3) Patient perceptions of barriers to specialty referrals. Referral barriers were analyzed as predictors of patients' ratings of their physicians. The results of this study were almost all patients valued the role of a primary care physician as a source of first contact care (94%) and coordinator of referrals (89%). Depending on the specific medical problem, 75% to 91% of patients preferred to seek care initially from their primary care physicians rather than specialists. 23% percent reported that their primary care physicians or medical groups interfered with their ability to see specialists. Patients who had difficulty obtaining referrals were more likely to report low trust and low satisfaction with their primary care physicians. The conclusions of this study were Patients value the first contact and coordinating role of primary care physicians. However, managed care policies that emphasize primary care physicians as gatekeepers impeding access to specialists undermine patients' trust and confidence in their primary care physicians (Grumbach, Selby, Damberg, Bindman, Quesenberry, Truman, Uratsu, 1999).

Settat Province is a city in Morocco. Which the researchers were carried out the study. It was conducted in two rural and two urban health centers covering a total population about 94,000.

The study was involved the health centers, only 31 to 52% of patients referred from the first to the second level of care reached the hospital. The researchers' methods were consisted of two steps. First they analyzed retrospectively various determinants (age, gender, distance, time until appointment) that might influence the compliance of patients referred by the four health centers in 1994. Second they observed curative medical consultations conducted in each of these health centers over a three-day period; 38 patients referred to the hospital over this period were interviewed and the hospital organization was analyzed. The researchers' results revealed low compliance: only 43% of the patients referred actually for consultant from the hospitals departments. The compliance rates varied from one health center to another and were lower in rural than urban areas taken as a whole (34% versus 48% respectively). The interviews revealed that patients did not trust the last-year medical students who staffed the emergency rooms. Another organizational problem in the hospital was identified: patients referred to the hospital for specialist consultant were not seen immediately but given appointments at later dates, and these waiting times influenced the final success of the referral process. Thus, if the patients were seen immediately, compliance rate increased. The researchers were concluded that most important determinants of compliance all associated with the way health services were organized and the quality of communication between health professionals and patients (Bakry, Laabid, De Brouwere, Dujardin, 1999).

In Zimbabwe in 1980, a study has suggested inefficiency in the pyramidal health care referral system as a part of its primary health care (PHC) model. The aim of this study was to assess the functioning of the pyramidal referral system in two rural districts surrounding Harare, Zimbabwe, with regard to two common indicators. Pneumonia in children and malaria in adults. For a three-month period, all complete inpatient records with discharge diagnoses of pneumonia or malaria from three hospitals representing different levels of care were analyzed

(n=227). Data were collected on demographic and patient care variables. The appropriateness of admissions and referrals was determined by an assessment of the severity of illness and intensive of care required. Data were analyzed for differences among the three hospitals and between the two indicator conditions. Per night inpatient bed costs for each hospital were also calculated. For pneumonia in children, 56.8% of patients admitted at the secondary level, 81/5% of patients at the tertiary level and 54.3% at the quaternary level were of mild severity. For pneumonia, there were no differences in severity between the three hospitals whereas for malaria significant case-mix differences among the hospitals were found. Most patients attending the highest level referral facility were inappropriate admissions who could have been treated at a lower level of care. There were large variations in the inpatient per night bed costs between the three hospitals. The study concluded that the network did not meet design expectations as the central level referral hospital cared for a similar case-mix of patients as the district level, but at six times the cost. The appropriateness of admissions and referrals could be improved by developing or strengthening intermediate level facilities, by changing mechanisms of access to specialist facilities and by training health professionals in community settings (Sanders, Kravitz, Lewin, and McKee, 1998).

Saudi Arabia implemented the referral health system in mid-1989. the researchers conducted study at Wasat Abha PHC center in the Asir region, which has 15,000 inhabitants. They studied the structure and the process of the referral system to identify the obstacles, determined the rate and quality of referral letters, also the rate and quality of hospital feedback reports, tested the hypothesis of quality of referral letters and hospital feedback reports was related to the type of clinical specialty. The referral process composed of several consecutive steps. It was observed that the referral letters were still handwritten, difficult to read, also

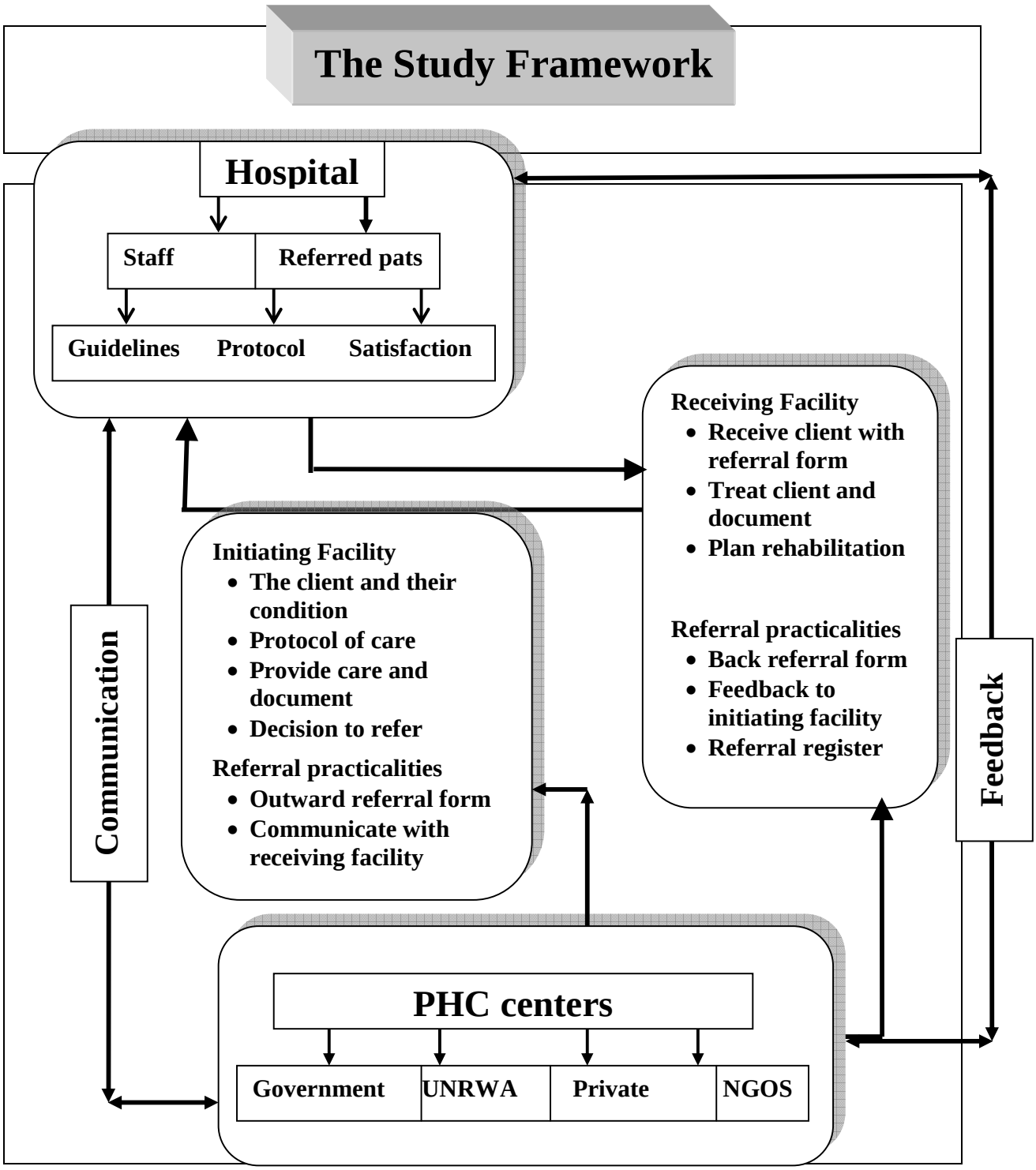
some patients delivered the referral letters to the hospital coordination offices themselves and others had the letters with them for a considerable period of time. Some of these letters were delivered in a crumpled condition, making it difficult for the doctors to obtain the full information; hospital coordination offices did not maintain any record of incoming or outgoing referral letters. It registered only the appointment on the referral letters and returned them to the patient, which lead to difficulties in monitoring the referral system. No feedback reports were issued at all from the hospital unless requested by the patient or the PHC doctor. There was no direct telephone line facility, and only an extension was in operation. The hospital coordination offices did not have any facility for typing the hospital feedback reports. The researchers results that there was decreased in the rate of appropriate feedback hospital report, the hospital consultants rarely recorded advices to the patient or relatives concerning the patient's health disorder and inadequacies hindering the effectiveness of the referral system in a primary health care center. The advices was well recording of essential patient information by the PHC centers in their referral letters, also feedback report by the hospitals to whom patients were referred, and maintain care continuity for patients leading in better patient satisfaction, (Khatab, Abolfotouh, Al-Khaldi, Khan, 1998).

Ministry of Health of Saudi Arabia has introduced a referral system as one of its strategies to make the best use of hospitals and primary health care services. In order to provide a comprehensive and integrated health service for the people of Saudi Arabia, a retrospective study to examined the patterns of attendance and referrals from health centers to hospitals in Riyadh region, changes in the patient attendance at outpatient clinics and emergency departments, and changes in the number of inpatients in the hospitals after implementation of the referral system. In this system firstly, all patients should be seen by primary health care

physicians who decide whether a referral to secondary care is necessary or not, to access the hospital care except for emergency cases where patients can access the hospital directly through the accident and emergency departments. A systematic random sampling for a hospitals and primary health care centers from family health records in 6 general hospitals and 59 primary health care centers in Riyadh region. It was thought that implementing such a referral system would lead to better cost-effective utilization of the health services. It was a clear that the referral system has, an impact on primary and secondary health care services. In order to optimize positive and minimize negative aspects of this impact, communication between primary health centers and hospitals should be of high standard. Raising public awareness of the referral system, and training health professionals and managers, to gain public trust and help achieve effective and efficient handling of referral tasks were recommend, operational research on multiple fronts of the referral system, such as functions and indicators, quality of referral service, cost-effectiveness, adequacy and efficiency of the system, consumer satisfaction and qualitative improvement in health service need to be undertaken. Researchers in universities, medical colleges, research institutes and agencies should be encouraged to participate and cooperate in such research and regular reviews and studies of referral systems were recommended (Khoja, T.A.M., Al Shehri, A .M., Abdul-Aziz, A.F., and Aziz, K.M.S, 1997).

Chapter: 3 Conceptual Framework

The researcher assumption of the framework of referral health system at Al-Ahli Arab hospital illustrated in figure 3.1.



This conceptual framework was developed by researcher focuses on referral system. In this study the researcher evaluated the referral health system between the primary health care centers and the hospital, which is a component of health care system, and think that be effective in improving the health. Also the researcher discovered the awareness of health care providers about referral health care system, the health staff who offered health services to the patients; they are nurses, midwives, administrator, and doctors. Also the researcher discusses factors that affect the referral health system. Organizational factors, communication and feedback between the primary health care centers and the hospital.

3.1 Demographic Factors:

These factors include gender, age, marital status, residency, qualification, profession, and the main job.

3.2 Organization Factors:

Factors affect on the referral health system. These include guidelines, protocols, of the referral health system, supplies, and medical equipments in the PH centers. Also evaluated the referred cases satisfaction from the services offered in PHC centers and hospital, referral decision and referral form.

3.3 Communication and Feedback:

These items is important for PHC centers and hospitals for providing support and information for organization, the communication is a channel must be clear between health care providers in the hospital and PH centers, and sharing information about referral patients to promote effective management and work. Also feedback is very important for all health care providers, to follow up and management done to the patients.

Chapter: 4 Methodology

This chapter discus the methodology and how the researcher applied it.

4.1 Study Design

The design of this study is a cross sectional study. It is usually used to identify and evaluate the common factors associated with referring patients, to explore the factors that impede the functioning of the referral system among primary care and secondary care, and will highlight the main strength and weak points related to referral system. Data are collected at single point of time. Causes and effect on referring patients are studies at certain point to give some ideas about the possible relationships. In general, cross sectional studies are economical and quick.

4.2 Study Population

The study populations were all patients who were referred from primary health care centers to Al-Ahli Arab hospital from February to April. All health care providers who were working at Al-Ahli Arab hospital and providing services for the patients are included in this study.

4.3 Period of the Study

The study was conducted in August 2009 after the administrative procedures for getting the ethical approval from the general director health of Al-Ahli Arab hospital to conduct the study. Data entry, data clearing, reviewing the literatures, analysis and the writing final report continue till the end of April 2010.

