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Responsiveness of the Gaza Strip Healthcare System: Dimensions and correlates

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Responsiveness of the Gaza Strip Health Care System: Dimensions and correlates

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Dedication

I dedicate this study to my best friend, my son “Sammy”, whose laugh has been the source of my energy and strength every time I was knocked down.

To my extraordinary parents and my dearest sister Mona; without whom this study would not have been completed two years later.

Hala Mohammed Abd Al-Qader Jouda

Declaration

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

Signed:

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Date: 31/05/2021

Acknowledgment

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Yours faithfully

Hala Mohammed Abd Al-Qader Jouda

Abstract

Responsiveness of the health system is the ability of the health system to meet the population's legitimate expectations regarding their interaction with the health system, apart from expectations for improvements in health or wealth. It has seven dimensions as articulated by the World Health Organization; dignity, autonomy, confidentiality, prompt attention, social support, basic amenities, and choices of providers.

The researcher assessed the responsiveness of the healthcare system by using triangulation method. Quantitative method by a responsiveness module of the World Health Survey questionnaire collected throughout 409 household interviewed surveys. Qualitative method by using two focus group interviews to collect data from healthcare system beneficiaries on their experiences related to non-health aspects of the healthcare services. The study population were people aged 18 years and above in Gaza Governorate.

The overall responsiveness level was very good (84.99%). The best evaluated domains were access to social support (99.51%) and confidentiality (98.61%) based on participants' experiences regarding their interaction with the health system. Autonomy (73.59%) and choice of health provider (68.83%) were showed weakness areas in the health system. Capturing participants' preference of domains, the first suggestion for most of the study participants was dignity (22%), followed by prompt attention (20%), meanwhile, choice (5%) and quality of basic amenities (11%) were suggested as the least important. Comparing the findings of domains' scores in outpatient care and inpatient care. Quality of basic amenities and Autonomy were reported better in outpatient than in inpatient care with differences of 15.78% and 10.27% respectively. However, dignity was reported better in inpatient care than in outpatient care (by 5.93%). The findings of qualitative data were similar to quantitative findings in social support, quality of basic amenities, choice and autonomy, while they were less than quantitative findings in dignity, confidentiality and prompt attention.

Females were reported to be treated in a more dignified manner more than males and are more likely to have access to social support during hospitalization periods than males. Moreover, participants aged from 46 to 60 years have a statistically higher score of quality of basic amenities than participants aged 61 years and more. Participants with a low level of education reported a higher level of responsiveness than those with higher level of education. From study participants' points of view, the overall responsiveness level in Private clinics is statistically higher than that in Ministry of Health clinics and statistically higher than that in UNRWA clinics. On the other hand, Ministry of Health clinic attendants reported less responsiveness level than that in UNRWA clinics. Study participants who benefited from governmental hospitals reported a lower level of responsiveness than participants who benefited from non-governmental hospitals.

The responsiveness of health system could be improved by providing training for policy makers, health managers and health care providers in responsiveness concept and domains, working towards improving responsiveness through less resource-dependent domains such as dignity, autonomy, and confidentiality.

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List of Abbreviations

AHRQ	Agency for Health Research and Quality
ANOVA	Analysis of Variances
CBO	Community Based Organization
COVID 19	Corona Virus Disease 2019
EMS	Emergency Medical Services
GP	General Practitioner
GS	Gaza Strip
ICCPR	International Covenant on Civil and Political Rights
MCH	Mother and Child Health
MMS	Military Medical Services
MOH	Ministry of Health
NCDS	Non-Communicable Diseases
NGOs	Non-Governmental Organizations
OCHA	United Nations Office of the Coordination of Humanitarian Affairs
PCBS	Palestinian Central Bureau of Statistics
PhD	Doctor of Philosophy
PHC	Primary Health Care
PWD	People with disabilities
SD	Standard deviation
SPSS	Statistical Package of Social Sciences
UNDP	United Nations Development Programme
UNICEF	The United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency
UNSCO	Office of the United Nations Special Coordinator for the Middle East Peace Process
USA	United States of America
WHO	World Health Organization
WHS	World Health Survey

Chapter 1

Introduction

1.1 Background

The main purposes of the health care system are to maintain and improve the overall health status of people. Having a successful health care system can't be achieved without being responsive to people's expectations of care-providing methods and non-clinical aspects of service delivery (World Health Organization-WHO-, 2012).

Responsiveness of the health system has been identified as "all aspects related to the way individuals are treated and the environment in which they are treated" (Valentine et al., 2015). To emphasize its significance, responsiveness is considered as one of the outcomes of any health care system besides the improved overall health and financial fairness (WHO, 2012), and as a standard to assess health system performance.

Responsiveness has seven dimensions as articulated by the WHO; the seven dimensions are dignity, autonomy, confidentiality, prompt attention, social support, basic amenities, and choices of providers. The first three of these dimensions (dignity, autonomy, confidentiality) reflect aspects of the interaction of individuals with the health system that often have an important ethical dimension. While the latter four (prompt attention, social support, basic amenities, and choices of providers) include the major components of consumer satisfaction that are not a function of health improvement (Mirzoev & Kane, 2017) (Jiang et al., 2014).

In addition to attaining a high level of responsiveness, responding equally well to everyone, without discrimination or differences in how people are treated does matter. The disparity in responsiveness across individuals results from differences related to social, economic, demographic, and other factors.

According to key-informant surveys, conducted by WHO, in 35 countries to measure responsiveness, in almost every country of them, the poor were treated with less respect for their dignity, had less choice of providers, and were offered poorer quality amenities than the non-poor which reflects the inequity in the distribution of responsiveness (WHO, 2015). The findings suggest that while elements such as prompt attention and quality of basic amenities are resource-dependent, other elements such as dignity, autonomy, and confidentiality are less so. This suggests that even resource-constrained economies which is the case in all developing countries could work towards improving responsiveness.

1.2 Problem statement

Health system responsiveness is part of WHO's broader conceptual framework on health systems, used as an indicator to measure how well a health system performs against non-medical aspects, which have potential influence on health care as a whole. In addition to improving health and ensuring equitable financing of health systems, the way health systems interact with individuals, taking their human rights and their expectations into account, can impact their well-being and thus their quality of life (Mirzoev & Kane, 2017).

The limited resources that are available for the healthcare system of the Gaza Strip, lead to less responsive services and ultimately unsatisfied patient who became less likely to comply with medical treatment, provide relevant information to their health care provider and discontinue using medical services, which increase the burden on the originally limited resources.

Of all health systems' outcomes and aspects, the responsiveness of health care services in developing countries has been given little attention and is, unfortunately, the least studied (Mirzoev & Kane, 2017). For the Gaza Strip, there has not been, to the researcher's best knowledge, any research undertaken to study the level of responsiveness of the current health system at the household level.

Accordingly, this study aims at filling such a gap, exploring to which extent the health care system is responsive to people's needs and expectations, reviewing and understanding the current status, and contributing to making a more responsive system aiming at enhancing the quality of life of people.

The study will figure out the domains that are in need for improvement based on the feedbacks from participants. Moreover, the findings of the study will generate recommendations that would help and support the decision makers to make better and more effective actions at all stages (I.e., designs, monitoring, development...) and based on facts and feedbacks of participants of different natures (I.e., different age groups, sex, level of education...).

1.3 Justification

Responsiveness reflects the interaction between clients and the health system and for most countries, both developed and developing countries, it is a key objective of national health systems. Responsive health systems contribute to better health outcomes as they anticipate and adapt to existing and future health needs.

For all systems, the population will have expectations for how institutions and actors interact with them. For example, are human rights respected? How much do individuals participate in making decisions? Are people treated with dignity?

In lights of the scarcity of resources of the Palestinian health system, dissatisfied individuals may lose confidence in the health system, fail to follow service provider recommendations on treatment, or seek care in the event of future illness (De Silva, 2002), as a matter of fact, result in increasing complications and the burden and waste of originally limited resources.

This study primarily assessed for the first time the overall level of responsiveness of the health care system in the Gaza Strip. The researcher aimed at demonstrating the extent to which the current health system takes the human rights and beneficiaries' expectations into account, to which degree people are treated with dignity, and also all the other dimensions of responsiveness. The findings of the study could be utilized by policymakers to improve the overall level of responsiveness, thus, providing health services with the best attainable level of responsiveness which will eventually lead to improving health outcomes. Finally, the results of this study may help stakeholders who are engaged in decision-making to implement a set of actions that could lead to a higher level of patient satisfaction and eventually will promote health equity and improve the overall responsiveness of the health system.

1.4 General objective

The general objective of this study is to assess the overall responsiveness of the health care system in the Gaza Strip, in order to identify gaps, propose key recommendations that could help policymakers and providers to improve the responsiveness of the healthcare system which will ultimately improve the overall performance of health care services.

1.5 Specific objectives

- To assess the overall responsiveness of the health care system in the Gaza Strip;
- To explore the extent to which domains of responsiveness is upraised by beneficiaries in the Gaza Strip;
- To evaluate the differences of responsiveness in the Gaza Strip among social, economic and demographic factors;
- To come up with a set of recommendations aiming at contributing to improving the quality of health care services and specifically, responsiveness in the Gaza Strip.

1.6 Context

1.6.1 Geographical and demographical context

The location of the Gaza Strip is in the south of Palestine, on the eastern coast of the Mediterranean Sea, that borders Egypt on the southwest for 11 kilometers, and the occupying Israel on the east and north along a 51 km border, and with a total area of 365 km² divided into five governorates: North Gaza, Gaza City, Deir Al Balah, Khan Younis and Rafah, including 7 towns, 10 villages and 8 refugee camps (Palestinian Central Bureau of Statistics- PCBS-, 2019).

The Gaza Strip has an estimated population of 2.05 millions of which 1.0 4million males and 1.01million females, 695,967 particularly in Gaza Governorate, (PCBS, 2017). The Gaza Strip population includes some 1.4 million Palestinian refugees, 40 % of whom live in the eight recognized Palestinian refugee camps distributed in the governorates of the Gaza Strip (United Nations Relief and Works Agency -UNRWA-, 2020). The population density in the Gaza Strip is 5,479 persons/km2 (UN, 2017) which is considered noticeably

high compared to 528 persons/km2 in West Bank, 84 persons/km2 in Egypt as a whole, 115 persons/km2 in Jordan, and 400 persons/km2 in Israel.

According to the PCBS report for the year 2017, the urban population of Palestine is accounted for 77% and the percentage of the population living in the rural areas is 15% while in the refugee camps 8% (PCBS, 2017). Most of the Gaza Strip residents are young as the percentage of individuals aged (0-14) years constituted 41.5% and 4.4% for people aged 60 years and above. The annual population growth rate is 2.91% (PCBS, 2019).

1.6.2 Socio-economic context

At the socio-economic level, conditions are dire. The Gaza Strip is under severe and worsening socioeconomic conditions after more than 14 years of Palestinian internal political fragmentation, strict siege, and three sequential wars during which many attacks occurred (UNRWA, 2020).

Poverty and food insecurity are increasing. It is estimated that at least 58% of the population does not have a regular source of income (United Nations Development Programme-UNDP-, 2016). Unemployment continues to increase amongst youth and adults. The unemployment rate exceeds 47% (World bank, 2019), and the percentage can be increased dramatically in light of the increasing number of graduates and the absence of job opportunities.

Poverty rates among individuals according to monthly consumption patterns in Gaza Strip reached 53%, while the deep poverty rate reached about 34% (PCBS, 2018).

1.6.3 Health System

Reviewing indicators of Palestinian health status, it is found that the average number of years a newborn is expected to live in the Gaza strip is 74.4, while the rate of people with disabilities is 2.4% on average (MoH, 2019). The infant mortality rate in the Gaza Strip was reported to be 12.7 per 1000 live births (PCBS & UNCEF, 2019-2020), beds capacity per 10,000 population is 15.1, 15.2 physicians are available per 10,000 population, bed occupancy rate 95% (MoH, 2019), and approximately 94.8 % of the population of the Gaza Strip are covered by some form of prepayment for health care (PCBS & UNCEF, 2019-2020).

The main providers of health care services in the Gaza Strip are the Ministry of Health (MoH), UNRWA, Non-Governmental Organizations (NGO's), Military Medical Services (MMS), and the private sector (MoH, 2019).