4.4 Setting of the Study

The study was carried out at Al-Ahli Arab hospital in Gaza Strip. This hospital is non governmental. The study was conducted at all departments of the hospital including all health care providers who working in the hospital.

4.5 Study Subjects

All the health care providers offering the health services are included so no sampling is done.

For the patients referred from the PHC centers a cluster sample including all attendants during the study period.

4.6 Response Rate

The number of respondent from health care providers was 51, from 60 and the response rate was 84 %. The number of total respondent of referred patients was 200 cases with response rate 100 %.

4.7 Ethical Consideration and Procedures

- An official letter of approval to conduct the study was obtained from the Helsinki Committee in the Gaza Strip (Annex 6).
- An official letter of request was obtained from general director to conduct the study in the Al- Ahli Arab non governmental hospital (Annex 7)
- Explanatory letter was attached to questionnaire and provided to participants who included the study title, aim, objectives, and other information needed to make clarification to participants.

- In the interview questionnaire privacy was kept to patients.
- The right to participate or not, confidentiality of the information, anonymity was maintained into the explanatory letter (Annex 3)
- No participant would have experienced a sense of coercion, a sense of fear of not to answering.
- An ethical concept, respects for people was considered and maintain.

4.8 Construction of Questionnaires

The researcher developed a self administered two questionnaires. It was designed clear, no complex terms, nor jargons. Leading, duplicated and double parallel question was avoided. The questionnaires were organized and each item was a serial number. Data was collected through a structured two questionnaires, for health care providers and referred patients. The two questionnaires consist of three parts:

The first part was covered the information related to demographic and social data.

The second part was covered the referral cases, nature, pattern of referral, reason for referral, and the outcome.

The third part is for health workers and client knowledge and perception towards referring health system.

The researcher used likert scale format and some open ended questions which was covered the information related to personal factors concerns with referring process, strength and weak points of referral system (Annex 4, 5)

How to be plan and increase the effectiveness of the protocols and improving the referring process.

4.9 Validity of the Instrument

4.9.1 Face Validity:

As it is important to make people to response more to your questionnaire, the researcher checked the validity twice time, the first time during the pilot study as participants were asked about the structure of the questions, its shape, and typing clearance. The second checked was through expert persons who gave their opinion in the validity of questions.

4.9.2 Content Validity:

Content Validity is subject estimation of measurement based on judgment rather than statistical analysis, in order to validate the instrument used. It was done before data collection, by sending the questionnaires with covering letter and paper contain instructions about the study, over all aim, objection, and field of other relevant information.

The researcher sent the questionnaires to12 expert from the different backgrounds including doctors, nurses, expert in management, university educationist, and researchers.

They were asked to estimate the questionnaires in relation to study, clarity, and completeness of each item. Feedback was obtained from 12 expert, their opinions were taken in consideration. Modifications according my supervisor opinion were done.

4.10 Standardization of Measurement and Implementation

It was approved by using the same questionnaire for all health care providers; also the same questionnaire for the referred patients, the implementation also was standardized for all health care providers by receiving their questionnaire individually. Interview for all referred patients was performed by the researcher.

4.11 Inclusion and Exclusion Criteria

4.11.1 Inclusion Criteria

♦ All referring patients from primary health care centers to Al-Ahli Arab hospital that was presented at the time of study.

♦ All health care providers were working at Al-Ahli Arab hospital and who responsible for referred patients and provided services for them.

4.11.2 Exclusion Criteria

♦ This study was excluded any staff volunteer who were working or caring with the clients.

♦ This study was excluded students who were training in the hospital.

♦ This study was excluded any staff were deputed or delegated for working in the hospital.

4.12 Pilot Study

A pilot study done before data collection, and after experts evaluation has been done, pilot sample provides the study with many purposes. It gives an idea about response rate, and difficulty or vague questions can be minimized.

4.13 Data Collection

The data was collected, and used a design of entry model which is computer software Statistical Package for Social Science (SPSS) version 15.0 program.

With supporting from supervisor all time, the data was analyzed using SPSS program.

4.14 Data Entry

It was started by cleaning and coding variables cross tabulation for specific variables.

4.15 Data Analysis

Advanced statistical analysis was used to explore the potential relationship between study variables which including:

♦ Independent t test for comparing continuous variables for two categories.

♦ Chi square test for categorical variable.

♦ One way ANOVA for comparing continuous variables for more than two categories.

P-value equal or less than 0.05 will be considered statistically significant.

4.16 The Limitations of the Study

♦ The unusual political situation and the bad socio-economic condition of the clients during the implementation of the study might have some effects on their satisfaction level in general.

♦ Limited time available.

♦ Lack of qualitative data that play an important rule in explaining the feelings and perceptions.

♦ Limited education resources like books and journals.

Chapter 5: Descriptive Findings

This study evaluated the referral system at Al-Ahli Arab Hospital. It intended to discover the relationships and communication between health care providers at Al-Ahli Arab hospital and primary health care centers. As well as discovery of the gaps, strength and weakness points in the health system, also to explore the perceptions of the health care providers about referral health care system and to provide recommendations for policy makers in order to improve the status of referral health care system.

This chapter presents the results of the analysis of the data and the characteristic and distribution of the respondents. Then it represents some statistical tests to explore the differences between the dependent variables and independent variables. The chapter also explores the relationships between the independent variables for health care providers and referred patients, such as demographic variables, and organizational variables.

A. Descriptive Part

A.5.1 Health Care Providers Part

A.5.1.1 Demographic Variables:

The figure (5.1) shows the distribution of staff member according to gender, male is higher than female who represented 57.7%, while female represented 42.3%.

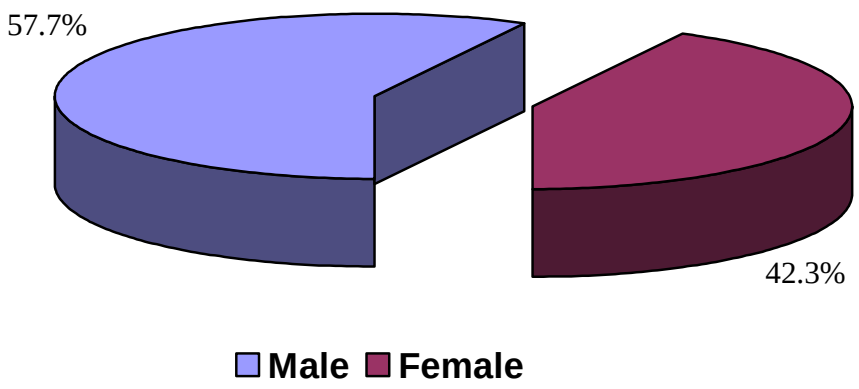


Figure 5.1: Distribution of Health Care Providers by Gender

Regarding health care providers' age, the table (5.1) below shows that the highest age group less than 29 years old, while the lowest age the highest percent was found in Gaza Governorate as represented 47.1 % due to location of the hospital, and the lowest percent was found in Khan Younis Governorate.

Table 5.1: Distribution of Health Care Providers by Demographic Data

Variables		**Frequency**	**Percentage**
Age	Less than 29	26	60.5 %
	30-49	13	30.2 %
	50& more	4	9.3 %
Marital Status	Single	22	43.1 %
	Married	28	54.9 %
	Divorced	1	2 %
Residency	North Governorate	8	15.7 %
	Gaza Governorate	24	47.1 %
	Mid Zone Governorate	14	27.5 %
	KhanYounis Governorate	5	9.8 %

Allocation of qualification, profession, and experience of health providers was presented in table (5.2) the table shows in relation to qualification the BS represented the highest percent,

while the lowest percent was master degree; in relation to profession the nurses represented the high percent, while the midwives represented the lowest percent. The years of experience more than twenty years represented 23.5%, while the majority of health providers was new experience in the hospital it was represented 56.9%. The researcher advises that the health staff need more training courses on health referring system.

Table 5.2: Distribution of Health Staff by Qualification

Variables		**Frequency**	**Percentage**
qualification	Diploma	19	37.3%
	BS	23	45.1%
	Postgraduate	4	7.8%
	Master	5	9.8%
profession	Nurse	41	78.8%
	physician	7	13.5%
	midwife	4	7.7%
Experience	Less than 5years	29	56.9%
	6 - 19 years	10	19.6%
	More than 20 years	12	23.5%

The figure below shows the period of study courses related to health referral system, there is a variation in percent between health providers who had courses or not had courses. The percent is 73.9% for the staff who had courses while 26.5% for the staff who hadn't courses. The courses varied from one week to months, the percent is high with courses in months.

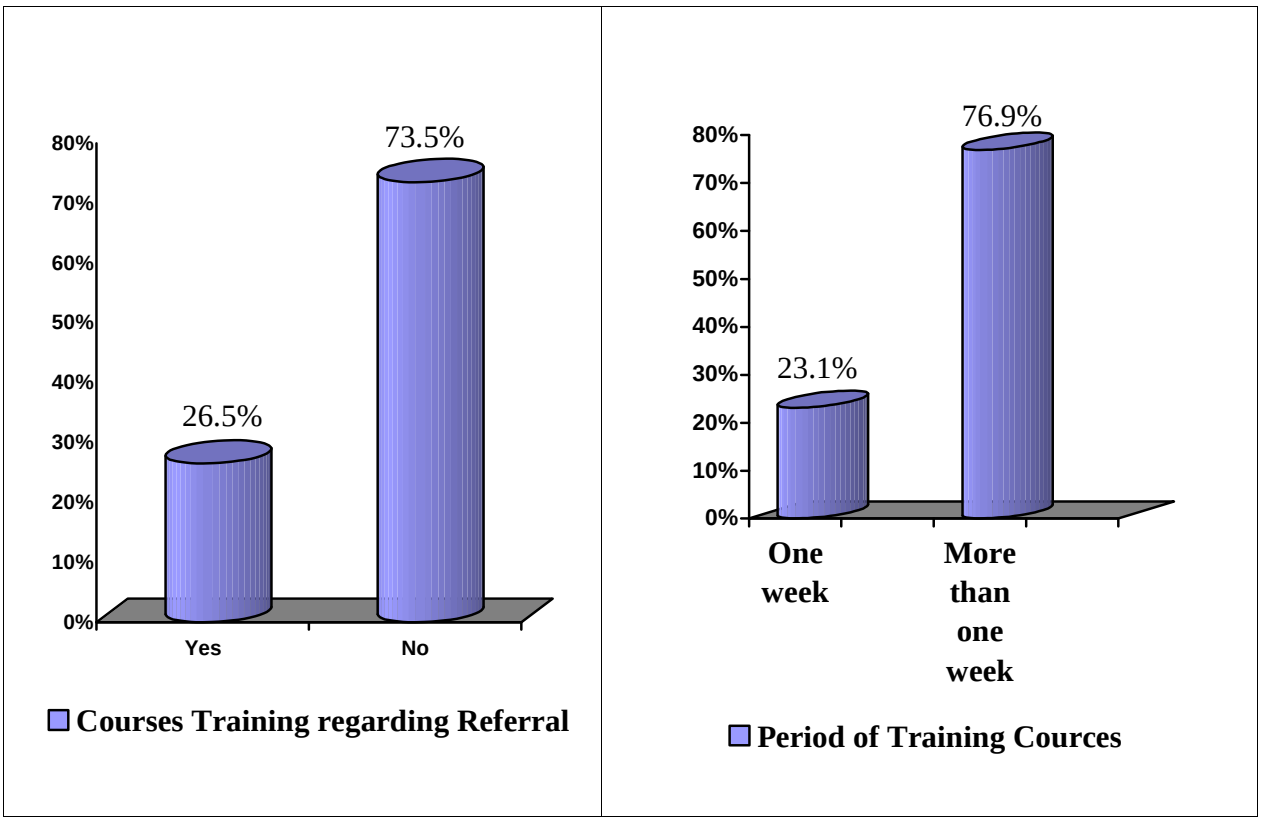


Figure 5.2: Study Courses about Referral Health

A .5.1.2 Organizational Variables:

Table (5.3) clarifies the awareness of health care providers in Al-Ahli hospital about guidelines and protocols of referral health care system. The majority of health staff hadn't knowledge about guidelines and protocols, the percent represents 68%, while the others staff had few knowledge with 32% percent. The guidelines and protocols not available, the percent represent 78%, which lead to decrease in awareness and knowledge. Despite of availability of guidelines as opinion of some staff, the usage of these guidelines is low with 38% percent, also the other opinion of the staff about guidelines not available with 27.8% percent. All staff had the same practice for referred patients with 50% percent.

Table 5.3: Staff Awareness about Referral System

Variables		Frequency	Percent
Knowledge of Guideline	Yes	16	32%
	No	34	68%
Availability of Guideline	Yes	11	22%
	No	39	78%
Usage of Guideline	Available & used	6	33.3%
	Available & not used	7	38.9%
	Not available	5	27.8
Practicing Referral	Yes	25	50%
	No	25	50%
Referral Frequency	Always	4	12.1%
	Frequently	3	9.1%
	Sometimes	21	63.6%
	Never	5	15.2%
Referral Decision	Health provider order	36	83.7%
	Patient request	7	16.3%
Method of Referral	Verbal	6	13%
	Official	40	87%
Reason for Referral	Too complicated cases	35	71.4%
	To perform diagnosis	2	4.1%
	Rolling out risky condition	9	18.4%
	Confirm management plan	3	6.1%
Factors affecting the Referral Process	Comprehensive services	21	43.8%
	Better management	16	33.3%
	Experience	7	14.6%
	Better communication	4	8.3%
Barriers of Referral	Insurance	27	56.3%
	Patient resistance	13	17.1%
	Others	8	16.7%
Common Referral Cases	Emergency	34	70.8%
	Cold	12	25.0%
	Self referral	2	4.2%
Continuity &Follow up	Yes	44	88.0%
	No	6	12.0%
Importance of Referral	Yes	37	74.0%
	No	13	26.0%

The health care providers who referred cases sometimes are the highest percent, while the health care providers who referred cases frequently represent the lowest percent. The decision with official represents the highest percent 87%, while the verbal referral was 13% percent, with patient request 16.3%. The complicated problems represent the majority of causes that's lead for referring to the hospital, while referring for diagnosis is the lowest percent. The referring process affected by many factors the comprehensive services represents 43.8%, while better management represent 8.3% percent. The health insurance is one of the barriers that affect on the referral process its represent 56.3%, the barriers from other opinion like money, bad communication, decreased quality of care, no trust of other facility, some patients refused to referred, Gaza siege and closure, and the hospital policy are represent the lowest percent represents16.7%. Emergency referral represents the highest percentage; while the patient went by himself represent the lowest percent. Many of health care providers agree about continuity and better follow up for referral cases which leading to reduction of health referral, it represent 88%, while the others staff not accepted with 12% percent, this agreed with study, (Abolfotouh, Al-Khaldi, Khan, 1998). Staff represented 74% who accepted and agree that the referral health system is vital issue in our country, while the other staff answered with (no) represents 26%. In my opinion, the referral system is very important in our country.

The frequency of referring cases depends on many factors, such as poverty, population densities, the density of the net work of health centers, the availability of transport and organization of emergency transport and performance and facilities of health system. The distance and transport are often critical problems. This factors represents nagging problem for managers.

The researcher rank the most important factor which affects on the frequency of referring patients, it includes poverty, crowds, overload, transportation and performance. The performance is the highest affecter, it represents 43.8%, and also it represents the lowest one as the staff opinion. This result not agree with (Bossyns, 2006), the researchers explained that the lack of money to pay the ambulance fees was the major obstacles and the distance for referral cases considered problem but not in all districts.

Table 5.4: Factors Affects on the Frequency of Referral Health

Variables										
	Poverty		**Crowds**		**Overload**		**Transportation**		**Performance**	
Rank	**Fre.**	**Percen.**	**Fre.**	**Percen.**	**Fre.**	**Percen.**	**Fre.**	**Percen.**	**Fre.**	**Percen.**
1	12	25.0%	3	6.3%	8	16.7%	4	8.3%	21	43.8%
2	14	29.2%	13	27.1%	7	14.6%	5	10.4%	9	18.8%
3	9	18.8%	12	25.0%	19	39.6%	7	14.6%	1	2.1%
4	5	10.4%	11	22.9%	12	25.0%	19	39.6%	1	2.1%
5	8	16.7%	9	18.8%	2	4.2%	13	27.1%	16	33.3%

Table (5.5) shows points related to coordination of referring, referral form, and existing ambulance. The staff reported 56% that the coordination office not available, despite of 60%

of staff coordinates for referring without office. 65.3% of staff said that there is trust relationship between health staff in the PHC centers and hospital. 38% of staff not dealing ethically so these attitudes needs to follow up by the supervisors and explain the problem with the staff to solve it. The majority of health staff accepted to writing and reporting in a clear line in the referral form, while the others not accepted to writing with 18%, this answer need explain between staff. A weakness of existing referral system and lack of commitment to employees, deteriorate the relation, the staff accepted to answer with 88%, but the other staff represent 12% of the answer.

Table 5.5: Items Concern Referral Form

Variables		**Frequency**	**Percent**
Coordination Office	Yes	22	44%
	No	28	56%
Coordination for Referral	Yes	30	60%
	No	20	40%
Trust Relation between PHC Staff& Hospital	Yes	32	65.3%
	No	17	34.7%
Dealing Ethics with the Patients	Yes	31	62%
	No	19	38%
Clear Writing & Reporting	Yes	41	82%
	No	9	18%
Lack of Commitment	Yes	44	88%
	No	6	12%
Lack of Awareness Increase Referral Rate	Yes	42	85.7%
	No	7	14.3%
Adequate of Medical Equipment	Yes	8	16%
	No	42	84%
Percent of Official Referral	Less than 50%	8	16%
	51% & more	42	84%
Existing Ambulance	Yes	17	34%
	No	33	66%
Transportation	Ambulance	21	42%
	Private	29	58%
Idea for Change	Yes	14	28%
	No	36	72%

The majority of staff said that the lack of awareness about referral system among community increase the referral rate, while 14.3% said no affect on the referral rate. Most of staff reported that there isn't adequate medical equipment at PHC centers, with low percent said there are adequate equipments. The question divided into two percent group in proportion of official referral it was 84% of group 51% and more, but the other group less than 50% represent 16%. The existing of ambulance represents only 34%, as my opinion the availability of the ambulance is very important in centers for patients' services. The majority of health staff didn't want change the referral form, while few of them suggest changing the referral form as writing clearly with complete history taking and diagnosis, management well, and improving the communication and coordination between PHC centers and hospital.

In response to open ended questions the most of health care providers reported that relationship between PHC centers and hospital only referred case, and minority said there is no relation. The majority of them said that there is poor communication, no feedback and follow up for cases, and emergency cases make a problem with referral process, the opinion of others isn't important. The most important things is the gap of awareness and knowledge of guidelines and protocols of referral health system, the majority of health staff reported that they haven’t knowledge about this system, so they want to improve their knowledge as: increasing number of workshops, training courses for health staff. Better communication between health care provides in the hospital and PHC centers, feedback, follow up plan for referral cases. Monitoring from supervisors to the referral process, provision qualified health staff and medical equipment to reduce the referral cases, and providing support, understanding to health staff. Finally availability of good health protection and better environment.

A.5.2 Patient Related Findings

A.5.2.1 Demographic Variables:

The figure (5.4) shows the distribution of referred patient according to sex, referred female is higher than male which represents 61.5%, while referred male represent 38.5%.

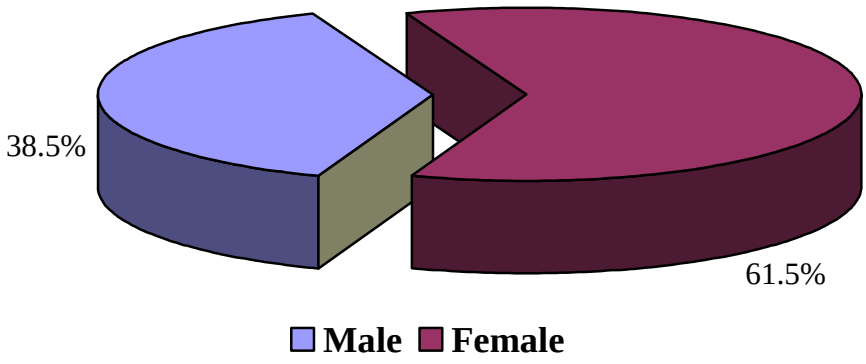


Figure 5.4: Distribution of Referral Patient According to Gender

The table below shows the frequency distribution of referred patients by socio-demographic variables according to age, address and patient locality, the table shows that the majority of age group (19-45) of referred patients represents 55%, while the lowest group represent 5.5% which is less than eighteen years old. The most common referral cases was from Gaza city centers it represents 38% percent, while KhanYounis city centers represent 10%. Also the lowest percent of patients were from village, it represents 10.5%. That means the patients with aged (19-45) is the group who need more care and follow up. The most of referred patient had health insurance, the governmental insurance is the highest percent represent 84.4%, while the social insurance represent 15.6% percent, this indicate that most of referred patients are

governmental insured and refused caring from governmental hospital, and preferred to pay for NGO hospital.

Table 5.6: Distribution of Patients according to Demographic Variables

Variables		**Frequency**	**Percent**
Age	Less than 18 years	11	5.5%
	19-45 Old	110	55 %
	46-60 Old	53	26.5 %
	61 & more	26	13 %
Address	North Gaza	31	15.5%
	Gaza City	76	38%
	Mid Zone	34	21.5%
	KhanYounis	20	10%
	Rafah	30	15%
Locality	City	99	49.5%
	Camp	80	40%
	Village	21	10.5%
Health Insurance	Yes	177	89.8%
	No	20	10.2%
Type of Health Insurance	Governmental Insurance	151	84.4%
	Social Insurance	28	15.6%
Facility Type	UNRWA	154	39.9%
	Government	1	6%
	Other	9	5.5%

Regarding to patients satisfaction from Al-Ahli hospital and PHC centers system table (5.7) shows that there is available of a registration and appointment system represent 86%, the referral patients satisfy from this system with 66.3%, despite of refusing waiting time with highly percent it represent 78.5%. As my opinion, its good phenomena for all people which lead to decrease the overload of the organization, and the patients must accept this system and help to improve it. The patients who referred from the health clinics not satisfy from medical team with 61.8%, also without trust from them with 86.3%. These results need to be more interesting and follow up by health supervisors to changing the idea about the staff attitudes.

Table 5.7: Patient Satisfaction about Referral System

Variables		Frequency	Percent
Availability of Registration & Appointment System	Yes	172	86%
	No	28	14%
Satisfaction from Registration System	Yes	132	66.3%
	No	67	33.7%
Satisfaction from Waiting Time	Yes	43	21.5%
	No	157	78.5%
Satisfaction from Medical Team	Yes	76	38.2%
	No	123	61.8%
Trust with Medical Team	Yes	63	31.7%
	No	136	68.3%

A.5.2.2 Organizational Variables:

The organization factors clarify in table (5.8), the referred patients said that there is well trained staff in the PHC centers with 52.5% percent, while there is highly percent of specialist attendance represent 88%. The highest quality of PHC care represent 93%, while the lowest quality care represent 7%, this is a good indicator for the system. The health care services offered by the health staff at the PHC centers to referred patients represent 46%, while the adequacies of medical facility represent 35.9%. The availability of ambulance services was 55.5% percent, with 56% percent of coordination between health staff and ambulance services. These results need to be more interesting and follow up by health supervisors to improve these points for offering good services to referral patients.

Table 5.8: PHC Centers Characters

Variables		Frequency	Percent
Trained staff	Yes	105	52.5%
	No	95	47.5%
Specialist Staff Attendance	Yes	176	88%
	No	24	12%
Quality of PHC Centers	Yes	185	93%
	No	14	7%
Efficient Care in PHC Centers	Yes	92	46%
	No	108	54%
Adequate Medical Facility	Yes	71	35.9%
	No	127	64.1%
Availability of Ambulance Services	Yes	111	55.5%
	No	89	44.5%
Coordination for Ambulance Services	Yes	112	56%
	No	88	44%

Regarding to patient health condition and disorder, the referred cases has health disorder it represents 53.8% percent, the medical problem was hypertension, diabetes, heart problems, infection.. The admission for operation represents 52%, while admission for follow up represents 48%. Explanation by health staff to referred patient about his problem represents 41.5%, while the other staff don't offered information represents 58.5%. The highest percent of follow up and treatment in hospital, while the PHC centers is the lowest percent. About 64.5% of referral cases don't inform for the referring to hospital., but later on 95% of them have referral form, while the others cases admitted to the hospital on their own account without referral form, represent 5%. The referral cases haven't awareness of referral health system, it represent 99.5% percent, while the patients who have awareness represent 0.5% percent. These findings needs follow up from health supervisors to the health staff attitudes to increase knowledge, information and services offered to referred patients from PHC center to hospital.