At the level of primary health care, people receive services at 159PHC centers of which 52 centers are belonging to MoH (16 of them are located in Gaza governorate), 22 centers belonging to UNRWA, (6 of them are located in Gaza governorate), besides NGOs are providing services in 80 centers and MMS in 5 centers (MoH, 2019). The MoH classifies PHC centers into 4 levels, according to the different health services provided by the center, from basic (Level 2) to comprehensive with emergency room capacity and centers covering reproductive health services (Level 3 - 4). Out of the 52 PHC governmental centers, 19 centers are classified as level 2, 22 centers as level 3, and 10 centers as level 4 (WHO, 2018).

According to the MoH annual report, the average number of inhabitants per health center in the Gaza Strip was 12,788, and the highest number of inhabitants per health center was in the Gaza governorate (15,612 people per health center) (MoH, 2019).

The main providers of secondary care services in the Gaza Strip are the MoH through 13 hospitals, 7 of them are located in the Gaza governorate (WHO, 2018), besides 17 hospitals belonging to NGOs, 6 of them are located in Gaza Governorate, 2 hospitals for the Ministry of Interior and 2 private hospitals (MoH, 2019). The total number of available beds at governmental hospitals providing public secondary health services is 2,313 beds. 50.1% of these beds are at Gaza governorate hospitals (WHO, 2018).

Tertiary care services in the Gaza Strip are provided by the MoH and the private sector, such as cardiovascular surgery, open-heart surgery, ophthalmic, and neurosurgery (MoH, 2019). Typically, MoH and UNRWA contract out tertiary care services not available in their facilities, e.g., cancer treatment and complicated cardiac surgeries. The limited quality of health service provision is due to the Israeli blockade, severe deterioration of medical equipment, and the inability to appropriately maintain equipment in the lack of spare parts of technical equipment and training. To mitigate the consequences, medical missions are taking place throughout the year in which international medical specialists deploy to Gaza to conduct surgeries and on-job trainings for their technical counterparts in Gaza. Another mitigation measure is the costly and complex referral of patients with surgical requirements to health facilities outside of Gaza (Health Cluster, 2014). Hospitals in east Jerusalem accounted for the single largest destination for referrals from the Ministry of Health (45%), followed by West Bank hospitals (39%), Gaza Strip hospitals (6%), Egyptian and Israeli hospitals (each 5%) and Jordanian hospitals (1%) (World bank, 2016).

In the end, it is found that the aforementioned facts have many returns on services provision to people in the Gaza Strip at all levels, particularly the health sector as it is considered one of the most vital sectors that directly and seriously affected by the deteriorated situations. In other words, the early mentioned demographic characters and ongoing increase in population size and the deterioration of socio-economic conditions of the Gaza Strip imply that there is an increasing demand for health services and an enormous load on the health sector.

1.7 Corona Virus Disease 2019 (COVID-19)

COVID-19 is a highly infectious disease caused by a newly discovered coronavirus in 2019, spread around the world. The virus mainly affects the respiratory system. Older people, and those with serious medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness (WHO, 2020).

Throughout the period of conducting this study, the Gaza Strip witnessed a sharp increase in cases of COVID-19. The situation in the Gaza Strip were extraordinarily fragile, with severe movement and access restrictions to prevent the infection, and these restrictions sharply worsened social and economic conditions. The dramatic events of 2020 have weakened Palestinian public services and hindered efforts to mitigate the impact of COVID-19. The Palestinian economy contracted 10-12% in 2020, one of the largest annual contractions (UNSCO, 2021). Despite a global mobilization around the COVID-19 response, international donor support to Palestinians has continued its long downward trend (UNSCO, 2020).

1.8 Definitions

Responsiveness

The researcher adopted the responsiveness module of the world health survey to measure the responsiveness of the healthcare system. WHO defines responsiveness as: “The ability of the health system to meet the population's legitimate expectations regarding their interaction with the health system, apart from expectations for improvements in health or wealth” (WHO, 2000).

Domains of healthcare system responsiveness are:

1. Respect of persons (Dignity, Autonomy, Confidentiality).
2. Client orientation (Access to social support, Quality of basic amenities, Choice, Prompt attention).

Dignity

Is the right of a care seeker to be treated as a person in their own right rather than as a patient who due to asymmetric information and physical incapacity has rescinded his/her right to be treated with dignity.

Autonomy

It includes the right of an individual to get information on his/her disease and alternative treatment options, the right to be consulted about treatment, and informed consent in the context of testing and treatment.

Confidentiality

Is defined as protecting the information of patients and their illness and not being revealed, except in specific contexts, without the permission of the patient.

Responsiveness scoring

- Very poor: from 20% to 35.8%
- Poor: from 36% to 51.8%
- Moderate: from 52% to 67.8%
- Good: from 68% to 83.8%
- Very good: from 84% to 100%

Chapter 2

Literature Review

2.1 Conceptual framework

According to the literature, health system responsiveness entails an actual experience of interaction between people and the utilized health system. It is a multi-dimensional concept and is usually measured through several domains. This involves some domains that relate to respect for human rights which often have an important ethical dimension while others that relate to interpersonal aspects of the care that eventually lead to consumer satisfaction with the provided services and with the system's overall performance. Following are the seven domains of responsiveness that have been recognized by the WHO and assessed in this study:

2.1.1 Respect for person

Dignity: This domain involves the right of a care seeker to be treated as a person in their own right rather than as a patient who due to asymmetric information and physical incapacity has rescinded his/her right to be treated with dignity. This includes treatment with respect by health care staff, the right to ask questions and provide information during consultations, and treatment "concern".

Autonomy: In the context of this study, it includes the right of an individual to get information on his/her disease and alternative treatment options, the right to be consulted about treatment, and informed consent in the context of testing and treatment.

Confidentiality: is defined as protecting the information of patients and their illness and not being revealed, except in specific contexts, without the permission of the patient. This

would involve conducting consultations with the patients in a manner that protects their privacy and safeguarding the confidentiality of information provided by the patient, and information relating to an individual's illness.

2.1.2 Client orientation

Prompt attention: Incorporates the ability to gain care speedily through conveniently located health care units that would improve individuals' psychic welfare and it focuses on welfare enhancement through minimizing waiting time for consultation, treatment and operation lists.

Quality of basic amenities: Focuses on non-health enhancing physical attributes of health care units such as the cleanliness of the facility, adequacy of furniture, and quality of food.

Choice of care provider: includes the choice between and within health care facilities, which extend to opportunities of accessing specialist care and another opinion.

Access to social support: Networks during care integrating community interactions with health care activities. This domain is currently operationalized in the context of inpatient care only.

Figure (2.1) outlines the framework of the health system responsiveness and its domains in this study.

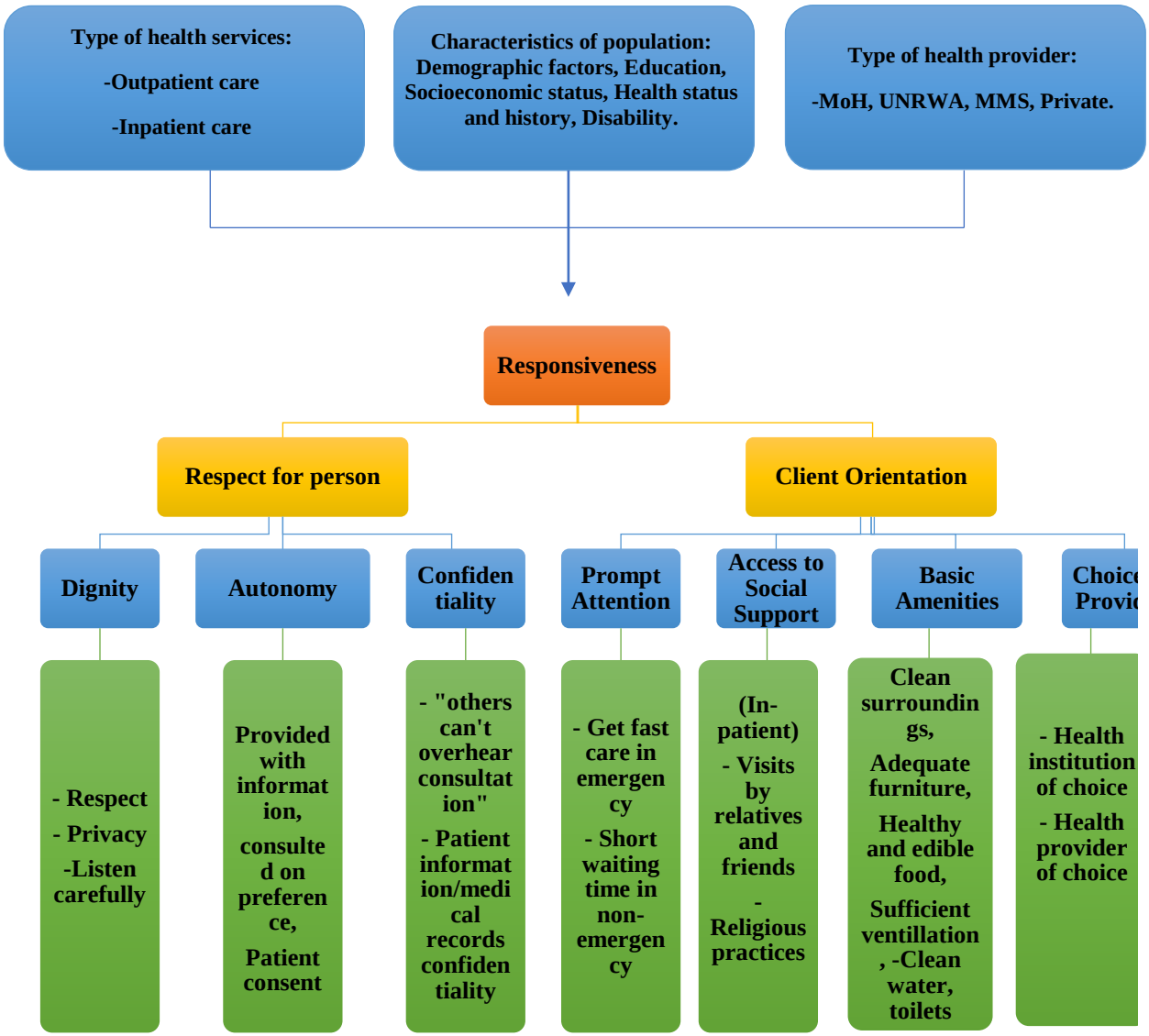

Figure (2.1): Self-developed Conceptual Framework

2.2 Literature

2.2.1 Definition

Responsiveness of the health system is "the aspects that are related to the way individuals are treated and the environment in which they are treated. It covers a set of non-clinical and non-financial dimensions of quality of care that reflect respect for human dignity and interpersonal aspects of the care process" (WHO, 2012).

2.2.2 Development of responsiveness concept

Since WHO defined the health system in 1948 it was recognized that the health system must address the medical needs of individuals, but traditionally it also focused on other factors affecting people's well-being (Valentine et al., 2003). Decades later, Donabedian 1980 defined quality of medical care as much broader than simply the ability to enhance health, including management of interpersonal processes (Donabedian, 1980). Client satisfaction was of fundamental importance to the management of the interpersonal process as it gave information on the provider's success at meeting the client's values and expectations. Since the 1980s, the interest in patient satisfaction as a separate outcome measure has grown, however, the need to capture the actual patient experience, in addition to patient satisfaction with the care received, has also been recognized, since it provides a direct link to actions to improve quality (Valentine et al., 2003). In 1997, the Agency for Health Research and Quality (AHRQ) in the United States of America (USA) had developed a survey to capture patient experiences through patient reports rather than their satisfaction with these experiences. WHO redefined and broadened the concept of patient experience to cover the interpersonal process between practitioner and patient or client and also cover the interaction between the health system and the population it serves. This concept was called responsiveness (Murray & Frenk, 2000).

2.2.3 Importance of responsiveness

The importance of responsiveness stems mainly from its relation to people's health (Bleich et al. 2009; Valentine et al., 2007; WHO, 2012). Enhancing better experiences with non-health factors could lead patients to be more cooperative with their health problems, accept treatment procedures, and follow the advice of medical staff (Chen et al., 2020; Aliman & Mohamad, 2013). In developing countries, it has been shown that a lack of responsiveness in health systems can lead to an underutilization of health services and leading to poor health outcomes (Banerjee & Duflo, 2011). Additionally, responsiveness is fundamental due to its relationship with patients' rights as human rights theory and principles support the need to pay attention to the responsiveness domains when delivering health services not only to improve health outcomes but to further respect for human rights that underlie the intrinsic value of the domains themselves (Gostin et al., 2003).