Table 5.9: Health Disorders of Referred Patients

Variables		Frequency	Percent
Health Disorder	Yes	106%	53.8
	No	91	46.2%
Type of Disorder	Hypertension	10	5%
	Diabetes Mellitus	3	1.5%
	Hyper& Diabetes	18	9%
	Others	18	9%
Admission Reason	Diagnosis	96	48%
	Operation	104	52%
Information about Disorder	Yes	38	41.5%
	No	117	58.5%
Regular Follow up& Treatment in PHC Centers	Yes	119	59.5%
	No	81	40.5%
Regular Follow up& Treatment in Hospital	Yes	180	90%
	No	20	10%
Informed for Referral	Yes	71	35.5%
	No	129	64.5%
Referral Letter	Yes	190	95%
	No	10	5%
Awareness of Referral System	Yes	1	0.5%
	No	199	99.5%

In response to open ended question about satisfaction from waiting time at the PHC centers, the most of the referred cases reported there is long waiting period to access the health services by doctor examination and investigations, also there is more number of patient, chaos and crowded area. The highest number of referred cases said that they want from health staff to deal with all patients fairly and attention to physical state of them, the provision of an ambulance at all times, change in routine clinics and improve nurses attitude towards patients, don't neglecting the patients, trust relationship between the patient and health staff, provision of possibilities that are required in maintaining the health system, renew the experience of health workers, offering high equality and efficiency of services for patients, more instructions from staff about patients illnesses by increasing the programs and educational sessions. The

patient must comfort and examined thoroughly before refer to hospital, with good communication and coordination between the clinics and hospital and follow up for referred patients, provide knowledge and awareness to health care providers for guidelines and protocols of referral health system and commitment to this protocols.

B.5.3 Inferential Statistics

This part discusses the relationships between the dependent and independent variables for both health care providers and referred cases by applying statistical tests. The researcher provides an explanation and opinion regarding the findings of the study. The dependent variable is the staff communication and feedback group which consists from group of questions. The independent variables were age, gender, residency, and others in addition of organizational variables.

B.5.3.1 Health Care Providers Part

The researcher computed the Likart scale for the questions 42 to 54 into two groups, group of communication which contain questions (Q 42, 43, .44, 45), while group of feedback which contain (Q 46, 47, 48, 49, 50, 51, 52, 53, and 54). Gender difference with two group (table 5.10) using independent t-test which shows that the male and female hadn't statistically significant; the female mean in feedback group is higher than other mean. A dependent t-test was used to examine the communication and feedback with independent gender and other various factors related to health referral guidelines and awareness to the referral system. As the table (5.10) shows the communication with coordination before referred cases is statistically significant (p=.024), weakness of existing referral system and lack of commitment to the employees is statistically significant (p=.020) and the lack of awareness among the community about referral system is statistically significant (p=.000), these finding is

consistence with open ended question that the health staff reported there is knowledge deficit and lack of awareness towards health referral system guidelines and protocols, regarding to other factors all showed no statistically significant differences, only little variations in the mean of the variables.

Table 5.10: Differences in Gender with Various Factors related to Referral System

Dependent Var.	Ind.Var.	N	Mean	SD	t	Sig
Communication	Male	28	3.4196	.81948	-.656	.343
	Female	22	3.5909	1.02802		
Feedback	Male	26	3.7009	.52377	-1.419	.480
	Female	18	3.9136	.43211		
Communication with health staff hearing about guidelines	Yes	16	3.6563	.93486	.856	.714
	No	34	3.4191	.90395		
Feedback with health staff hearing about guidelines	Yes	13	3.7265	.55484	-529	.962
	No	31	3.8136	.47435		
Communication with availability of guidelines	Yes	11	3.4091	1.03243	-.351	.596
	No	39	3.5192	.88738		
Feedback with availability of guidelines	Yes	9	3.5185	.60093	1.886	.306
	No	35	3.8571	.44735		
Communication with referred patient staff to health sittings	Yes	25	3.4700	.76485	-.192	.103
	No	25	3.5200	1.05307		
Feedback with referred patient staff to health sittings	Yes	21	3.7249	.53127	-.804	.765
	No	23	3.8454	.46268		
Communication with availability of coordination office	Yes	22	3.5341	.93317	.266	.744
	No	28	3.4643	.90960		
Feedback with availability of coordination office	Yes	20	3.7000	.55975	-1.078	.232
	No	24	3.8611	.43127		
Communication with coordination before referred cases	Yes	30	3.6333	.70934	1.325	.024*
	No	20	3.27875	1.13924		
Feedback with coordination before referred cases	Yes	26	3.7778	.54342	-.161	.171
	No	18	3.8025	.42873		
Communication with weakness and lack of commitment	Yes	44	3.5398	.83691	.940	.020*
	No	6	3.1667	1.40238		
Feedback with weakness and lack of commitment	Yes	39	3.8006	.51500	.471	.180
	No	5	3.6889	.30832		
Communication with lack of awareness among community	Yes	42	3.6786	.67238	4.042	.000*
	No	7	2.3571	1.39087		
Feedback with lack of awareness among community	Yes	37	3.8288	.49869	1.272	.361
	No	7	3.5714	.44179		

Table 5.11: Differences with Various Factors related to Health Staff and Referral Form

Dependent Var.	Ind.Var.	N	Mean	SD	t	Sig
Communication with trust relationship between health staff	Yes	32	3.5781	.81428	.921	.125
	No	17	3.3235	1.09959		
Feedback with trust relationship between health staff	Yes	28	3.6825	.52702	-1.927	.237
	No	16	3.9722	.37952		
Communication with follow ethics	Yes	31	3.6935	.81063	2.030	.254
	No	19	3.1711	.99322		
Feedback with follow ethics	Yes	26	3.8632	.57203	1.222	.091
	No	18	3.6790	.34064		
Communication with writing clearly in the referral form	Yes	41	3.6037	.78457	1.843	.008*
	No	9	3.0000	1.29301		
Feedback with writing clearly in the referral form	Yes	36	3.8148	.53121	.763	.060
	No	8	3.6667	.26561		
Communication with change referral form	Yes	14	3.3036	.99120	-.925	.564
	No	36	3.5694	.88158		
Feedback with change referral form	Yes	13	3.8034	.46736	.133	.690
	No	31	3.7814	.51279		
Communication with adequate medical equipments	Yes	8	3.2813	1.15293	-.720	.291
	No	42	3.5357	.86879		
Feedback with adequate medical equipments	Yes	7	3.6984	.63736	-.518	.237
	No	37	3.8048	.47170		
Communication with ambulance services	Yes	17	3.7353	.68163	1.350	.170
	No	33	3.3712	.99632		
Feedback with ambulance services	Yes	13	3.7265	.55112	-.529	.994
	No	31	3.8136	.47608		
Communication with continuity and follow up of referred cases	Yes	44	3.5966	.73969	2.219	.000*
	No	6	2.7500	1.63554		
Feedback with continuity and follow up of referred cases	Yes	39	3.7778	.50146	-.375	.587
	No	5	3.8667	.48048		
Communication with vital issue	Yes	37	3.4189	.97013	-.996	.300
	No	13	3.7115	.70597		
Feedback with vital issue	Yes	31	3.7455	.44370	-.875	.068
	No	13	3.8889	.60689		

Regarding to dependent t-test variables which is communication and feedback with health staff relationship in PHC centers and Al-Ahli hospital, adequate medical health services, and referral form characteristics.

Table (5.11) showed that witting clearly in the referral form is statistically significant (p=.008), continuity and follow up of referral cases statistically significant (p= .000), this findings agreed with result before, which represented 88% and it consistence with study in Saudi Arabia (Khatab, Abolfotouh, 1998) , researcher also agree and accept for writing clearly in the referral form. The mean of all variables relatively no differences between them, despite of no statistically significant.

One way ANOVA used to examine the differences between communication and feedback with age health staff. The age group was divided into three groups, group one was less than 29 year, group two 30-49 years, group three 50 years and more, residency divided into five governorate, qualification, profession, experience group which divided into three groups, group one less than 5 years experience, 6-19 years experience, 20 years and more experience. The table (5.12) below the group feedback with qualification shows Scheffe test shows statistically significant (p=.037), while the other variables are not statistically significant. The researcher found that the health staff communication between PHC centers and Al-Ahli hospital was poorly, this finding consistence with (Bossyns, 2004). As researcher opinion this need more investigation and follow up to clarify why no communication between the health staff.

Table 5.12: Differences in Communication & Feedback with Health Staff Characteristics

Dependent Variables	Indep. Var.	Sum of Square	DF	Mean Square	F	Sig.
Communication with Age Group	Between group	2.362	2	1.181	1.336	.275
	Within group	33.589	38	.884		
	Total	35.951	40			
Feedback with Age Group	Between group	.759	2	.380	1.794	.183
	Within group	6.774	32	.212		
	Total	7.533	34			
Communication by Residency	Between group	4.908	3	1.636	2.062	.119
	Within group	35.712	45	.794		
	Total	40.620	48			
Feedback by Residency	Between group	.226	3	.075	.287	.835
	Within group	10.233	39	.262		
	Total	10.459	42			
Communication with Qualification	Between group	3.417	3	1.139	1.385	.260
	Within group	37.019	45	.823		
	Total	40.436	48			
Feedback with Qualification	Between group	2.016	3	.672	3.123	.037*
	Within group	8.391	39	.215		
	Total	10.407	42			
Communication with Profession	Between group	3.646	2	1.823	2.313	.110
	Within group	37.040	47	.788		
	Total	40.686	49			
Feedback with Profession	Between group	.933	2	.466	1.995	.149
	Within group	9.581	41	.234		
	Total	10.514	43			
Communication with Experience	Between group	1.529	2	.764	.918	.407
	Within group	39.157	47	.833		
	Total	40.686	49			
Feedback with Experience	Between group	.038	2	.019	.074	.929
	Within group	10.476	41	.256		
	Total	10.514	43			

B.5.3.2 Referred Cases Part

The researcher analyzed the data of referral cases by using cross tabulation, the analysis between patients sex and satisfaction from health services offered and system at PHC centers and Al- Ahli hospital. The table (5.13) shows that no statistically significant with this relation despite of female is more satisfy from registration system, but not accepted the waiting time because of long waiting period for follow up and examination, more crowded, no regulation, male and female not satisfy and no trust relationship from medical team, because of neglecting the pats, poor communication, no dealing well with the pats.

Table 5.13: Patient Satisfaction about Referral System by Sex

Variables		Males		Females		P value
		No	%	No	%	
Satisfy from Registration System	Yes	45	59.2%	87	70.7 %	.095
	No	31	40,8%	36	66.3 %	
Satisfy from Waiting Time	Yes	16	20.8%	27	22 %	.844
	No	61	79.2%	96	78 %	
Satisfy from Medical Team	Yes	29	37.7%	47	38.5%	.903
	No	48	62.3%	75	61.5 %	
Trust with Medical Team	Yes	24	31.2%	39	32 %	.906
	No	53	68.8%	83	68%	

The table (5.14) shows the satisfaction of referred cases by age group, which divided into four groups, the group one less than 18 years old, 19-45 years, 46-60 years old, 61 and more years. Cross tabulation examined this relation, which shows no statistically significant, despite of the group 61 and more is satisfied from registration system represent 73.1%, while the group 46-60 years not satisfied from waiting time with 83% and medical team with 65.4%. Low trust relationship between referral cases and health providers, the age group 19-45 yrs represent 70.9% of not satisfied from medical team.

Table 5.14: Patient Satisfaction about Referral System by Age Group

Variables		Age Group								
		Less 18 yrs		19-45 yrs		46-60 yrs		61+ yrs		P value
		No	%	No	%	No	%	No	%	
Satisfy from Registration System	Yes	7	63.6%	73	66.4%	33	63.5%	19	73.1%	.860
	No	4	36.4%	37	33.6%	19	63.5%	7	26.9%	
Satisfy from Waiting Time	Yes	2	18.2%	24	21.8%	9	17%	8	30.8%	.563
	No	9	81.8%	86	78.2%	44	83%	18	69.2	
Satisfy from Medical Team	Yes	7	63.6%	40	36.4%	18	34.6%	11	42.3%	.303
	No	4	36.4%	70	63.6%	34	65.4%	15	57.7%	
Trust with Medical Team	Yes	5	45.5%	32	29.1%	16	30.8%	10	38.5%	.598
	No	6	54.5%	78	70.9%	36	69.2%	16	61.5%	

The patients governorate divided into five area which is North Gaza, Gaza city, M, Zone, Kan Younis, Rafah area, the table (5.15) shows that patients from all governorates satisfied from registration system, statistically significant (P=.025), also there is statistically significant with trust from medical team (P=.039). That mean there is a difference with answers of pats, may be due to lack of knowledge and awareness. The patients who are from Rafha are highly not satisfied from waiting time which represents 96.7%.