2.2.4 Domains of responsiveness

2.2.4.1 Dignity

In 1948 was the first time the Universal declaration of human rights set out "All human beings are born free and equal in dignity and rights". Dignity is important to every individual irrespective of the situation, especially in healthcare settings. It protects each individual from potentially abusive practices, bodily infringements, and mental harm.

In this study, the dignity domain includes assessing if patients are treated respectfully, treated with concern and safeguarding their privacy.

Results of key informant's surveys for measuring responsiveness in 35 countries showed that with regard to dignity, Vietnam, Mexico, Cyprus, Malaysia, China, Philippines, and

UAE score above 6.50 out of 10, where the sample average is 5.59. Considering the countries that score low on dignity, with scores below 4.50 are Sri Lanka and Nepal (WHO, 2015).

In Gaza Strip, through the evaluation of the family health team approach at UNRWA health centers, 78% of participants have indicated that health providers are courteous and polite and 77% of them thought that health providers showed interest in their questions (Safi, 2018).

Perhaps the most important way of ensuring human dignity is to stop invidious discrimination (Gostin et al., 2003). Discrimination based on race, sex, religion, ethnicity, political views, property, birth, disability, or other status is deeply hurtful to human beings, including to their health. For instance, and based on the results of research carried out locally by Hammad O. evaluating Type 2 diabetic services, 83% of beneficiaries answered that they were treated equally (Hammad, 2019).

As evidence by literature, the old aged are likely to get treated with less dignity; the higher the level of education of individuals, the better treatment in a dignified manner is offered (Valentine et al. 2000). In terms of socio-economic aspects, poor individuals were identified as the main disadvantaged group with regard to dignity (De Silva & Valentine, 2000).

2.2.4.2 Confidentiality

Confidentiality in healthcare settings refers to the patient's right to expect that healthcare workers or others will not improperly access, use, or disclose identifiable health data without the person's consent (Gostin et al., 2003) and they must be applied sensitively, with respect for different cultural, social, and religious traditions. In the context of this

study, confidentiality involves conducting consultations, treatment and operations for patients in a manner that protects their privacy and safeguarding the confidentiality of patient's information and their medical records (De Silva, 2000). Regarding this domain, findings of a study conducted in 2001 to measure responsiveness in 35 countries showed that confidentiality was rated high in many countries. Confidentiality has a higher sample average of 6.53 with regard to a scale from 0 to 10. When considering 7.50 as the cutoff point, China, Malaysia, Mexico, UAE and Vietnam could be classified to be doing relatively well. However, Nepal is not as it has a score below 4.5 (WHO, 2015). Meanwhile, another study conducted to assess health care responsiveness domains in Turkey revealed that Turkish health care system met confidentiality expectations of Turkish citizens better than their expectations of other aspects of responsiveness (Ugurluoglu & Celik, 2006). Also, confidentiality was the highest in findings with those in Iran (Baharvand, 2019; Mohammadi & Kamali, 2015; Rashidian et al., 2011), Tanzania (Kapologwe et al., 2020), and South Africa (Peltzer & Phaswana-Mafuya, 2012).

Locally, in assessing client centeredness of governmental primary health care services, it was found that 76% of participants scored high for confidentiality domain (Anan, 2017).

Regarding the relation between this domain and the economic factor, literature showed that countries with higher levels of per capita income seem to attain higher scores with regard to carrying out consultations in separate consultation rooms that safeguard the confidentiality of the patient-provider information exchange.

2.2.4.3 Autonomy

The principle of respect for autonomy is usually associated with allowing or enabling patients to make their own decisions about which health care interventions they will or will

not receive (Entwistle et al., 2010). This ties into key human rights principles such as freedom to seek, receive and impart information (the International Covenant on Civil and Political Rights (ICCPR), Article 19, 1976).

The importance of this domain within health aspects is that with enhanced patient participation, and considering patients as equal partners in healthcare decision-making, patients are encouraged to actively participate in their treatment process and follow their treatment plan and thus a better health maintenance service would be provided (Farrell, 2004). Autonomy domain in this study involves that individuals should be provided with information, consulted on preference and provide consent to medical procedures.

Despite autonomy being a primary principle in bioethics that is discussed and protected by many international treaties, many providers in the Saudi Arabian healthcare sector and other countries fail to deliver services following best practices that preserve patient autonomy (Bukhari, 2017). Moreover, independence and autonomy were the lowest in findings according to studies in Iran (Baharvand, 2019; Sajjadi et al., 2015; Javadi et al., 2011), and Egypt (Mosallam et al., 2013).

According to surveys conducted by WHO in several countries, only China, the Philippines and the UAE score above the average 6.5 out of 10 for autonomy. While, many countries scored below the average including Bangladesh, Bolivia, Sri Lanka, Trinidad, Chile, Brazil, Burkina Faso, Nepal, Peru and Uganda (WHO, 2015). In the same manner, in the Gaza Strip, and according to Anan H. study, only 62% of the study population answered that consent was obtained before the examination (Anan, 2017).

Another survey conducted in 191 countries for estimating responsiveness level and distribution showed that increased human capital increases the ability to demand and

exercise autonomy better. Increased health expenditure leads to higher staffing levels, so more time allows patients to become more involved in the decision-making process (WHO, 2015).

2.2.4.4 Prompt Attention

Showing respect for peoples' time and feelings is the issue at stake here rather than providing urgent medical care, having timely service avoids potential anxiety and inconvenience created by any delays in receiving attention or care (Gostin et al., 2003). Prompt attention domain in this study involves rapid care in emergencies and short waiting times both with regard to consultation and operation lists.

Valentine and colleagues found from general population surveys of 'health system responsiveness' in 41 countries that majority of respondents selected prompt attention as the most important domain (Valentine et al., 2007). Referring to different studies conducted in South Africa, it was found that the key reasons for dissatisfaction with public and private health services included long waiting times (Peltzer & Phaswana-Mafuya, 2012). In the same manner, prompt attention was found to score the lowest according to studies conducted in Ghana (Ratcliffe et al. 2020) and Iran (Baharvand, 2019).

Locally, 77% of the beneficiaries of type 2 diabetic services were satisfied with waiting time (Hammad, 2019), and in another study, a total of 76% of participants have indicated that they can reach health services at right time (Safi, 2018).

After reviewing the literature, it was indicated that rural populations are likely to be disadvantaged with prompt attention. Bangladesh, Botswana and India in particular noted that the illiterate and those with low educational attainments are likely to be disadvantaged (WHO, 2015).

2.2.4.5 Social Support

Humans are naturally social and social support is vital to health and quality of life. For example, in a meta-analytic review conducted in 2010 across 148 studies to determine the extent to which social relationships influence the risk of mortality, findings indicated a 50% increased likelihood of survival for participants with stronger social relationships (Holt-Lunstad et al., 2010). The ability of patients to seek their family, friends, or others within a social network for support during health care serves patients' welfare (Kruse et al., 2002).

Most of the 35 countries targeted in the WHO survey to assess responsiveness domains score high on social support networks with the sample average being 7.12 out of 10 (WHO, 2015). Regarding the importance of this domain, in different countries including Iran (Baharvand, 2019; Javadi et al., 2011) and Tanzania (Kapologwe et al., 2020), patients considered access to social support during the hospitalization period as the best aspect of non-medical services.

2.2.4.6 Quality of basic amenities

The basic amenities of health services such as clean waiting rooms, adequate beds, and quantity and quality of water and food in hospitals are aspects of care that are often highly valued by individuals (Mirzoev & Kane, 2017). The availability of Clean and well-maintained facilities provides the enabling environment for health facilities and health care providers to function effectively. Nevertheless, data from 54 low- and middle-income countries, such as Ghana, Kenya, Mali, Tanzania… etc., reported that 38% and 19% of health facilities respectively, lacked access to clean water and sanitation, while 35% did not have water and soap for handwashing (WHO, 2015). In another study in 35 countries

for measuring responsiveness, with regards to the quality of basic amenities domain, 11 countries scored below 4.5 out of 10, where the sample average is 5.22. On the other hand, China, Cyprus, Malaysia, Mexico, South Korea, UAE and Thailand have scored over 6.50 (WHO, 2015).

Locally, the quality of basic amenities scored 80% for governmental health services considering that cleanliness facility as a subdomain scored the least (61.5%) (Anan, 2017). While 85% of beneficiaries of type 2 diabetic services at UNRWA health centers were satisfied with the cleanliness of health centers (Hammad, 2019).

After the literature review, the quality of basic amenities was considered to be adversely affected by economic status. Meanwhile, competition within the private sector is likely to contribute to a better quality of basic amenities.

2.2.4.7 Choice of provider

Patients should be able to reach health services of choice without too much difficulty and within a health care unit individual should be able to choose their health care provider (Darby et al. 2000). The ability to consult the same doctor regularly has the added advantages of systematic comprehensives diagnosis and treatment, as well as better compliance through the development of patient trust (De Silva, 2000). Offering individuals, a choice of medical providers is a valued feature of health systems in industrialized countries like the United States (WHO, 2015) as it is related to the percentage of private sector involvement in the health system.

After literature review, it appears that choice of provider domain scored the lowest compared to other domains in most countries, both developed and developing, and the effect it would have on the final score in measuring responsiveness was minimized as the

web values survey on the importance of elements gave it the lowest weighting among all the domains (only 5 %) (WHO, 2015).

Nejru and colleagues in a study conducted in Kenya, which is a developing country with low income of which is similar to some extent to Gaza context, showed that regarding the choice of provider domain that the majority of users (71%) reported that a choice of health provider was not offered in governmental secondary care facilities (Nejru et al., 2007). In the same manner, in the study by Javadi and colleagues on non-medical aspects of health services in patients admitted to Isfahan governmental secondary care, patients described the choice of a therapist as the weakest point of the medical centers (Javadi et al., 2011). Additionally, in Ebrahimipour 's study 2013 and Baharvand's in 2019, Iranian patients evaluated the right to choose a therapist lower in public hospitals rather than private hospitals.

Free choice of therapist or hospital for treatment is unusual in many countries; even more, Europeans are not used to choose provider freely, as in studying responsiveness in 8 European countries, the majority of people in 7 countries assessed the right to choose a therapist to be low and attributed this to insufficient knowledge for choice; among the countries studied, only Swedish respondents had no problem with it (Coulter & Jenkinson, 2005). Moreover, according to a study conducted by WHO, choice of care provider within a health care unit fares badly in 14 out of 35 countries and about 75% of the countries surveyed reported that choice of care provider is disadvantaged for rural populations (WHO, 2015).

In the local context of the Gaza Strip, only 28% of participants mentioned that they chose health providers in primary health services (Anan, 2017).

Chapter 3

Methodology

This chapter discusses the methodology used in this research. The adopted methodology to accomplish this study is detailed in the following: study design, study settings, study population, sample size, data collection and study instrument, scientific rigor, data entry and analysis and ethical considerations.

3.1 Study design

The study design is cross sectional with triangulation between quantitative and qualitative methods. The quantitative part assesses the responsiveness of the health system and its domains, the importance of the domains from participants' perspectives. Beside that the qualitative part explores and explains with some in-depth, perspectives about the domains of health system responsiveness. Both qualitative and quantitative designs together lead to a complete view of what's occurring.

3.2 Study period

The study has started in July 2020 and after obtaining the Helsinki ethical approval in October 2020 as shown in annex (1) and the official letter of approval from the Ministry of Interior annex (2) the data collection started. The study was completed in April 2021. Annex (3) describes the duration of each activity.

3.3 Study settings

The study was conducted through face-to-face interview at the household level in the Gaza governorate benefiting from health care system services considering that Gaza governorate

entailing all levels of health care services and all types of health care providers in addition to the different social and economic levels of its population and due to the limited time of the study. A random sample from households of the Gaza Governorate was obtained regarding different geographical areas.