Table 5.15: Patient Satisfaction about Referral System by Governorates

Variables		Address										P value
		North		Gaza		M. Zone		Kan Younis		Rafah		
		N	%	N	%	N	%	N	%	N	%	
Satisfy from Registration System	Yes	23	74.2%	39	52%	32	74.4%	15	75%	23	76.7 %	.025*
	No	8	25.8%	36	48%	11	25.6%	5	25%	7	23.3 %	
Satisfy from Waiting Time	Yes	9	29%	21	27.6 %	8	18.6%	4	20%	1	3.3 %	.065
	No	22	71%	55	72.4 %	35	81.4%	16	80%	29	96.7 %	
Satisfy from Medical Team	yes	15	48.4%	33	43.4 %	17	40.5%	6	30%	5	16.7 %	.066
	No	16	51.6%	43	56.6 %	25	59.5%	14	70%	25	83.3 %	
Trust with Medical Team	Yes	12	38.7%	30	40%	13	30.2%	5	25%	3	10%	.039*
	No	19	61.3%	45	60%	30	69.8%	15	75%	27	90%	

The patients who insured are satisfied from registration system with statistically significant (P=.033) as the table (5.16) showed while the other variables no statistically significant, the referred pats who had insurance also not satisfied from waiting time with 78.5%, this finding need management and solving from the health responsible.

Table 5.16: Patient Satisfaction from about Referral System by Type of Insurance

Variables		Yes		No		P value
		No	%	No	%	
Satisfy from Registration System	Yes	121	68.8%	9	45%	.033*
	No	55	31.3%	11	55%	
Satisfy from Waiting Time	Yes	38	21.5%	4	20%	.879
	No	139	78.5%	16	80%	
Satisfy from Medical Team	Yes	68	38.4%	7	36.8%	.893
	No	109	61.6%	12	63.2%	
Trust with Medical Team	Yes	57	32.2%	5	26.3%	.600
	No	120	67.8%	14	73.7%	

Regarding to the awareness towards health referral system by sex, and age group as table (5.17, 5.18) no statistically significant, despite of the majority of male and female patients in all aged group had lack of knowledge and unaware about referral system, with highly percent which represent 98.7%, and 100%. It consistent with frequency and with open ended question reported. These findings need clarification and increase community awareness towards referral health system.

Table 5.17: Awareness about Referral System by Sex

Variables		**Male**		**Female**		**P value**
		No	**%**	**No**	**%**	
Informed for Referral	**Yes**	23	29.9%	48	39%	.188
	No	54	70.1%	75	61%	
Referral letter availability	**Yes**	73	94.8%	117	95.1%	.920
	No	4	5.2%	6	4.9%	
Awareness of health referral system	**Yes**	1	1.3%	0	.0%	.205
	No	76	98.7%	123	100%	

Table 5.18 Awareness about Referral System by Age Group

Variables		**Age Group**								
		Less 18 yrs		**19-45 yrs**		**46-60 yrs**		**61+ yrs**		**P value**
		No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	
Informed for Referral	Yes	4	36.4 %	38	34.5 %	19	35.8 %	10	38.5%	.985
	No	7	63.6 %	72	65.5 %	34	64.2 %	16	61.5%	
Referral letter availability	Yes	11	100 %	101	91.8 %	52	98.1 %	26	100%	.146
	No	0	.0%	9	8.2 %	1	1.9 %	0	.0%	
Awareness of health referral system	Yes	0	.0%	1	.9%	0	.0%	0	.0%	.844
	No	11	100 %	109	99.1 %	53	100 %	26	100%	

The table (5.19) shows that no statistically significant regarding information offered about health disorders by sex. The male reported 63.6% that they hadn't receive information about health disorders, while female reported 55.3%. Despite of the majority of the male reported that they received regular follow up and treatment in the hospital 94.8% and female represent 87%. That mean the health services offered for the referral cases at the hospital better and accepted by the all sex, and the patient not accepted the care offered at PHC centers.

Table 5.19: Information about Health Disorders by Sex

Variables		Male		Female		P value
		No	%	No	%	
Patients with Health Disorders	**Yes**	37	48.1%	69	57.5%	.194
	No	40	51.9%	51	42.5%	
Admission Reason	**Yes**	35	45.5%	61	49.6%	.569
	No	42	54.5%	62	50.4%	
Received Information about Health Disorders	**Yes**	28	36.4%	55	44.7%	.243
	No	49	63.6%	68	55.3%	
Received Regular Follow up in PHC Centers	**Yes**	46	56.7%	73	59.3%	.956
	No	31	40.3%	50	40.7%	
Received Regular Follow up in Hospital	**Yes**	73	94.8%	107	87%	.073
	No	4	5.2%	16	13%	

Regarding to health information disorders with age groups, the table (5.20) shows that patients health disorders, admission reason, receiving information about health disorders, received regular follow up and treatment in PHC centers all are highly statistically significant with (P=.000). That means there is variation with patient answer about health care at PHC centers.

Table 5.20: Information about Health Disorders by Age Group

Variables		Age Group								
		Less 18 yrs		19-45 yrs		46-60 yrs		61+ yrs		P value
		No	%	No	%	No	%	No	%	
Health Disorders	Yes	0	0%	40	36.7 %	43	82.7 %	23	92%	.000*
	No	11	100 %	69	63.3 %	9	17.3 %	2	8.0%	
Admission Reason	Yes	1	9.1%	37	33.6 %	37	69.8 %	21	80.8 %	.000*
	No	10	90.9 %	73	66.4 %	16	30.2 %	5	19.2 %	
Received Information about Health Disorders	Yes	0	.0%	31	28.2 %	31	58.5 %	21	80.8 %	.000*
	No	11	100 %	79	71.8 %	22	41.5 %	5	19.2 %	
Received Regular Follow up in PHC Centers	Yes	6	54.5 %	49	44.5 %	41	77.4 %	23	88.5 %	.000*
	No	5	45.5 %	61	55.5 %	12	22.6 %	3	11.5 %	
Received Regular Follow up in Hospital	Yes	9	81.8 %	99	90%	48	90.6 %	24	92.3 %	.803
	No	2	18.2 %	11	10%	5	9.4%	2	7.7%	

Regarding to adequate medical equipments by sex, no statistically significant, while there is variations with some factors. Male reported that there is availability of registration system with 88.6%, while 91.1% of female said that the irregular attendance of specialist doctors in the PHC centers increased the request of hospital services without referral form. Highly percent of female and male were accepted that the health services at PHC centers are lower level than services offered to referral cases in the hospital. These need more investigations and improve the patients' idea about the PHC centers, and what the problems that they faced during accessible health services.

Table 5.21: Availability of Medical Equipments by Sex

Variables		Male		Female		P value
		No	%	No	%	
Availability of Registration & Appointment System	**Yes**	63	81.8%	109	88.6%	.177
	No	14	18.2%	14	11.4%	
Adequate Medical Facility	**Yes**	30	40%	41	33.3%	.343
	No	45	60%	82	66.7%	
Availability of Ambulance Service	**Yes**	42	54.5%	69	56.1%	.830
	No	35	45.5%	54	43.9%	
Coordination of Ambulance Services	**Yes**	43	55.8%	69	56.1%	.972
	No	34	44.2%	54	43.9%	
Trained Health Staff for Referral Cases	**Yes**	40	51.9%	65	52.8%	.902
	No	37	48.1%	58	47.2%	
Irregular Attendance Specialists	**Yes**	64	83.1%	112	91.1%	.093
	No	13	16.9%	11	8.9%	
Services Provided Lowest	**Yes**	68	89.5%	117	95.1%	.130
	No	8	10.5%	6	4.9%	
Received Efficient Care	**Yes**	34	44.2%	58	47.2%	.679
	No	43	55.8%	65	52.8%	

The table (2.22) shows that the referred patient over 61 years reported that, there is 69.2 % of trained health staff in the PHC center, while the age group less than 18years represented 36.4 %, which is statistically significant with (P=.010). The age group with received efficient care in the PHC centers statistically significant (p =.031). The referred patients with aged group over 61 years reported that there is adequate medical facility in the PHC centers represented 50%, while the age group (19-45) represented 33.3%. The majority of the cases reported that, the services provide in the PHC care is lower than the services in the hospital, that need more follow up and clarify the result.

Table 5.22: Availability of Medical Equipments by Age Group

Variables		Age Group								
		Less 18 yrs		19-45 yrs		46-60 yrs		61+ yrs		P value
		No	%	No	%	No	%	No	%	
Availability of Registration & Appointment System	Yes	7	63.6	95	86.4	46	86.8	24	92.3	.141
	No	4	36.4	15	13.6	7	13.2	2	7.7%	
Adequate Medical Facility	Yes	4	40%	33	33.3	21	39.6	13	50%	.247
	No	6	60%	76	69.7	32	60.4	13	50%	
Availability of Ambulance Service	Yes	5	45.5	64	58.2	31	58.5	11	42.3	.425
	No	6	54.5	46	41.8	22	41.5	15	57.7	
Coordination of Ambulance Services	Yes	5	45.5	60	54.5	36	67.9	11	42.3	.131
	No	6	54.5	50	45.5	17	32.1	15	57.7	
Trained Health Staff for Referral Cases	Yes	4	36.4	48	43.6	35	66%	18	69.2	.010*
	No	7	63.6	62	56.4	18	34%	8	30.8	
Irregular Attendance Specialists	Yes	10	90.9	92	83.6	48	90.6	26	100	.114
	No	1	9.1%	18	16.4	5	9.4%	0	.0%	
Services Provided Lowest	Yes	10	100	100	90.9	49	92.5	26	100	.326
	No	0	.0%	10	9.1%	4	7.5%	0	.0%	
Received Efficient Care	Yes	5	45.%	42	38.2	27	50.9	18	69.2	.031*
	No	6	54.5	68	61.8	26	49.1	8	30.8	

Chapter 6: Conclusion and Recommendation

This chapter, the researcher presents the conclusions of this study, and then suggested recommendations to improve the status referral health system at Al-Ahli Arab hospital. Also suggested recommendations for policy makers which help for improving referral health presented in the next chapter.

Conclusion

In order to evaluate the referral health care system at non governmental hospital, a descriptive analytic study was conducted at Al-Ahli Arab hospital, to assess the awareness of the heath care providers about guidelines and protocols of health referral system. The two sample groups were collected from Al-Ahli Arab hospital; they were referred patients from PHC centers and all health staff who offered health services to them.

Health care providers and 200 respondents were included in this study. Questionnaires tool were used in order to test the awareness and perception of the health care providers towards referral health care system. The response rate of health staff was 84%, while the referral respondents were 100%, both response rate considered high. The findings of the study with health staff showed that a male participant was higher than female participants, while the referred cases the female is higher than male. The most of the health staff seems young and new in the job, with new experience in the hospital, also most of them from Gaza governorate. Bachelor qualification represented the highest percent from nurses, while the midwives represented the lowest percent. The years of experience more than twenty years represented 23.5%.

As the staff opinion they reported that the performance is the highest affecter on the frequency of referring cases.

In response to open ended questions the most of health care providers reported that relationship between PHC centers and hospital only referred case, and minority said there is no relationship. The majority of them said that there is poor communication, no feedback and follow up for cases, and emergency cases make a problem with referral process. The majority of health staff didn't want change the referral form, while few of them suggest changing the referral form as writing clearly with complete history taking and diagnosis, management well, and improving the communication and coordination between PHC centers and hospital.

The most important things is the gap of awareness and knowledge of guidelines and protocols of referral health system, the majority of health staff reported that they have lack of knowledge about this system, so they want to improve their knowledge as: increasing number of workshops, training courses for health staff. Better communication between health care providers in the hospital and PHC centers, feedback, follow up plan for referral cases. Monitoring from supervisors to the referral process, provision qualified health staff and medical equipment to reduce the referral cases, and providing support, understanding to health staff. Finally availability of good health protection and better environment.

The most of health care providers in addition, to the majority of referred patient in Al-Ahli hospital have a lack of knowledge and awareness towards guidelines and protocols of referral health system. They accept to have lectures, workshops and information related to this system. This is a problem which is in need for solving by health care providers in the PHC centers and in the hospital.

Recommendation

The study provided the researcher with a chance to make recommendations that based on the study findings and can be achieved within Al-Ahli Arab hospital. As a result of these study findings, every level of health service delivery has access to a higher level for patients whose condition can either not be satisfactorily diagnosed or managed at the referring level.

♦ Increase health care providers' awareness and knowledge towards health referral system.

♦ Administrative rules and regulations governing referral should be worked out for all members of the health service facilities, and available for scrutiny at both the referring and referral facilities.

♦ Every center that provides referral service has to determine the material infrastructure minimally required to effective referral.

♦ Health personnel carrying out referrals should be trained to recognize problems that cannot be satisfactorily handled at their level of care.

♦ Improvement of community awareness towards referral system and following its rules.

♦ Policy makers and managers from all organization are required to support and focus on the solutions problems for referral health system.

♦ The communication must be strengthening between health care providers in all the organizations with follow up for all referred patients.

♦ To improve satisfaction of referred patients need to change the health care providers' attitude, and to increase trust relationship with patients.

♦ The health care providers must follow up the referred cases in the organization.

Area for Further Research

♦ Further study is needed to include other health organization in Palestine to assess and compare the staff opinion in relation to referral health care system.

♦ There is a need to study factors affecting creation of a unified guideline with other organization in Palestine.

♦ Further studies including more health care providers are needed.

Reference

Akande, T. M. (2004): "Referral system in Nigeria: Study of tertiary health facility": ***Annals of African Medicine Vol. 3, No. 3; 130 – 133.***

Akbari, A., Mayhew, A., Al-Alawi, MA., Grimshaw, J., Winkens, R., Glidewell, E., Pritchard, C., Thomas, R., Fraser, C.(2008): "Interventions to improve outpatient referrals from primary care to secondary care": ***Cochrane database of systematic reviews, October,Vol. 8;(4):CD005471.***

American Evaluation Association, website http://www.wikiorg/index.php/evaluation_D# what_is_evaluation20/2/2008.

Atkinson, S., Ngwengwe, A., Macwan'gi, M., Ngulube, T.J., Harpham, T., and O'Connell, A.(1999): "The referral process and urban health care in sub-Saharan Africa: the case of Lusaka, Zambia". ***Social Science and Medicine, July, Vol. 49 (1): 27-38.***

Bakry, N., Laabid, A., DeBrouwere, V., and Dujardin, B. (1999): "Why patients do not comply with reference decision made by general practitioners?" U.S. ***National Library Medicine National Institutes of Health. October, Vol. 47 (12) 2S:65-74.***

Bossyns, B. and Lerberghe, W.V. (2004): "The weakest link: competence and prestige as constraints to referral by isolated nurses in rural Niger". ***Human Resources for Health, Vol. 2:1.***

Bossyns, P., Abache, R., Abdoulaye, MS., Lerberghe, W.V.(2005): "Unaffordable ore cost-effective?: introducing an emergency referral system in rural Niger". ***Tropical Medicine International Health, September, Vol.10:879-887.***

Bossyns, P., Abache, R., Abdoulaye, M.S., Miye. H., Depoorter, A.M., Van Lerberghe, W.V. (2006): "Monitoring the referral system through benchmarking in rural Niger: an evaluation of the functional relation between health centers and the district hospital". ***BMC Health Services Research Vol. 6:51***

Cender-Carbonero, M.T., Sanz-Lopez, R., and Martinez-Ramos, C. (2005): "Improving communication between levels of health care: direct referral of patients to a one-stop service for major outpatient surgery". ***Aten Primaria, Apr 15; Vol. 35(6):283-7.***

C: //Evaluation-wikipedia, the free enclopedia.htm http//.en. Wikipedia. Org/wiki/Patien. (3/2008).

DePrado-Ptieto, L., Garcia-Olmos, L., Rodriguez-Salvanes, F., and Otero-Puime, A., (2005): "Evaluation of referral in primary care". ***Aten Primaria, Feb.28; Vol.35 (3):146-51.***

El-Haj, M.(2008): "Perception of hospitalized patients about the services provided at European Gaza Hospital" Master of Nursing Management, Al Quds University, Palestine.

Forest, C.B., Shadmi, E. Nutting, P.A., and Starfield, B. (2007): "specialty referral completion among primary care patients: result from the ASPN Referral Study". ***Annals of Family Medicine, July, Vol. 5(4):361-367.***

Fournier, P., Dumont, A., Tourigny, C., Dunkley, G., Drame, S. (2009): "Improved access to comprehensive emergency obstetric care and its effect on institutional maternal mortality in rural Mali". ***Bull Word Health Organization, Vol. 87:30-38.***

Gandhi, T.K., Sitting, D.F., Franklin, M., Sussman, A., Fairchild, D.G., and Bates,D.W., (2000):" Communication Breakdown in the Outpatient Referral Process". ***Journal of General Internal Medicine (JGIM), September Vol.15:626-631.***

Grimshaw, JM., Winkens, R.A.G., Shirran, L., Cunningham, C., Mayhew, A., Thomas, R., Fraser, C. (2005): "Interventions to improve outpatient referrals from primary care to secondary care (Review)". ***The Cochrane Database of Systematic Reviews, Issue 3. Art. No.: CD005471. DOI: 10.1002/14651858.CD005471.***

Grumbach, K., Selby, J.V., Damberg, C., Bindman, A. B., Quesenberry, C., Truman, A., Uratsu, C.(1999): "Resolving the Gatekeeper Conundrum What Patients Value in Primary Care and Referrals to Specialists". ***Journal of the American Medical Association (JAMA), 21 July Vol. 282,(3):261-266.***

Haimann, T. (1991): **Supervisory Management for Health Organization, fourth edition.**Wm. C. Brown Publishers, United State.

http://healthinsurance.about.comp/od/glossary/g/referral.htm.(Kelly Montogomery, former About. Com Guide Updated January 27, 2009.

http://www.lynda. Us/content-Ahli.shtml.

http://en.Wikipedia.org/Wiki/Primary_Health_Center (November, 2009)

Jamison, D.T., Breman, J.G., Measham, A.R., Alleyne, G., Claeson, M., Evans, D., Jha, P., Mills, A., Musgrove, P.(2006): **Disease control priorities in developing countries second edition.**

Khatab, M.S., Abolfotouh, M.A., Al-Khaldi, Y.M., Khan, M.Y. (1998):" Studying the Referral System in one Family Practice Center in Saudi Arabia" 9 September 1998.

Khoja, T.A.M., Al Shehri, A.M, Abdul-Aziz, A.F., and Aziz, K.M.S (1997):" Patterns of referral from health centers to hospitals in Riyadh region". ***Eastern Mediterranean Health Journal, Vol. 3, (2): 236-243.***

Kongnyuy, E.J., Mlava,G., van den Broek,N.(2008):" Criteria-based audit to improve a district referral system in Malawi: A pilot study". BMC Health Services Research 2008, 8:190 http://www.biomedcentral.com/1472-6963/8/190

MARAM Protocols, (2005): For use in Maternity Homes, health services in West Bank and Gaza Strip. Palestine.

Mion, L. C., Palmer, R. M., Anetzberger, G. J., and Meldon, S. W" (2001): "Establishing a Case-Finding and Referral System for At-Risk Older Individuals in the Emergency Department Setting The Signet Model***". Journal of the American Geriatrics Society, Vol. 49: 1379-1386.***

Murray S.F., Davies S., Phiri RK., Ahmed Y. (2001): "Tools for monitoring the effectiveness of district maternity referral system". ***Health Policy and Planning, Vol. 16(4):353-361.***

Palestinian Central Bureau of Statistics (2007): population, housing units, building and establishment, Palestine.

Palestine. MOH (1999): National Strategic Health Plan, 1999-2003. Gaza.

Palestine. MOH (January, 2005): Health Sector Review. Final Report draft 1. Rome.

Palestine. MOH (2005): health status in Palestine: Annual Report 2004, Gaza.

Palestine. MOH (2006): health status in Palestine: Annual Report 2005, Gaza.

Sanders, D., Kravitz, J., Lewin, S., and McKee, M. (1998): "Zimbabwe's hospital referral system: does it work?" ***Health Policy and Planning, Vol. 13 (4): 359-370***

Siddiqi, S., Kielmann, A. A., Khan, M.S., Ali, N., Ghaffar, A., Sheikh (2001): "The effectiveness of patient referral in Pakistan***". Health Policy and Planning,Vol. 16 (2): 193-198.***

Sitting, D.F., Franklin, M., Sussman, A.J., Fairchild, D.G., Bates, D.W., (2000): "Communication breakdown in the outpatient referral process". ***Journal of General International Medicine, Vol. 15:626-631.***

Wong, B. C.Y., Chan, C.K., Wong, K. W., Wong, W. M., Yuen, M. F., Lai, K. C., Hc Hu, W., Lau, G. K.K., Lai, C. L., and Lam, S. K. (2000): "Evaluation of a new referral system for the management of dyspepsia in Hong Kong: Role of open-access upper endoscopy". ***Journal of Gastroenterology and Hepatology Vol. 15: 1251-1256.***

http://www.glossary_definition.Wordnetweb.princeton.edu/perl/wedwn (2009)

WHO (2005) Primary Health Care, (http//:www.wpro.who.int/health-topics/primary-health-care/htm, 10.11.2007.

Annexes

Map of Palestine **Annex 1**

Adopted from State Information Services

Map of Primary Health Care Center in Gaza

Annex 2

MOH, Information System Department, 2009

Annex (3)

Explanatory letter

♦ I am Haleema El-za'neen, has been in rolled in master program in public health at Al-Quds University

♦ The title of my study is:

Evaluation of the Referral Health Care System between Primary Health Care Centers and Al- Ahli Arab Hospital.

♦ The aim of the study is to evaluate the referral health system and identify the gaps, strong, weak points for improving referral health system.

♦ Dear collage you are invited to participate in this research study and I'm looking for participation in the filling the questionnaire.

♦ It takes about 20 minutes to complete it. Your participation is voluntary, you have the right to refuse to answer the questions, and you have the right not to participate.

♦ I would like to assure that your information will be kept confidential and the questionnaire will be coded.

♦ The information will be used for scientific purpose.

♦The questionnaire will be help in identifying the gaps, strong and weak points, awareness of health care providers about referral health care system at Al-Ahli Arab hospital so I hope from you to give accurate answer.

♦ I appreciate your cooperation.

Thank you for your cooperation

Annex (4) [a]

Questionnaire (A) for staff

Personal information:

Serial Number:

1. Gender:

1 ☐ Male 2. ☐ Female

2. Age: _____ years

3. Residency place:

1. ☐ North Governorate 2. ☐ Gaza Governorate
3. ☐ M. Zone Governorate 4. ☐ Khanyounis Governorate
5. ☐ Rafah Governorate

4. Marital status:

1. ☐ Single 2. ☐ Married 3. ☐ Divorced 4. ☐ Widow

5. place of work:

1. ☐ Hospital 2. ☐ PHC

6. Qualification:

1. ☐ Diploma 2. ☐ BS 3. ☐ Postgraduate
4. ☐ Master 5. ☐ Others

7. Profession :

1. ☐ Nurse 2. ☐ Midwife 3. ☐ Physician
4. ☐ Others

Organization information:

8. Name of organization _____

9. Place of work _____

10. Present job _____

11. Years of experience at the present job_____

12. Did you receive any courses regarding referral system after graduation?

1. ☐ Yes 2. ☐ No

13. If yes, the period was:

1. ☐ One week to one month.
2. ☐ More than one month.

14. If there is a relationship between primary health care centers and hospital, Please would you describe this relation?

_____

_____

_____

15. Have you ever hear about referral health system guidelines?

1. ☐ Yes 2. ☐ No

16. Do you have the guidelines?

1. ☐ Yes 2. ☐ No

17. If yes, indicate if the guidelines is available and used at the facility?

1. ☐ Available and used.
2. ☐ Available and not used.
3. ☐ Not available**.**

18. Have you ever referred patients to any health settings?

1. ☐ Yes 2. ☐ No

19. If yes, how did you refer?

1. ☐ Always. 2. ☐ Frequently.
3. ☐ Sometimes 4. ☐ Never

20. Most of the referred patients were referred by:

1. ☐ Verbal referral. 2. ☐ Official referral.

21. What are the problems would you lead to make a referral?

_____

_____

_____

22. In your opinion what is the most important reasons for referral?

1. ☐ Too complicated cases.
2. ☐ To perform a medical diagnosis.
3. ☐ Ruling out a risky condition.
4. ☐ Confirm management plan.

23. Do you initiate the idea or patient request a referral?

1. ☐ I decided. 2. ☐ Patient request.

24. What factors do you believe influence referral process?

1. ☐ More comprehensive services.
2. ☐ Better management.
3. ☐ Experience.
4. ☐ Better communication.

25. What barriers do you perceive might limit the referral process?

1. ☐ Insurance.
2. ☐ Patients resistance.
3. ☐ Others (specify) _____,

   _____,

   _____.

26. The frequency of health referral depends on many factors, which is the most important one (rank them according to its importance, start from 1).

- ☐ Poverty.
- ☐ Rowdiness of people.
- ☐ The over load of the work of health center.
- ☐ The availability of the transport and organization, and the emergency transport.
- ☐ Performance and facilities of health centers.

27. Is there a co-ordination office between hospital and primary health centers for referring patients?

1. ☐ Yes 2. ☐ No

28. Is there a co-ordination before referring cases?

1. ☐ Yes 2. ☐ No

29. Is there a trust relationship between health care providers in the primary health centers and the hospital?

1. ☐ Yes 2. ☐ No

30. Are the health care providers follow the ethics of the medical profession when dealing with the patients on the principle of mutual trust and respect?