3.4 Study population

The population of this study is the residents of the Gaza governorate with an estimated population of 678،669 people and 351،826 of them are 18 years and above (PCBS, 2020). It is worth mentioning that the Gaza governorate is characterized by a diverse population at social and economic levels including 5 areas (refugees and non-refugees). All levels of health services are provided at the Gaza governorate including primary, secondary and tertiary services. In addition, all kinds of health care providers (Governmental, UNRWA, NGO's and Private) introduce their services in Gaza Governorate. A representative sample out of Gaza governorate population who are 18 years old and above and supposed to be served by the health care system has been interviewed through household visits.

3.5 Selection criteria

3.5.1 Inclusion criteria:

- Individuals who live in Gaza Governorate (at least spent the last year in Gaza Governorate).
- Individuals who are 18 years old or above.

3.5.2 exclusion criteria:

- Any person doesn't meet the above criteria.

3.6 Study sample and sampling

Regarding the quantitative part: between October to November 2020, a total of 409 people were interviewed through household visits, selected out of the households of Gaza governorate (135,733) using a confidence level of 95% and 5% margin of error. A two-stage sampling approach was used:

1. Systematic random method: Gaza Governorate was divided into 56 quarters. Then a random sample (11 quarters) was selected, by choosing every sixth quarter (period interval 6), as per annex (4).
2. Around 37-38 households cluster selected from each quarter, beginning from a starting point then choosing every fifth household. Then from each household, an adult individual who is 18 years or older was selected.

Regarding the qualitative part: Two focus group discussions were held with a purposive sample of beneficiaries selected out of the study population.

- The participants of the first group were 4 men and 4 women who are beneficiaries from the health system services and came from different geographical areas, the meeting held in Qatar Red Crescent office.
- The participants of the second group were 5 women and 3 men from community gathered in coordination of a local CBO.

3.7 Study instrument

3.7.1 Quantitative part – Questionnaire

The main tool used for the quantitative part was a responsiveness module of the World Health Survey (WHS) questionnaire, which is a valid, reliable and comparative instrument developed by WHO (Darby et. al., 2000), the questionnaire is available in English and Arabic language as per annexes (7,8), with most questions being close-ended questions. The following items were involved in the questionnaire:

- Socio-demographic and economic characteristics of people.
- Health services utilization.
- Importance of responsiveness domains from people's view.
- People's view about the responsiveness domain of outpatient and inpatient services which were used.

Pilot study

For assessing the appropriateness of the questionnaire, a pilot study for 10 households was conducted. As no major modifications were introduced after the pilot, data collected through the pilot study were included in the study sample.

3.7.2 Qualitative part – Guiding Questions

The main tool used for the qualitative part was guiding questions for the focus group discussions that were developed to complement the quantitative data in order to address the study objectives, as per annex 9.

The guiding questions were developed, validated and used under direct supervision and coordination with the supervisor. The participants joined by their free will, the discussions

were recorded and notes were taken. All materials have been saved and accessible only to the researcher.

3.8 Scientific rigor

3.8.1 Quantitative part - Validity and Reliability

The following steps were done to assure instruments validity and reliability:

- The questionnaire was reviewed by 5 experts (Annex 11) to ensure the appropriateness and relevance of the questions. Minor modifications were made based on expert review on the general characteristics part.
- A pilot study was conducted before the beginning of actual data collection, by which participants' responses were examined and their understanding of the questionnaire was assessed.
- Cronbach's Alpha was calculated with a result of 0.8 for the health system responsiveness scale.
- Training of data collectors on the client interviewing steps and the way of asking questions. This assured standardization of questionnaire filling.
- Ongoing checking and verifications of the completed questionnaires.
- Data entry on the same day of data collection allowed possible interventions to check the data quality or to re-fill the questionnaire when required.

3.8.2 Qualitative part

To assure the trustworthiness of the qualitative part in this study, the researcher ensured compatibility between research objectives, methods of data collection, and tools of data collection. Peer-check for the questions to ensure that they cover all the required

dimensions. Measures also included standardization of implementation, using interview guide and members check.

3.9 Ethical and administrative considerations

- An official letter of approval to conduct the study was obtained from Al-Quds University.
- Ethical approval was received from Helsinki Committee, as per annex (1).
- An official letter of approval to conduct the survey was obtained from the Ministry of Interior, as per annex (2).
- Informed consents for people who participated was developed to ensure confidentiality, explaining the purpose of the study and they were aware of voluntary and confidentiality of participation as per annexes (6,9).
- Participants in focus group discussions were asked for their permission to record the interviews.

3.10 Data Collection

The researcher and two males and one female trained data collectors collected the data and filled questionnaires through face-to-face interviews (taking into consideration all safety measurements against COVID-19 pandemic e.g., wearing masks and gloves and safety distance). A training was conducted on what are the needed key data, how to ask the questions, complete the questionnaire in order to unify the collection process, ensure consistency and improve reliability for data collectors. The researcher conducted the two focus group discussions.

3.11 Data entry and analysis

3.11.1 Quantitative part

The researcher used Statistical Package of Social Science (SPSS) program version 20 for data entry and analysis, following different steps:

- Data entry was conducted immediately after the collection of data.
- The study variables ware coded and entered into SPSS.
- Data cleaning was conducted after the data entry.
- The frequency distribution of all the variables was done.
- Bi-variate statistical tests such as t-test and one-way ANOVA to investigate the relationships between the different variables and the different relationships between them.
- The percentage scores (%) used by Abd Al-Fattah have been adopted as references for evaluating responsiveness and its domains as in table below (Abd Al-Fattah, 2017).

3.11.2 Qualitative part

Through the focus groups, all participant comments were boiled down to essential information using a systemic method. Being by taking notes during and after hearing the group tapes. Clean up the notes by stripping off nonessential words. Simultaneously assign each participant comment/quote as separate line on the page as well as each new thought or idea therein.

The quantitative and qualitative findings were compared and integrated to validate the findings and create rich information.

3.12 Limitations of the study

The first limitation of the study is the spread of COVID-19 epidemic in the Gaza Strip since March 2020 and the lockdown imposed on the Gaza strip population, which affected gaining the approvals for conducting the research earlier and prevent the ability to reach other areas in the Gaza Strip. Moreover, limited financial resources and limited time available to conduct the study. Also, the qualitative component is somewhat limited.

Chapter 4

Findings and Discussion

4.1 Introduction

This chapter presents the main results of the quantitative and qualitative analysis of the collected data and the discussion of the main findings. It starts with describing of socio-demographic, economic and health characteristics of the study population. Then, it shows the main inferential analysis of selected variables. Additionally, the findings of this study will be discussed in light of previous related research studies.

4.2 Characteristics of the study population

4.2.1 Socio-demographic characteristics of the study population

As shown in figure (4.1), the percentage of males and females in the study population was approximately equal with a slight increase in the number of males (53.5%). This is consistent with the sex ratio of the population in the Gaza Strip according to PCBS, where the percentage of males and females 51% and 49% respectively (PCBS, 2019).

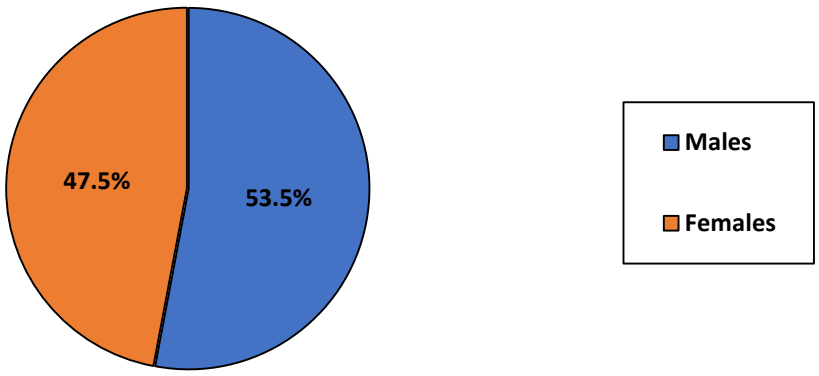

Figure (4.1): Distribution of study population according to their gender.

Table (4.1) shows that the mean age of the study population was 49.35 years (SD 14.4). Disaggregating the study population, it is found that 38.4% aged between 18 and 45 years, 36.7% aged between 46 and 60 years, and 24.9% aged more than 60.

With regards to marital status at the time of data collection, the majority of the study population were married (83.6%), 6.9% were single, 7.1% were the widow and 2.4% were divorced.

The findings of the study population regarding family size reveal that 39.1% of population families have from 5 to 8 members, while 33.5% of families have less than 5 members and 27.4% of families of the study population have more than 8 members.

As for academic qualifications, nearly half (47.9%) of the study population were bachelor's degree level or higher, only 3.9% were illiterate and 16.9%, 16.1%, 15.2% were preparatory (lower secondary), general secondary and diploma levels respectively.

Table (4.1): Distribution of study population in terms of socio-demographic characteristics.

Item	**No.**	**%**
Age groups		
From 18 to 45	157	38.4
From 46 to 60	150	36.7
More than 60	102	24.9
Total	**409**	**100.0**
Mean= 49.35 years, SD= 14.4		
Marital Status		
Single	28	6.9
Married	342	83.6
Divorced	10	2.4
Widow	29	7.1
Total	**409**	**100.0**
Family size		
5 or less	137	33.5
Between 5 and 8	160	39.1
9 or more	112	27.4
Total	**409**	**100.0**
Education level		
Illiterate	16	3.9
Preparatory	69	16.9
General Secondary	66	16.1
Diploma	62	15.2
Bachelor	189	46.2
High studies	7	1.7
Total	**409**	**100.0**
Refugee status		
Refugee	219	53.5
Non-refugee	190	46.5
Total	**409**	**100.0**

With regards to the refugee status, more than half of the study population are refugees (53.5%), while 46.5% of them are non-refugees. This finding is consistent with PCBS's findings that two-thirds of the Gaza Strip population are refugees (PCBS, 2019).

4.2.2 Economic characteristics of the study population

As shown in figure (4.2), it is noticeably clear that more than half of the study population were unemployed at the time of data collection (56.2%), while 32.8% were employed and 11% of the study population were retired. The distribution of employment status by gender reveals that 38.4% of males were employed compared to 26.3% of females. On the other side, nearly half of males out of the study population were unemployed (49.8%), while about two-thirds of females were unemployed (63.7%) at the time of data collection.

These findings are slightly different to the findings of PCBS, where the unemployment rate exceeded 52% of the population (PCBS, 2018) and the participation rate of females in the workforce was only 18% (PCBS, 2020a).

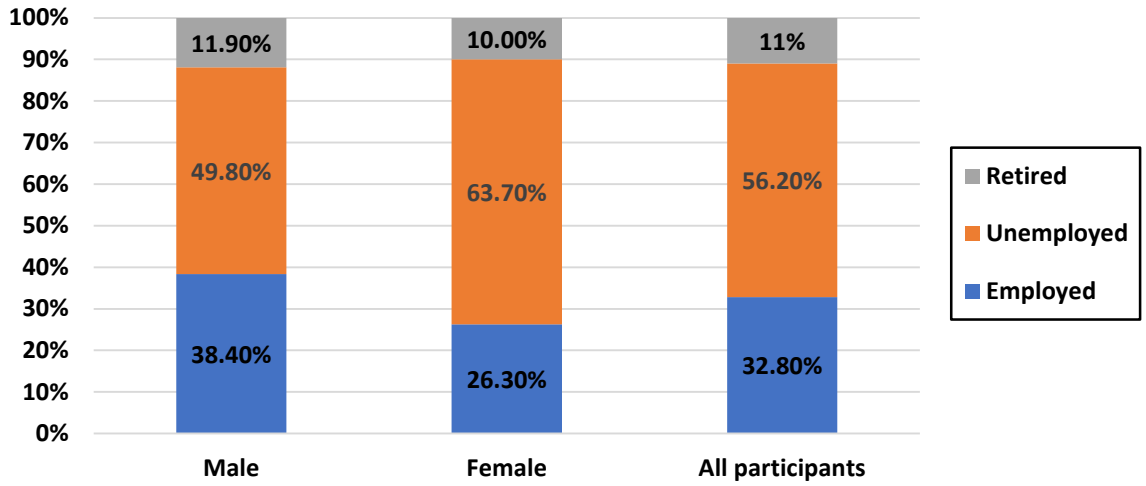

Figure (4.2): Distribution of employment status by gender.