1. ☐ Yes 2. ☐ No

31. The health care providers at the primary health centers and hospital required to writing in a clear line in the form of referral and the report of the hospital.

1. ☐ Yes 2. ☐ No

32. A weakness of the existing referral system and lack of commitment to the employees, lead to deterioration of this relation?

1. ☐ Yes 2. ☐ No

33. Lack of awareness among the community about the referral system and its relevance and purpose increased the referral rate.

1. ☐ Yes 2. ☐ No

34. Is there adequate medical equipment in the PHC centers for health services?

1. ☐ Yes 2. ☐ No

35. In your opinion proportion of the referred who have official referral may be (%):

_____

36. The most common referred cases are:

1. ☐ Emergency referrals.
2. ☐ Cold referrals (the patient expressed agreement and accepted to be referred).
3. ☐ Self referral.

37. Is the cases referred from the primary health centers by ambulance?

1. ☐ Yes 2. ☐ No

38. The most common way which the patients referred by:

1. ☐ Ambulance 2. ☐ Private

39. Do you want to change any things in the health referral form?

1. ☐ Yes 2. ☐ No

40. If yes, what suggestions do you have to change the guidelines?

_____

_____

_____

41. Based on your own view, what do you think are current referral system strength and weakness?

_____

_____

Questions about the communication and feedback in the referral health system. (S.D)Strongly disagree,(D)Disagree, D.K)Don't Know,(A)Agree
(S.A)Strongly Agree.

Number	Item	S.D	D	D.K	A	S.A
42.	The communication is effective between health care providers in the primary health care centers and hospital.					
43.	The health care providers dealing well with the patients before referring to the hospital.					
44.	An effective referral health care system includes good communication, skilled attendant, and transportation to the referral hospital.					
45.	Communication contains feedback of specific findings, special investigations, diagnosis, treatments offered and follow up.					
46.	The feedback health referral from the hospital is vital and important.					
47.	The feedback health referral must be written in the patient record form.					
48.	The feedback health referral is written on a separate paper.					
49.	Feedback health referral may be sent by fax or mail to the clinic.					
50.	Information feedback to primary health care centers is describing the findings, the actions to be taken and follow up needed.					
51.	Monitoring monthly upwards and backward referral health letters is an important.					

52.	Feedback health referral should be discussed by health care providers.					
53.	The health care providers should follow up the cases that have been referred without feedback.					
54.	The feedback health referral is the weakest aspect in the current referral health system.					

55. Continuity and better follow up between health care providers and pts may reduce the referral rate.

1. ☐ Yes 2. ☐ No

56. Is the referral health a vital issue in our country?

1. ☐ Yes 2. ☐ No

Thanks you for your co-operation,,,

Researcher:

Haleema El-Za'neen

Annex (4) [b]

استبانه (A)

معلومات شخصية

1. الجنس:

1. ☐ **أنثى** **2.** ☐ **ذكر**

2. العمر: _____

3. السكن:

1. ☐ **محافظة الشمال** **2.** ☐ **محافظة غزة**

3. ☐ **محافظة الوسطى** **4.** ☐ **محافظة خان يونس**

5. ☐ **محافظة رفح**

4. الحالة الاجتماعية:

1. ☐ **أعزب** **2.** ☐ **متزوج** **3.** ☐ **مطلق**

4. ☐ **أرمل**

5. مكان العمل:

1. ☐ **مستشفى** **2.** ☐ **مراكز صحية**

6. المؤهل العلمي:

1. ☐ **دبلوم** **2.** ☐ **بكالوريوس** **3.** ☐ **مكمل جامعة**

4. ☐ **ماجستير** **5.** ☐ **أخرى**

7. المهنة :

1. ☐ **ممرض** **2.** ☐ **قابلة قانونية** **3.** ☐ **طبيب**

4. ☐ **أخرى**

معلومات عن المؤسسة

8. اسم المؤسسة _____

9. مكان العمل _____

10. المهنة الحالية _____

11. سنوات الخبرة في العمل _____

12. هل تلقيت أي دورات بشأن نظام الإحالة بعد التخرج؟

1. ☐ **نعم** **2.** ☐ **لا**

13. إذا نعم : فما هي المدة؟

1. ☐ **أسبوع وحتى الشهر**

2. ☐ **أكثر من شهر**

14. إذا كان هناك علاقة بين مراكز الرعاية الصحية لأولية والمستشفيات، الرجاء أن تصف هذه العلاقة.

_____

_____

15. هل سبق وأن سمعت عن المبادئ التوجيهية لنظام الإحالة الصحي؟

1. ☐ **نعم** **2.** ☐ **لا**

16. هل ليك المبادئ التوجيهية ؟

1. ☐ **نعم** **2.** ☐ **لا**

17. إذا كانت الإجابة نعم، فهل هي متوفرة ومستخدمة في المؤسسة ؟

1. ☐ **متوفرة ومستخدمة**

2. ☐ **متوفرة وغي مستخدمة**

3. ☐ **غير متوفرة**

18. هل سبق وقمت بتحويل أي مريض إلي أي مؤسسة؟

1. ☐ **نعم** **2.** ☐ **لا**

19. إذا كان الإجابة نعم، فكيف كنت تحول؟

1. ☐ **دائما** **2.** ☐ **في كثير من الأحيان**

3. ☐ **أحيانا** **4.** ☐ **أبدا لا**

20. تحول معظم المرضي عن طريق:

1. ☐ **طريقة شفهية** **2.** ☐ **طريقة رسمية**

21. ما هي المشاكل التي تؤدي إلى إجراء الإحالة؟

_____

_____

_____

22. في رأيك ما هي أسباب الإحالة؟

1. ☐ **حالات معقدة جدا** **2.** ☐ **للتشخيص الطبي**

3. ☐ **استبعاد الحالات الخطيرة**

4. ☐ **للتأكيد على الخطة**

23. من قرر الإحالة على المريض؟

1. ☐ **أنت قررت** **2.** ☐ **قرار المريض**

24. ما هي العوامل التي تؤثر في اعتقادك على عملية الإحالة؟

1. ☐ **مزيد من الخدمة الشاملة** **2.** ☐ **إدارة أفضل**

3. ☐ **الخبرة** **4.** ☐ **تحسين الاتصال**

25. ما هو تصوركم للحواجز التي قد تحد من عملية الإحالة؟

1. ☐ **التأمين** **2.** ☐ **مقاومة المريض**

3. ☐ **أشياء أخري حدد** _____ ،

_____ ،

_____ .

26. يعتمد تواتر الإحالة الصحية على عدة عوامل صنفهم حسب الأهمية وتبدأ:

1. ☐ **الفقر** **2.** ☐ **زحمة الجمهور**

3. ☐ **ضغط العمل داخل المراكز الصحية**

4. ☐ **وجود وسائل النقل المنظمة في حالات الطوارئ**

5. ☐ **الأداء والتسهيلات المقدمة داخل المراكز الصحية**

27. هل هناك مكتب تنسيق بين المستشفيات ومراكز الرعاية الصحية الأولية لإحالة المرضى؟

1. ☐ **نعم** **2.** ☐ **لا**

28. هل يوجد تنسيق قبل إحالة المريض؟

1. ☐ **نعم** **2.** ☐ **لا**

29. هل هناك علاقة ثقة بين مقدمي الرعاية الصحية في مراكز الرعاية الصحية الأولية و المستشفيات؟

1. ☐ **نعم** **2.** ☐ **لا**

30. هل مقدمي الرعاية الصحية على إتباع لأخلاقيات المهنة عند التعامل مع المرضى وعلى مبدأ الثقة المتبادلة والاحترام؟

1. ☐ **نعم** **2.** ☐ **لا**

31. يطلب من مقدمي الرعاية الصحية في مراكز الرعاية الصحية والمستشفيات الكتابة في خط واضح في ورقة الإحالة وتقرير المستشفى.

1. ☐ **نعم** **2.** ☐ **لا**

32. ضعف نظام الإحالة القائم وعدم التزام الموظفين يؤدي إلى تدهور هذه العلاقة.

1. ☐ **نعم** **2.** ☐ **لا**

33. عدم وجود الوعي الصحي لدى المجتمع حول نظام الإحالة والغرض منه وأهميته يؤدي إلى زيادة معدل الإحالات.

1. ☐ **نعم** **2.** ☐ **لا**

34. هل هناك الكافي من المعدات الصحية في مراكز الرعاية الصحية لتقديم الخدمات الصحية؟

1. ☐ **نعم** **2.** ☐ **لا**

35. في رأيك النسبة للتحويلات قد تكون؟

_____

36. أكثر الحالات المحولة هي ؟

1. ☐ **حالات الطوارئ**

2. ☐ **الإحالات الباردة (المريض يعبر عن موافقته عن الإحالة)**

3. ☐ **يذهب المريض بنفسه وبدون إحالة صحية**

37. هل حالات الإحالة من مراكز الرعاية الصحية تحول بواسطة الإسعاف؟

1. ☐ **نعم** **2.** ☐ **لا**

38. الطريقة الأكثر شيوعا لإحالة المريض هي:

1. ☐ **الإسعاف** **2.** ☐ **خاص**

39. هل تريد تغيير أي شيء في شكل الإحالة الصحية؟

1. ☐ **نعم** **2.** ☐ **لا**

40. إذا كانت الإجابة نعم، ما هي الاقتراحات لديكم لتغيير المبادئ التوجيهية؟

_____

_____

_____

41. واستنادا إلي وجهة نظرك الخاصة، ما هي نقاط القوة والضعف في نظام الإحالة؟

_____

_____

_____

تساؤلات حول الاتصال والتفاعل في نظام الإحالة الصحي: أعارض بشدة، لا أوافق، لا أعرف، أوافق، أوافق بشدة

الرقم	البنـــــــــــود	لا أوافق مطلقا	لا أوافق	لا أدري	أوافق	أوافق مطلقا
42.	التواصل وسيلة فعالة بين مقدمي الرعاية الصحية في مراكز الرعاية الصحية والمستشفيات الصحية					
43.	يتعامل مقدمي الخدمات الصحية مع المريض بطرقة جيدة قبل تحويله.					
44.	نظام الإحالة الفعال يشمل تواصل و حضور جيد ووسيلة نقل فعالة لنقل المريض					
45.	يحتوي الاتصال على ردود الفعل من تحديد للنتائج الخاصة، التشخيص، العلاج والمتابعة للمريض المحول.					
46.	التغذية الراجعة من المستشفي للإحالة تعتبر أمر مهم.					
47.	التغذية الراجعة للمريض المحال يجب أن تكتب في سجل المريض.					
48.	يتم كتابة التغذية الراجعة للإحالة الصحية على ورقة منفصلة.					
49.	إرسال التغذية الراجعة إلى مركز الرعاية الصحي عن الإحالة الصحية ممكن عن طريق الفاكس أو البريد					
50.	معلومات التغذية الراجعة لمراكز الرعاية الصحية توصف النتائج والإجراءات اللازمة التي يجب اتخاذها لمتابعة الإحالة الصحية.					
51.	المراقبة الشهرية من أعلى إلى أسفل لورق الإحالات الصحية مهمة.					
52.	التغذية الراجعة للإحالة الصحية يجب أن تناقش من قبل مقدمي الرعاية الصحية.					
53.	يجب على مقدمي الرعاية الصحية متابعة الإحالة الصحية التي أحيلت دون تغذية راجعة.					
54.	التغذية الراجعة هي الأضعف لنظام الإحالة الصحي.					

55. استمرارية ومتابعة أفضل بين مقدمي الرعاية الصحية والمرضى قد يخفض معدل الإحالة.

1. ☐ نعم 2. ☐ لا

56. هل الإحالة الصحية قضية حيوية؟

1. ☐ نعم 2. ☐ لا

وشكرا لتعاونكم.....

الباحثة/ حليمة الزعانين

Annex (5) [a]

Questionnaire (B) for referred patient

Personal information:

Serial number:

1. Gender:

1. ☐ Male 2. ☐ Female

2. Age: _____ years

3. Address:

1. ☐ North Gaza 2. ☐ Gaza city 3. ☐ M. Zone
4. ☐ Khan Younis 5. ☐ Rafah

4. Locality:

1. ☐ City 2. ☐ Camp 3. ☐ Village

5. Do you have health insurance?

1. ☐ Yes 2. ☐ No

6. Type of health insurance_____

7. You receive health services from?

1. ☐ UN 2. ☐ Governmental 3. ☐ Others

8. Do you have any health disorders?

1. ☐ Yes 2. ☐ No

9. If yes, what kind of health disorders you faced? Specify please.

_____

_____

10. The reason for admission to Al-Ahli hospital?

1. ☐ Admission for diagnosis, follow up and treatment.
2. ☐ Admission for operation and post operation follow up.