With regards to monthly income, figure (4.3) shows that only 2.2% of the study population have an average monthly income above 2470 NIS. On the other hand, 82.6% of them have an average monthly income between 1974-2470 NIS and 15.2% under 1974 NIS. These findings can be attributed to the exceptional circumstances due to the COVID-19 crisis and the lockdown imposed on the Gaza Strip population during the epidemic which forced the day laborers who are the majority of the workforce to lose their jobs.

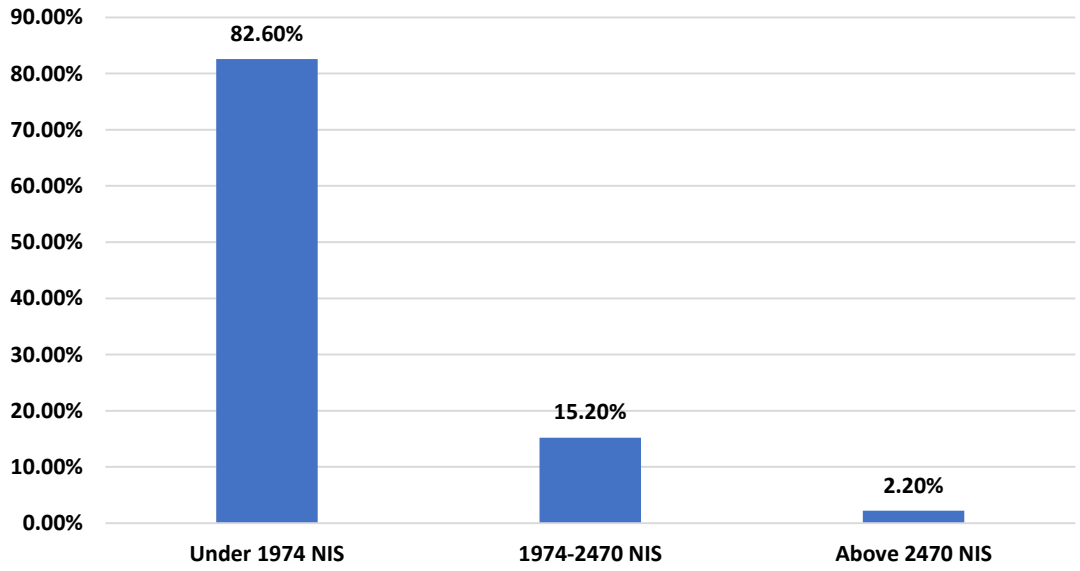

Figure (4.3): Distribution of the study population according to their monthly income.

4.2.3 Health characteristics of the study population

As shown in table (4.2), 81.4% of the study population rated their health status as good or better while only 18.6% rated their health status as moderate or bad.

Findings show that 93.2% of the study population didn't have any type of disability at the time of data collection and only 6.8% were people with disabilities.

With regards to non-communicable diseases, 41.8% of the study population had one or more chronic diseases, while 58.2% did not have any chronic diseases at the time of data collection.

Table (4.2): Distribution of the study population according to health characteristics.

Item	**No.**	**%**
Health rate		
Very good	214	52.3
Good	119	29.1
Moderate	67	16.4
Bad	9	2.2
Total	**409**	**100.0**
NCDs		
People with NCDs	171	41.8
People w/o NCDs	238	58.2
Total	**409**	**100.0**
Disability		
People without disability	381	93.2
PWD	28	6.8
Total	**409**	**100.0**

4.2.4 Health history of the study population

A total of 409 persons participated in this study of which 80% received health care in the last 12 months. According to the table (4.3), most of the participants (98.8%) got health care at an outpatient health facility (An outpatient health facility is a doctor's consulting room, a clinic or a hospital outpatient unit, any place outside the home where you did not stay overnight) while 40.7% of participants got an inpatient health care and stayed overnight in hospital in the last 12 months.

The majority of participants received outpatient services at UNRWA clinics (56.1%), this can be explained by the fact that UNRWA provides its services free of charge. However, 39.3% of participants attended Ministry of Health clinics, 2.8% of participants received services at private centers, only 0.9% got their services from Military Medical Services centers and the same percentage got their services from NGOs centers. These results are very similar to the MoH primary health care report (2018) which showed that the majority of PHC services are provided by UNRWA (60.4%) and MoH (32.6%) centers.

For inpatient health care services, about 89.5% of participants attended Ministry of health hospitals, 8.3% attended a privately operated health facility and 2.2% received health services from other providers (MMS, NGOs). These findings are consistent with the annual MoH report (2019) who showed that about 90% of people attend governmental hospitals. It is worth mentioning that UNRWA does not provide inpatient services through its centers.

More than 56% of participants was their last (most recent) visit to a health facility in the last 30 days at the time of data collection. In addition, 27.2% of participants visited health care facilities twice in the last 12 months, 24.8% had three-time visits and 22% of participants were the ones who have had more than 4 times visits to the health care facility.

Table (4.3): Distribution of study population according to health history.

Item	No.	%
Have you received any health care in the last 12 months?		
Yes	327	80.0
No	82	20.0
Total	**409**	**100.0**
In the last 12 months, did you get any health care at an outpatient health facility?		
Yes	323	98.8
No	4	1.2
Total	**327**	**100.0**
What is the health center (outpatient) you usually go to when you need medical care?		
Government (MoH)	127	39.3
Government (MMS)	3	0.9
UNRWA	181	56.1
NGOs	3	0.9
Private	9	2.8
Total	**323**	**100.0**
Have you stayed overnight in hospital in the last 12 months?		
Yes	133	40.7
No	194	59.3
Total	**327**	**100.0**
What was the type of the hospital you stayed in most recently?		
Government (MoH)	119	89.5
Government (MMS)	2	1.5
NGO	1	0.7
Private	11	8.3
Total	**133**	**100.0**
When was your last (most recent) visit to a health facility or provider? Was it…		
In the last 30 days	181	56.0
In the last 3 months	109	33.8
In the last 6 months	25	7.7
Between 6 months and 12 months ago	8	2.5
Total	**323**	**100.0**
In the last 12 months, how many times did you visit the health center?		
Once	20	6.2
Twice	88	27.2
Three times	80	24.8
More than four times	71	22.0
Total	**323**	**100.0**

4.3 Health system responsiveness

Figure (4.4) shows the findings of the overall level of the health system responsiveness and the seven domains from the study population's perspectives in Gaza governorates. The overall responsiveness was very good "84.99%" based on the study reference values.

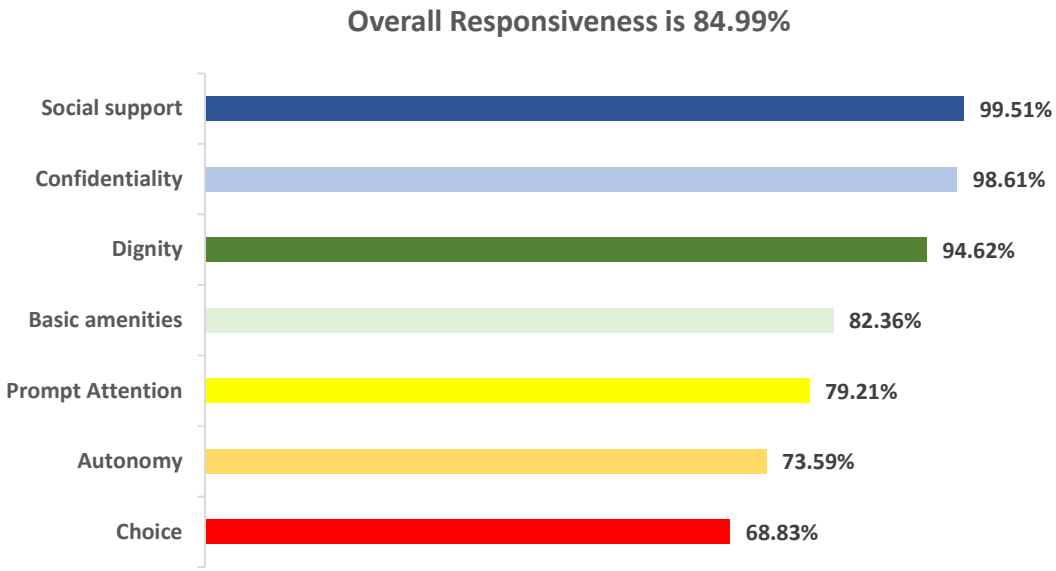

Figure (4.4): Overall responsiveness and domains level.

The best performing domain was access to social support (99.51%) based on participants' experiences regarding their interaction with the health system, followed by confidentiality (98.61%), dignity (94.62%), quality of basic amenities (82.36%) and prompt attention (79.21%), whilst, autonomy and choice of health provider were evaluated the lowest in both outpatient and inpatient care with means of 73.59% and 68.83% respectively.

Except for the one research that assessed the responsiveness of inpatient services at the public general hospitals in Gaza (Shaqura et al., 2021), this may be the first household-based study about the overall healthcare system responsiveness in the Gaza Strip, while

several studies on patient satisfaction and quality of care were conducted by (Alkhalaileh et al., 2017), (Safi, 2018), (Hammad, 2019), (Abu-El-noor et al., 2020).

The findings of the study reveal that the overall responsiveness of the health system in Gaza (84.99%) is higher than in other countries with similar contexts. The results of Valentine et al.'s study concerning the health system responsiveness in 41 different countries, which included Egypt, Cyprus and the United Arab Emirates, indicated that 62%, 70.9% and 74.4% of the respondents rated responsiveness performance as good in these countries, respectively (Valentine et al., 2007). This may be attributed to the nature of Gazans people who faced successive occupation, more than fourteen years of blockade, stifled access to key resources with disastrous humanitarian and economic consequences in addition to the internal Palestinian political divide, which made people of Gaza more resilient, flexible and adaptable. Also, these circumstances may lead people to be more concerned about different and more crucial issues than their non-health needs in health facilities.

Moreover, high levels of responsiveness from participants' point of view were found in the results of a study aimed to measure and compare the health system responsiveness across 16 countries, as it was found that low-income countries were more satisfied with their health systems than the rich ones and this is more likely to be due to differences in expectations -perhaps linked to lower standard of life- than to any preferential treatment of the poor.

The best performing domains were access to social support, confidentiality and dignity, this agrees with the findings of Vafaee and his colleagues' study (2019), this may be attributed to the fact that people of Gaza are conservative and religious, also patients might know that their conversations with a provider took place in private but are less likely to

know how their health records are managed and who has access to them. On the other hand, the least performing domain was "choice of health provider", generally, the Palestinian health system limits the ability of patients to choose their providers, rather, patients are compelled to receive the health services in specific health facilities according to the geographical distribution and place of residency due to the shortage of specialists and resources.

4.4 Importance of domains of responsiveness

Drawing on participants' viewpoints of the importance of domains, dignity (22%) and prompt attention (20%) were the most important domains, whereas, choice (5%) and quality of basic amenities (11%) were reported as the least important as shown in figure (4.5).

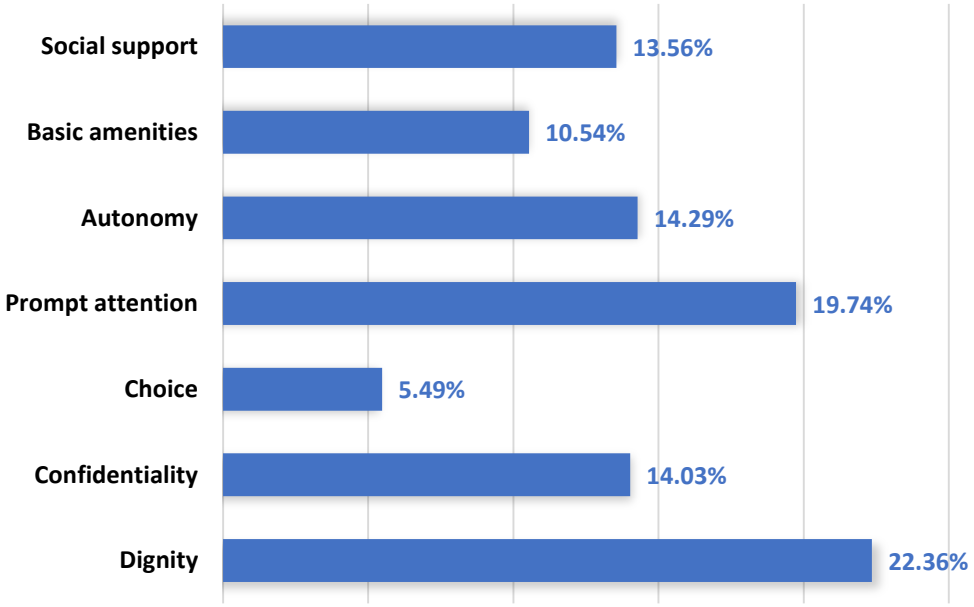

Figure (4.5): Percentage of respondents rating a responsiveness domain as the most important

Although the importance of different dimensions of responsiveness for patients is dissimilar in different societies, the dimensions of dignity and prompt attention were also considered most important in Egypt (Mosallam et al., 2013) and Iran (Baharvand, 2019). On the other hand, in a study by Valentine and colleagues in 2007 found from general population surveys of 'health system responsiveness' in 41 countries, it is found that most respondents selected prompt attention as the most important domain followed by dignity. As dignity is important to every individual irrespective of the situation, especially in healthcare settings, also providing patient care services along with immediate action and reducing the waiting time avoids potential anxiety and inconvenience about the health service delivery system.