11. Did you receive any information about your health disorder?

1. ☐ Yes 2. ☐ No

12. Do you receive a regular follow up and treatment in the primary centers?

1. ☐ Yes 2. ☐ No

13. Do you receive a regular follow up and treatment in the hospital?

1. ☐ Yes 2. ☐ No

14. Is there a registration and appointment system in the primary center and hospital?

1. ☐ Yes 2. ☐ No

15. If yes, are you satisfied about this system?

1. ☐ Yes 2. ☐ No

16. Are you satisfy from waiting time at the primary health system?

1. ☐ Yes 2. ☐ No

17. If you are not satisfy, Please tell me why?

_____

_____

18. Is there adequate medical equipment and facilities in the primary health care centers for reducing the unnecessary referral?

1. ☐ Yes 2. ☐ No

19. Is there ambulance services at the primary health centers?

1. ☐ Yes 2. ☐ No

20. Is there co-ordination between health care providers and ambulance services before referring the patients?

1. ☐ Yes 2. ☐ No

21. Are there trained personnel in the primary health centers for referred cases?

1. ☐ Yes 2. ☐ No

22. Irregular attendance of specialist doctors in the primary health centers lead to request services from the hospital without a referral form?

1. ☐ Yes 2. ☐ No

23. Is the services provided in the primary health centers are the lowest level of the hospital services as your opinion?

1. ☐ Yes 2. ☐ No

24. Do you receive an efficient care in the primary health care centers?

1. ☐ Yes 2. ☐ No

25. Are you satisfied from the services offered from health care providers in the primary health care centers?

1. ☐ Yes 2. ☐ No

26. Are you trust from the health care providers in the primary health care centers?

1. ☐ Yes 2. ☐ No

27. Are you informed about your referral?

1. ☐ Yes 2. ☐ No

28. Do you have a referral letter from primary health care centers?

1. ☐ Yes 2. ☐ No

29. Are you awareness about the referral system and its purpose?

1. ☐ Yes 2. ☐ No

30. In your opinion, what do you think we need to make referral system is more successful?

_____

_____

_____

_____

_____

Thanks you for your co-operation,,,

Researcher:
Haleema El-Za'neen

Annex (5) [b]

استبانه (B)

معلومات شخصية

1. الجنس:

1. ☐ **أنثى** **2.** ☐ **ذكر**

2. العمر: _____

3. العنوان:

1. ☐ **محافظة الشمال** **2.** ☐ **محافظة غزة**

3. ☐ **محافظة الوسطى** **4.** ☐ **محافظة خان يونس**

5. ☐ **محافظة رفح**

4. مكان السكن:

1. ☐ **مدينة** **2.** ☐ **مخيم** **3.** ☐ **قرية**

5. هل لديك تأمين صحي؟

1. ☐ **نعم** **2.** ☐ **لا**

6. نوع التأمين الصحي _____

7. تتلقى الخدمات الصحية من :

1. ☐ **عيادة الوكالة** **2.** ☐ **عيادة الحكومية** **3.** ☐ **مؤسسة أخرى**

8. هل لديك أي اضطرابات صحية؟

1. ☐ **نعم** **2.** ☐ **لا**

9. . إذا كان الجواب نعم، أي نوع من الاضطرابات الصحية التي تواجها ؟ يرجى التحديد.

_____

_____

10. السبب لدخولك المستشفى؟

1. ☐ **الدخول للتشخيص والعلاج** **2.** ☐ **دخول للعملية والمتابعة**

11. هل تلقيت أي معلومات عن مشكلتك الصحية؟

1. ☐ **نعم** **2.** ☐ **لا**

12. هل تتلقى المتابعة المنتظمة والعلاج في مراكز الرعاية الصحية

1. ☐ **نعم** **2.** ☐ **لا**

13. هل تتلقى علاج ومتابعة في المستشفى؟

1. ☐ **نعم** **2.** ☐ **لا**

14. هل يوجد نظام تسجيل ومواعيد في المراكز الصحية والمستشفى؟

1. ☐ **نعم** **2.** ☐ **لا**

15. إذا كان الجواب نعم؟ هل أنت راضي عن هذا النظام؟

1. ☐ **نعم** **2.** ☐ **لا**

16. هل أنت راضي عن وقت الانتظار داخل مركز الرعاية الصحية ؟

1. ☐ **نعم** **2.** ☐ **لا**

17. . إذا كانت إجابتك غير راضي، فلماذا؟

_____

_____

18. هل هناك معدات طبية في مراكز الرعاية الصحية تكفي للحد من الإحالات التي لا لزوم لها؟

1. ☐ **نعم** **2.** ☐ **لا**

19. هل هناك خدمات صحية لسيارات الإسعاف داخل المراكز الصحية؟

1. ☐ **نعم** **2.** ☐ **لا**

20. هل هناك تنسيق بين مقدمي خدمات الرعاية الصحية وخدمات الإسعاف قبل إحالة المريض؟

1. ☐ **نعم** **2.** ☐ **لا**

21. هل هناك مدربون في مراكز الرعاية الصحية للحالات المحولة؟

1. ☐ **نعم** **2.** ☐ **لا**

22. عدم تواجد الأطباء المختصين بانتظام في مراكز الرعاية الصحية الأولية يؤدي إلى طلب الخدمات الصحية من المستشفى دون نموذج الإحالة الصحي؟

1. ☐ **نعم** **2.** ☐ **لا**

23. من وجهه نظرك هل الخدمات الصحية التي تقدم في مراكز الرعاية الصحية الأولية أدنى مستوى من خدمات المستشفى؟

1. ☐ **نعم** **2.** ☐ **لا**

24. هل تتلقى رعاية كافية في مراكز الرعاية الصحية الأولية؟

1. ☐ **نعم** **2.** ☐ **لا**

25. هل أنت راضي عن الخدمات الصحية المقدمة من قبل العاملون في مراكز الرعاية الصحية الأولية؟

1. ☐ **نعم** **2.** ☐ **لا**

26. هل أنت على ثقة من مقدمي الرعاية الصحية في مراكز الرعاية الصحية الأولية؟

1. ☐ **نعم** **2.** ☐ **لا**

27. هل أنت على علم بأنك ستحول إلي المستشفى؟

1. ☐ **نعم** **2.** ☐ **لا**

28. هل لديك رسالة الإحالة الصحية من مركز الرعاية الأولي الصحي؟

1. ☐ **نعم** **2.** ☐ **لا**

29. هل يوجد لديك وعي عن نظام الإحالات الصحي والغرض منه؟

1. ☐ **نعم** **2.** ☐ **لا**

30. من وجهه نظرك ، ماذا نحتاج لجعل نظام الإحالة الصحي أكثر نجاحا؟

_____

_____

_____

_____

_____

وشكرا لتعاونكم.....

الباحثة/ حليمة الزعانين

Annex (6)

Palestinian National Authority
Ministry of Health
Helsinki Committee

السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

التاريخ7/6/2010

Name:

الاسم: حليمة الزعانين

I would like to inform you that the committee has discussed your application about:

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

Evaluation of the Referral system between Primary health care centers and Ahli Arab Hospital.

In its meeting on June 2010

و ذلك في جلستها المنعقدة لشهر 6 2010

and decided the Following:-

و قد قررت ما يلي:-

To approve the above mention research study.

الموافقة على البحث المذكور عاليه.

Signature
توقيع

Member
عضو

Member
عضو

Chairperson

Conditions:-

- Valid for 2 years from the date of approval to start.
- It is necessary to notify the committee in any change in the admitted study protocol.
- The committee appreciate receiving one copy of your final research when it is completed.

Annex (7)

P.O. BOX 72
PALESTINE –GAZA
TEL NO. 08-2818400

المستشفي الأهلي العربي
غـزة - Gaza
Ahli Arab Hospital

ص . ب ٧٢
فلسطين – غـزة
ت ٠٨-٢٨١٨٤٠٠

٢٥ فبراير ٢٠١٠

السيد / د. بسام حمد
منسق عام برامج الصحة العامة
جامعة القدس
القدس
كلية الصحة العامة

بعد التحية ،

الموضوع : مساعدة الطالبة / حليمة الزعانين

إيماء لرسالتكم المؤرخة بتاريخ ٢٣ فبراير ٢٠١٠ بخصوص مساعدة الطالبة / حليمة الزعانين بإجراء بحث تحت عنوان :

"Evaluation of The Referral System Between Primary Health Care Centers and Ahli Arab Hospital"

نود إفادتكم أن إدارة المستشفى قد سمحت للطالبة / حليمة الزعانين من جمع البيانات اللازمة لاستكمال متطلبات بحثها الخاص لدرجة الماجستير في الصحة العامة وعليها الاتصال بإدارة المستشفى لتسهيل مهام عملها .

واقبلوا وافر التحيات.

سهيلة تيمور زي
مديرة المستشفى

Fax No. 972-8-2818406
فاكس رقم ٩٧٢-٨-٢٨١٨٤٠٦
Email: suhaila@palnet.com

ملخـص الدراســـــة

عالميا، تعتبر خدمات الإحالة مهمة للغاية لنظام الرعاية الصحية وذلك من أجل استمرارية وتتمة خدمات الرعاية الصحية. إن خدمات الإحالة مهمة لضمان فعالية وكفاءة وجودة الخدمات الصحية. يتمثل هدف الدراسة العام في تقييم الخدمات الطبية في المستشفى الأهلي العربي، حيث أن المستشفى غير حكومي ويخدم المرضى المحولين من مراكز الرعاية الصحية الأولية لوكالة الغوث الدولية حيث انه يمكن لهذه الدراسة أن تساعد في تحسين الخدمات الصحية للمستشفى والجمهور.

أجريت هذه الدراسة الوصفية التحليلية بين عام 2009- 2010 حيث أن الباحثة استخدمت استبانه قياسية للمرضى المحولين و الأخرى لمقدمي الخدمات الصحية في المستشفى الأهلي العربي.
استهدفت الدراسة جميع مقدمي الرعاية الصحية وعددهم 60 وكانت نسبة الاستجابة بينهم 84 %، أما المرضى المحولين فكان عددهم 200 بنسبة استجابة 100%.

لقد عكست نتائج الدراسة كلا من التصورات لمقدمي الرعاية الصحية والمرضى المحولين نحو نظام الإحالة الصحي، حيث أنها أوضحت افتقار العاملين الصحيين إلى المعرفة الكافية والوعي الصحي حول نظام الإحالة، حيث تمثلت بنسبة 32% ممن لديهم المعرفة لنظام الإحالة. وأشارت الدراسة إلى أن مستوى الاتصال والمتابعة والتغذية الراجعة بين المحولين و المؤسسة محدود. إضافة إلى أن 39% فقط من الإناث المحولات تلقت معلومات عن تحويلهم وكانت نسبة الذكور29.9%. كما وضحت النتائج بأن النساء أكثر رضا من الذكور من ناحية نظام التسجيل حيث مثلت 70.7 % والذكور59.2% ، بالرغم من قلة رضاهم من نظام الانتظار. وقد تبين أن المرضى المحولين ينظرون سلبيا على مواقف العاملين في مراكز الرعاية الأولية وقد تبين وجود اختلافات قليلة بين رضا النساء والذكور من الفريق الطبي مثلت 38.5% 37.7 %، حيث أن كبار السن (أكثر من 61 سنة) أكثر رضا من الشباب (أقل من 18) بنسبة 73.1% مقابل 63.6 %.
وضمن الأسئلة المفتوحة كشفت الدراسة بأن أسباب عدم الرضا عن الأطباء هو انعدام التخصص، وقلة الخبرة ، كما أن الإهمال من أهم الأسباب لعدم الرضا، فيما شكلت قلة أعداد الممرضين والتسيب للعمل وكثرة المرضى مشكلة مهمة.

وضحت هذه الدراسة الملامح العامة لخدمات الإحالة في المستشفى المعنية وتسليط الضوء على الثغرات والتحديات الرئيسة التي تواجه عملية الإحالة.
وأوضحت الدراسة أن التواصل من العوامل المهمة في تحسين وجهة نظر المرضى المحولين، لذلك من الضروري المراعاة لهم من قبل المسئولين وصناع القرار.

استخلصت الدراسة بأنه من الضروري العمل على زيادة معرفة مقدمي الخدمات الصحية حول نظام الإحالة مع الحوار بين المؤسسات الصحية تجاه الإحالة و ضرورة الحفاظ عليها، كما وينبغي زيادة معرفة المريض حول نظام الإحالة وينبغي أخذ اهتمامهم بعين الاعتبار.