On the other hand, the majority of study participants rated the choice of health provider as the least important domain. People of Gaza realize that they have no authority to choose the healthcare provider, accordingly, they underestimate the importance of this domain.

These results show and highlight clearly what are the most important areas from the beneficiaries' point of view, that need to be focused on and improved to ensure the provision of an integrated and acceptable service to the beneficiaries

4.5 Comparing Responsiveness in Outpatient Care and Hospital Inpatient Care

Figure (4.6) compares the findings of domains' scores in outpatient care and inpatient care. The best performing domains in outpatient care were confidentiality and dignity, while access to social support and dignity domains scored the best in inpatient care. Quality of basic amenities and Autonomy were reported better in outpatient than in outpatient care with differences of 15.78% and 10.27% respectively. However, Dignity was reported better in inpatient care than in outpatient care.

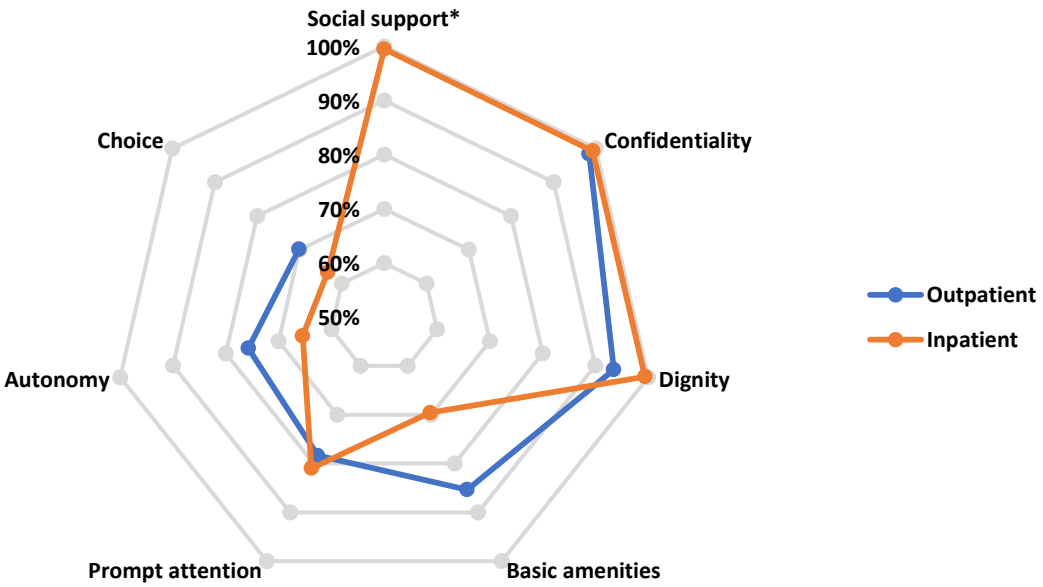

Figure (4.6): Comparing responsiveness domains of outpatient care and inpatient care. (*Social support is just applicable for inpatient care).

Concerning the basic amenities, table 4.4 shows that the quality of basic amenities domain score in inpatient care was (69.55%), while in outpatient care was (85.33%). A lower score in inpatient care may be attributed to the fact that clean rooms, adequate beds, quantity and quality of water and food are aspects of care that are often highly valued by the individuals who stay overnights in hospitals. Moreover, increasing the use of physical attributes of inpatient care facilities rather than in outpatient services eventually increases the need for constant and continuous cleaning and maintenance which is difficult in light of the lack of resources in hospitals.

As shown in table (4.4) the autonomy domain score in inpatient care was (65.45%), while in outpatient care was (75.72%). Autonomy, namely being provided with information, consulted on preference and providing consent to medical procedures, seems not to have been given sufficient attention from inpatient care services. A lower score in inpatient care

can be explained by the fact that inpatient care services are provided mainly by governmental hospitals, UNRWA, which is one of the main health services providers, does not provide inpatient services within its centers, which results in increasing the load on governmental hospitals to provide higher staffing levels and more time to allow patients to become involved in deciding on their care.

Researchers found that many healthcare service providers in the Saudi Arabian healthcare sector and other countries fail to deliver services following best practices that preserve patient autonomy (Bukhari, 2017). It is recommended to enhance the involvement of patients in decision making through training and orientation of medical and nursing staff as autonomy encourages patients to follow their treatment plan and thus a better health maintenance service would be provided.

Table (4.4): Overall responsiveness based on the rating of domains.

Domain		**Outpatient care**	**Inpatient care**	**Overall rate**
1	Social support	-	99.51%	99.51%
2	Confidentiality	98.39%	99.24%	98.61%
3	Dignity	93.46%	99.39%	94.62%
4	Basic amenities	85.33%	69.55%	82.36%
5	Prompt Attention	78.34%	80.96%	79.21%
6	Autonomy	75.72%	65.45%	73.59%
7	Choice	70.13%	63.33%	68.83%
Overall responsiveness				**84.99%**

4.6 Health system responsiveness of outpatient care

Figure (4.7) shows the level of responsiveness domains for outpatient care services. The performance was best for the domains of confidentiality (99.39%) and dignity (93.46%). The participants' reported the lowest percentage of responsiveness was for the domain of Choice (70.13%). These findings are consistent to some extent with a study conducted in Tehran assessing the responsiveness of outpatient services (Sajjadi et al., 2015).

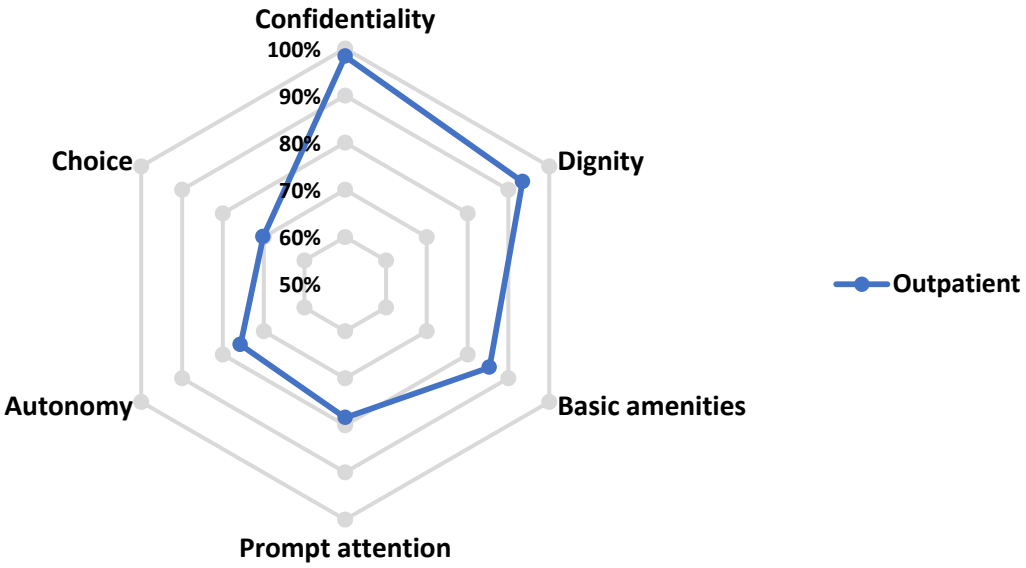

Figure (4.7): Responsiveness domains of outpatient services

4.6.1 Prompt Attention

Table (4.5) reflects the participants' responses to their experiences with getting rapid outpatient care services. The overall weighted mean for the prompt attention domain was 78.34%, indicating that the health system is characterized by a good level of prompt attention.

With regards to subdomains of prompt attention, table (4.5) shows that the highest weighted mean was for the time people had to wait before getting the health care (90.46%), assuming that the average acceptable waiting time is around 20 minutes for different patients ages (Hill, 2005). Results are compatible with the findings of a previous study where the majority of participants have indicated that they can reach health services at right time (Safi, 2018). This can be attributed to strict measures and emergencies due to the COVID-19 pandemic since March 2019, and the preventive measurements taken by service providers minimizing crowding (e.g., the appointment system, hotlines, mobile clinics …).

Despite that, when participants were asked about their general impression of the prompt attention of outpatient services, the results were quite different (approximately 66% of participants reported good prompt attention). This could be attributed to other factors not covered in this research and thus need further investigations in the future.

Table (4.5): Distribution of participants responses about prompt attention in outpatient care.

	Always		**Often**		**Usually**		**Sometime**		**Never**		**Weighted Mean**
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	
Got care when wanted	54	16.7	126	39	131	40.6	12	3.7	0	0	73.75%
Waiting time for health care	206	63.8	87	26.9	24	7.4	5	1.6	1	0.3	90.46%
Waiting time for requested tests	99	40.1	140	56.7	2	0.8	2	0.8	4	0.6	86.56%
	Very Good		**Good**		**Moderate**		**Bad**		**Very Bad**		
General impression of prompt attention	8	2.5	91	28.8	220	68.1	4	1.2	0	0	66.38%
Overall	Weighted mean % = **78.34**										

4.6.2 Dignity

Table (4.6) summarizes the participants' responses to being treated in a dignified manner in outpatient care. The overall weighted mean for this domain was (93.46%), reflecting that the health system is characterized by a very good level of dignity. The table shows that the highest weighted mean (99.75%) was for respecting privacy during physical examinations and treatments, this finding was in line to some extent with the findings of a previous study in outpatient clinics of Gaza Strip assessing respect of patients' privacy (Hammad, 2019). Nevertheless, the lowest weighted mean of dignity subdomains was for evaluating if patients were being listened for carefully by the health provider (73.19%), this result was close to some extent to Anan's study, where 79% of study participants agreed that the healthcare provider listens carefully to them (Anan, 2017). It is worth mentioning that the average number of medical consultations per doctor per day is 78 (UNRWA health department annual report, 2019), which can explain the aforementioned participants' feedback, as short time is offered by the doctor for each patient and thus limits the ability of doctors to fully pay attention and listen carefully to patients. Concerning the findings of focus group discussions, the majority of focus group participants mentioned that they were treated in a dignified manner, mainly for respect and privacy subdomains. However, a woman of 50-years-old woman of the participants of focus groups stated, *"the problem was with nurses, not doctors, they don't reply nor respond to my needs",* this may be attributed to the low scale of nurses' salaries and staff burnout.

Table (4.6): Distribution of participants' responses about dignity in outpatient care.

	Always		Often		Usually		Sometimes		Never		Weighted Mean
	No.	%	No.	%	No.	%	No.	%	No.	%	
Respected by medical staff	308	95.4	13	4	1	0.3	1	0.3	0	0	98.88%
Respected by office staff	311	96.3	9	2.8	2	0.6	1	0.3	0	0	99%
Listen carefully to you	34	10.5	154	47.7	126	39	9	2.8	0	0	73.19%
Privacy	319	98.8	4	1.2	0	0	0	0	0	0	99.75%
	Very Good		**Good**		**Moderate**		**Bad**		**Very Bad**		
General impression of dignity	273	84.5	43	13.3	7	1.7	0	0	0	0	96.47%
Overall	Weighted mean % = **93.46**										

4.6.3 Autonomy

Table (4.7) shows the participants' responses to the autonomy domain in outpatient care services. The overall weighted mean for Autonomy was (75.72%) indicating that outpatient care services provide a good level of involvement of patients in the decision-making process with regards to their medical condition. Table (4.7) shows that the highest weighted mean (97.28%) was for asking for patients' permission before conducting any medical procedures. The subdomain of having time to be able to ask questions scored 69.85%. It is worth mentioning that having enough time with patients, to be provided with information and consulted on preference, is a critical issue in patients' participation actively in their treatment process. The results of subdomains of autonomy are consistent to some extent with the findings of focus group discussions, where the majority of focus group participants mentioned that their consent was taken before any medical procedures. On the other hand, focus group discussions revealed that doctors don't provide patient with enough information about their health status, a 55-year-old man stated, *"Doctors usually don't inform me on my disease and alternative treatment options, if the treatment fails, I come back to the doctor for new treatment plan".*

Table (4.7): Distribution of participants' responses about autonomy in outpatient care.

	Always		Often		Usually		Sometimes		Never		Weighted Mean
	No.	%	No.	%	No.	%	No.	%	No.	%	
Explain things	17	5.3	181	56	108	33.4	17	5.3	0	0	72.26%
Got time to ask questions	24	7.4	141	43.7	128	39.6	30	9.3	0	0	69.85%
Involve in decision	33	10.9	180	59.2	69	22.7	22	7.2	0	0	74.74%
Ask for permission	287	88.9	29	9	6	1.9	1	0.3	0	0	97.28%
	Very Good		Good		Moderate		Bad		Very Bad		
General impression of autonomy	5	1.5	65	20.1	247	76.5	6	1.9	0	0	64.27%
Overall	Weighted mean % = **75.72**										

4.6.4 Confidentiality

Regarding the confidentiality of patients' information in outpatient care services, table (4.8) describe the weighted means of confidentiality and its subdomains. The total score for confidentiality was 98.39%; reflecting an agreement by participants that the health system with regards to outpatient care extremely safeguards information relating to their illness. This finding is consistent with a previous study conducted in Tanzania in which confidentiality scored the highest (Kapologwe et al., 2020). However, this was inconsistent with Anan study, that was assessing client centeredness of governmental primary health care services, and found that 76% of participants scored high for confidentiality domain (Anan, 2017). It may be attributed to that Anan's study targeted governmental centers only. In this regard; the findings of quantitative were inconsistent with qualitative results, in which most of the focus group participants mentioned that healthcare system does not safeguard their confidentiality during consultation nor protects their medical records. 45-year-old women stated, *"Everyone heard my consultation; medical staff, other patients,*

and anyone coming from outside the clinic". Another participant mentioned*, "My medical records were on health worker desk and my information was visible for all people in the room'.* This difference between quantitative and qualitative findings may be attributed to that quantitative data is exposed to acquiescence bias, in which respondents have a tendency to agree with all the questions in the measure, it also may figure the fact that patients are not fully aware about their rights, meanwhile, qualitative method allow in-depth discovering and exploring for opinions and experiences. Both quantitative and qualitative designs together lead to complete view of what's occurring. From researcher's experience and point of view for this domain, qualitative results may reflect more reliable findings.

Table (4.8): Distribution of participants' responses about confidentiality in outpatient care.

Confidentiality											
	Always		**Often**		**Usually**		**Sometimes**		**Never**		**Weighted Mean**
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	
1.No one can hear at consultation	303	93.8	18	5.6	1	0.3	1	0.3	0	0	98.58%
2.Confidentiality of personal information	299	92.6	24	7.4	0	0	0	0	0	0	98.51%
	Very Good		**Good**		**Moderate**		**Bad**		**Very Bad**		
3. General impression of Confidentiality	293	90.7	29	9	1	0.3	0	0	0	0	98.08%
Overall	Weighted mean % = **98.39**										

4.6.5 Choice

Table (4.9) shows a weighted mean of 70.13% for the patients' ability to reach health services of choice for outpatient care. This is consistent with a study conducted in Kenya, a developing country with low income and with a context similar to some extent to Gaza context, where the choice domain score was (71%) (Nejru et al., 2007). The highest score

was for the subdomain measuring the ability of a patient to benefit from a health facility of their choice with a score of (82.11%), this can be attributed to the high number of primary healthcare centers, as Gaza Strip has 159 PHC centers of which 52 centers are belonging to MoH, 22 centers belonging to UNRWA, besides NGOs are providing services in 80 centers and MMS in 5 centers (MoH, 2019). Study participants' score regarding their ability to choose the health provider was (64.83%) as the choice of health provider is not offered in the health facilities due to the shortage of healthcare workforce. According to qualitative findings, the majority of focus group participants expressed their inability to choose the health provider.

Table (4.9): Distribution of participants' responses about choice in outpatient care.

Choice											
Item	**No problem**		**Mild problem**		**Moderate problem**		**Severe problem**		**Extreme problem**		**Weighted Mean**
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	
Health provider of your choice	19	5.9	56	17.3	232	71.8	16	5	0	0	64.83%
Health facility of your choice	131	40.6	122	37.8	51	15.8	11	3.4	8	2.5	82.11%
	Very Good		**Good**		**Moderate**		**Bad**		**Very Bad**		
General impression of choice	8	2.5	52	16.1	251	77.7	12	3.7	0	0	63.47%
Overall	Weighted mean % = **70.13**										

4.6.6 Quality of basic amenities

As shown in table (4.10), most participants reported a good level of responsiveness in terms of quality of basic amenities and surrounding environment for outpatient care services, with a weighted mean of (85.33%).

For the quality of basic amenities subdomain, the highest weighted mean for study participants was for the quality of waiting room (i.e. space, seating and fresh air) with a mean of (91.02%), while the lowest weighted mean was for the cleanliness of the health

facility including cleanliness of toilets with a mean of (76.16%) This result is inconsistent with a previous study of primary health centers in Gaza strip, where participants scored (86%) with regards to the cleanliness of health centers (Hammad, 2019).

Table (4.10): Distribution of participants' responses about the quality of basic amenities in outpatient care.

Quality of basic amenities											
	Always		**Often**		**Usually**		**Sometimes**		**Never**		**Weighted Mean**
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	
Quality of waiting room "space, seating, fresh air"	184	57	133	41.2	6	1.9	0	0	0	0	91.02%
Cleanliness of the place including toilets	22	6.8	217	67.5	84	26	0	0	0	0	76.16%
	Very Good		**Good**		**Moderate**		**Bad**		**Very Bad**		
General impression of quality of basic amenities	146	45.2	173	53.6	4	1.2	0	0	0	0	88.79%
Overall	Weighted mean % = **85.33**										

4.7 Health system responsiveness of inpatient care

Figure (4.8) shows the level of responsiveness domains for inpatient care services. The performance was reported the best for the domains of access to social support (99.51%) and dignity (99.39%). The participants' reported the lowest percentage of responsiveness was for the domain of choice (63.33%). These findings are very close to Shaqura and Colleagues' study in Gaza city aiming at assessing responsiveness domains in five governmental hospitals (Shaqura et al., 2021).

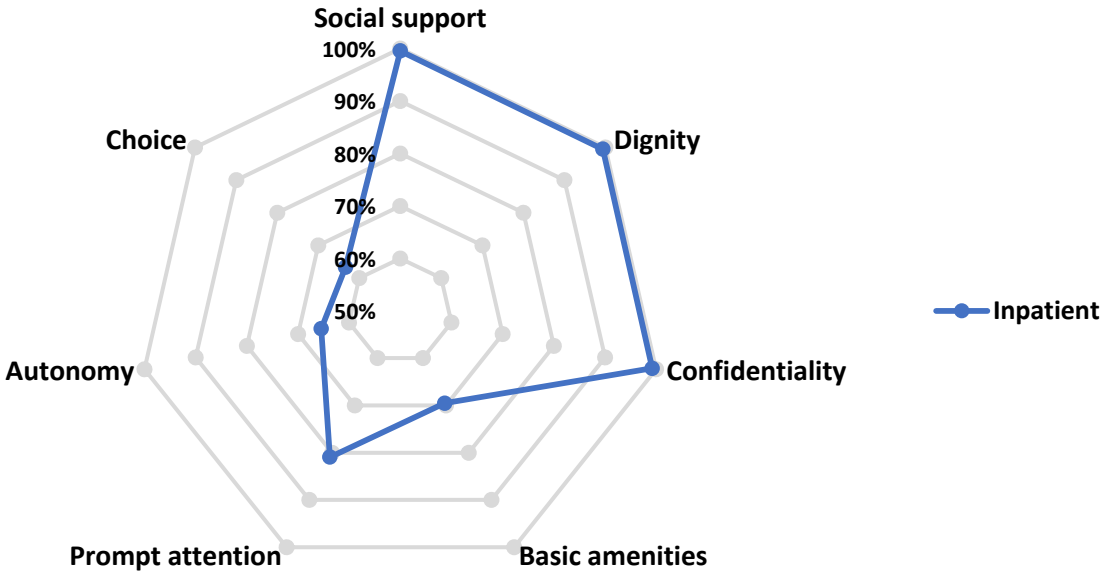

Figure (4.8): Level of responsiveness domains of inpatient care services

4.7.1 Prompt Attention

As shown in table (4.11), the overall weighted mean for getting rapid inpatient care services is (80.96%), this indicates a good level of responsiveness of the inpatient health system with regards to this domain. This finding is slightly higher than the result of Shaqura and his colleagues' study who found the prompt attention domain was 76% (Shaqura et al., 2021). It might be a kind of courtesy by the study participants. Moreover, these results are inconsistent with the findings of focus group discussions, where most of participants mentioned that they don't receive care as soon as needed during the hospitalization period. A man of 41-years-old of focus groups stated *"every health worker passed me to another one, I had to search for the sphygmomanometer to measure blood pressure, I found health workers drinking tea while I needed health care"*. It is worth mentioning that the Gaza Strip has strong ambulatory services due to the recurrent emergencies over the years, while other aspects of prompt attention need to be maintained.

Table (4.11): Distribution of participants' responses about prompt attention in inpatient care.

	Always		Often		Usually		Sometimes		Never		Weighted Mean
	No.	%	No.	%	No.	%	No.	%	No.	%	
Got care when wanted	125	94.7	7	1.7	0	0	0	0	0	0	98.94%
Got attention from doctors and nurses quickly	17	12.9	64	48.5	50	37.9	1	0.8	1	0.3	74.85%
	Very Good		**Good**		**Moderate**		**Bad**		**Very Bad**		
General impression of prompt attention	11	8.3	40	30.3	80	60.6	1	0.8	0	0	69.24%
Overall	Weighted mean % = **80.96**										

4.7.2 Social support

Table (4.12) summarizes participants' feedbacks on the level of accessibility to the social support domain during hospitalization periods from study participants' perspectives. The overall weighted mean for the domain was 99.51%, reflecting that the health system enhances the ability of patients to seek their family, friends, or others within a social network for support. It is worth mentioning that access to social support is a very important factor in the process of treatment and patients' recovery**.** These results were consistent with focus group discussion findings, where all participants agreed on being socially supported during their hospitalization period, being visited by family and friends and conducted their religious practices freely.

Table (4.12): Distribution of participants' responses about social support in inpatient care.

	No problem		Mild problem		Moderate problem		Severe problem		Extreme problem		Weighted Mean
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	
Allow visits	125	94.7	7	5.3	0	0	0	0	0	0	98.94%
Allow your family and friends to take care of your personal needs	129	97.7	3	2.3	0	0	0	0	0	0	99.55%
Practice religious acts	132	100	0	0	0	0	0	0	0	0	100.00%
	Very Good		**Good**		**Moderate**		**Bad**		**Very Bad**		
General impression of social support	129	97.7	3	2.3	0	0	0	0	0	0	99.55%
Overall	Weighted mean % = **99.51**										

4.7.3 Quality of basic amenities

Table (4.13) shows a weighted mean of 69.55% for the non-health enhancing physical attributes of inpatient care facilities such as the cleanliness of the facility, adequacy of furniture and quality of food. The quality of basic amenities is perceived by the respondents to be relatively good. In light of the quality of food provided for inpatients, nearly 69% of the study participants answered that they have a severe problem in getting healthy and edible food during their hospitalization period. In the Gaza Strip, hospitals do not generally have sufficient funds to provide patients with food. This result was very near to the results of a study conducted in Southeast Nigeria, where only 47% of study participants reported having healthy food in the hospitals (Ughasoro et al., 2017). Concerning qualitative findings, the majority of focus group participants mentioned that they didn't receive healthy food during their hospitalization period. 38-years-old women stated, *"The food provided in hospitals is unhealthy and does not take into account the health condition of the patient".*

Table (4.13): Distribution of participants' responses about the quality of basic amenities domain in inpatient care.

	No problem		Mild problem		Moderate problem		Severe problem		Extreme problem		Weighted Mean
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	
Have healthy edible food	13	9.8	8	6.1	20	15.2	91	68.9	0	0	51.36%
	Always		**Often**		**Usually**		**Sometimes**		**Never**		
Quality of the surroundings "space, seating, fresh air and cleanliness"	58	43.9	68	51.5	5	3.8	1	0.8	0	0	87.73%
Overall	Weighted mean % = **69.55**										

4.7.4 Dignity, Autonomy, Confidentiality and Choice.

Table (4.14) shows the scores of four domains of responsiveness in inpatient services, the highest weighted mean scores of responsiveness were related to dignity (99.39%) and confidentiality (99.24%) dimensions, while the minimum weighted mean scores were related to the autonomy (65.45%) and choice of provider (63.33%).

Table (4.14): Distribution of participants' responses about responsiveness domains in inpatient care.

	Very Good		Good		Moderate		Bad		Very Bad		Weighted Mean
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	
Dignity	128	97	4	3	0	0	0	0	0	0	**99.39%**
Autonomy	3	2.3	35	26.5	89	67.4	5	3.8	0	0	**65.45%**
Confidentiality	128	97	3	2.3	1	0.8	0	0	0	0	**99.24%**
Choice	2	1.5	21	15.9	106	80.3	3	2.3	0	0	**63.33%**

4.8 The relationship between some of the study participants' characteristics and the level of health system responsiveness and its domains.

4.8.1 Gender

An independent t-test was conducted to examine whether there was a statistically significant difference among study participants' gender with regard to the experienced domains of responsiveness. As shown in table (4.15), the test revealed a statistically significant difference between male participants (93.98%) and female participants (95.28%) with regards to the dignity domain (T= 2.84, Sig.= 0.005). In other words, females were reported to be treated in a dignified manner more than males. These findings are different from previous studies, Ughasoro and his colleagues found that there was no significant difference between males and females in the dignity domain (Ughasoro et al., 2017), while, Mohammed and his colleagues found that males were more likely to report higher dignity scores than females (Mohammed et al., 2013). In general, in local context, the health providers deal with females in more dignified manner due to the conservative context, and the fact that females have a less offensive nature imposing more respectful behavior.

Table (4.15): Differences in the level of responsiveness and its domains among study participants' gender.

Domain		Males	Females	T	Significance (Sig.)
1	Social support	99.02	99.93	2.915	0.005*
2	Confidentiality	98.65	98.57	0.171	0.864
3	Dignity	93.98	95.28	2.84	0.005*
4	Basic amenities	82.45	82.26	0.198	0.844
5	Prompt Attention	79.84	78.49	1.059	0.290
6	Autonomy	72.81	74.37	1.63	0.104
7	Choice	68.69	68.96	0.282	0.778
Overall responsiveness		85.06	85.4	1.89	0.059

Considering the access to social support domain, female participants are more likely to have access to social support during hospitalization periods than males (T= 2.915, Sig.= 0.005). This result is inconsistent with Ughasoro and his colleagues who found that there was no significant difference between males and females in the access to social support domain (Ughasoro et al., 2017).

Results of the t-test revealed that there was no significant difference between the gender of study participants in relation to confidentiality, basic amenities, prompt Attention, autonomy and choice domains. These findings are in line with Baharvand study in Iran (Baharvand, 2019).

4.8.2 Age

As shown in table (4.16), a one-way ANOVA test was conducted to examine whether there were statistically significant differences among participants in different age groups in relation to responsiveness level and its domains. The test revealed a statistically significant difference across participants' age groups regarding the quality of basic amenities domain (F= 3.278, Sig.= 0.039). A Bonferroni post hoc test was conducted to examine which of participants' age groups are significantly different in relation to the basic amenities domain. The test revealed that participants aged from 46 to 60 years have a statistically higher score of quality of basic amenities than participants aged 61 years and more (MD= 0.19, Sig.= 0.044). These findings can be attributed to that, in general, older people would suffer from more complicated illnesses, which result in greater demands on a health system to be responsive. This result is inconsistent with Shaqura and his colleagues who found that older people reported higher scores for the basic amenities domain (Shaqura et al., 2021).

The ANOVA test revealed that there were no significant differences among participants' age groups in the assessment of any of the rest of the responsiveness domains.

Table (4.16): Differences in the level of responsiveness and its domains among study participants' age groups.

Domain	Age group	No.	Mean	SD	F	Sig.
Social support	From 18 to 45 years	36	99.86	0.83	2.276	0.107
	From 46 to 60 years	45	99.29	1.26		
	61 years and more	51	99.12	2.39		
Confidentiality	From 18 to 45 years	103	98.51	4.04	0.253	0.776
	From 46 to 60 years	124	98.82	3.97		
	61 years and more	97	98.45	4.46		
Dignity	From 18 to 45 years	103	94.12	3.96	1.131	0.324
	From 46 to 60 years	124	94.81	4.44		
	61 years and more	97	94.93	4.08		
Basic amenities	From 18 to 45 years	103	82.88	8.69	3.278	0.039*
	From 46 to 60 years	124	83.41	9.03		
	61 years and more	97	80.45	8.98		
Prompt Attention	From 18 to 45 years	154	79.62	14.51	1.218	0.297
	From 46 to 60 years	149	79.97	12.61		
	61 years and more	102	77.49	11.13		
Autonomy	From 18 to 45 years	103	73.23	8.74	2.533	0.081
	From 46 to 60 years	124	74.88	8.72		
	61 years and more	97	72.31	8.34		
Choice	From 18 to 45 years	103	69.64	7.84	1.043	0.354
	From 46 to 60 years	124	68.90	9.91		
	61 years and more	97	67.87	7.92		
Overall responsiveness	From 18 to 45 years	154	85.46	9.3	1.809	0.165
	From 46 to 60 years	149	85.36	7.29		
	61 years and more	102	83.73	5.29		

4.8.3 Education level

An independent t-test was conducted to examine whether there was a statistically significant difference among study participants with different education levels with regard to the experienced domains of responsiveness. As shown in table (4.17), the test revealed that participants with a low level of education reported a higher level of responsiveness

than those with higher level of education (T= 4.833, Sig.= 0.000). This may be attributed generally to the lower expectations that patients with a low level of education might have and thus results in a better assessment of responsiveness. These findings are in line with Baharvand study in Iran (Baharvand, 2019).

Table (4.17): Differences in the level of responsiveness and its domains among study participants' education levels.

Domain		Education years		T	Sig.
		Less than 12 years	More than 12 years		
1	Social support	99.22	99.66	1.142	0.258
2	Confidentiality	98.30	98.77	0.95	0.343
3	Dignity	94.50	94.69	0.375	0.708
4	Basic amenities	81.27	82.90	1.55	0.122
5	Prompt Attention	84.30	76.29	6.225	0.000*
6	Autonomy	74.25	73.25	0.983	0.326
7	Choice	67.22	69.63	2.36	0.019*
Overall responsiveness		87.42	83.59	4.833	0.000*

4.8.4 Type of health providers – outpatient care

Concerning outpatient care services, A one-way ANOVA test was used to examine whether was a statistically significant difference among study participants who attend different types of healthcare providers in relation to the experienced domains of responsiveness. As shown in table (4.18), the test revealed the presence of a significant difference between the types of healthcare providers means in relation to the overall level of responsiveness (F= 18.6, Sig.= 0.000). Moreover, there are statistically significant differences among types of healthcare providers in relation to dignity, basic amenities, prompt attention, autonomy and choice. No significant difference among healthcare providers in the confidentiality domain.

Table (4.18): Differences in the level of responsiveness and its domains among types of healthcare providers in terms of outpatient care services.

Domain	Type of healthcare provider	No.	Mean	SD	F	Sig.
Confidentiality	Governmental health center (MoH)	127	98.22	5.00	0.23	0.922
	Governmental health center (MMS)	3	100	0.00		
	UNRWA	181	98.53	4.25		
	NGOs	3	97.78	3.85		
	Private	9	97.78	6.67		
Dignity	Governmental health center (MoH)	127	92.76	4.12	3.76	0.005*
	Governmental health center (MMS)	3	93.33	4.62		
	UNRWA	181	93.70	4.07		
	NGOs	3	96.00	0.00		
	Private	9	97.78	80.00		
Basic amenities	Governmental health center (MoH)	127	86.30	10.30	4.84	0.001*
	Governmental health center (MMS)	3	80.00	0.00		
	UNRWA	181	90.39	10.24		
	NGOs	3	86.67	11.55		
	Private	9	95.56	8.82		
Prompt Attention	Governmental health center (MoH)	127	70.94	12.34	12.79	0.000*
	Governmental health center (MMS)	3	70.00	10.00		
	UNRWA	181	76.89	10.16		
	NGOs	3	88.33	10.41		
	Private	9	92.78	5.65		
Autonomy	Governmental health center (MoH)	127	73.65	8.18	8.63	0.000*
	Governmental health center (MMS)	3	70.67	6.11		
	UNRWA	181	76.66	7.97		
	NGOs	3	73.00	15.72		
	Private	9	88.44	6.82		
Choice	Governmental health center (MoH)	127	68.71	7.95	7.818	0.000*
	Governmental health center (MMS)	3	71.11	3.85		
	UNRWA	181	70.31	8.65		
	NGOs	3	73.33	6.67		
	Private	9	85.19	16.59		
Overall responsiveness	Governmental health center (MoH)	127	81.24	4.21	18.60	0.000*
	Governmental health center (MMS)	3	81.59	3.55		
	UNRWA	181	85.11	4.10		
	NGOs	3	85.11	3.08		
	Private	9	92.30	5.81		

A Bonferroni post hoc test was conducted to examine which of the differences among healthcare provider types are statistically significant in relation to responsiveness level and its domains. As shown in table (4.19), that participants who attended private clinics scored their ability to reach health provider of choice statistically higher than participants who attended MoH (MD=16.48, Sig.= 0.000) and UNRWA centers (MD= 14.88, Sig.= 0.000). Participants who attended MoH clinics were less likely to express that they received prompt attention with 21.84 than participants who attended private clinics (Sig.= 0.000) and less with 5.94 than UNRWA attendants (Sig.= 0.000). The differences were statistically significant.

The results of post hoc test revealed that, from study participants' points of view, the overall responsiveness level in Private clinics is statistically higher with 11.06 than that in MoH clinics (Sig.= 0.000) and statistically higher with 8.01 than that in UNRWA clinics (Sig.= 0.000). On the other hand, MoH clinic attendants reported less responsiveness level with 2.54 than that in UNRWA clinics (Sig.= 0.000).

These results can be considered reasonable. Private clinics, where the number of patients is significantly less than that for other service providers, ensure the ability to provide a higher level of quality of health and non-health services and thus achieving higher patient satisfaction. On contrary, the huge number of beneficiaries, in light of the scarcity of resources, staff burnout and crisis of paying salaries to governmental health sector employees, contribute to the lower level of responsiveness.

Table (4.19): Bonferroni post hoc test for differences in responsiveness domains related to the type of healthcare provider.

Domain	Type of healthcare provider	MD	Sig.
Dignity	Private - MoH	5.02	0.005*
	Private - UNRWA	4.08	0.044*
	UNRWA - MoH	0.95	0.506
Basic amenities	UNRWA - MoH	3.44	0.003*
	MoH - NGOs	2.22	1.00
	Private - MoH	8.70	0.023*
Prompt attention	UNRWA - MoH	5.94	0.000*
	Private - MoH	21.84	0.000*
	Private - MMS	22.78	0.021*
	Private - UNRWA	15.90	0.000*
Autonomy	UNRWA - MoH	3.00	0.015*
	Private - MoH	14.78	0.000*
	Private - MMS	17.78	0.011*
	Private - UNRWA	11.78	0.000*
	MoH - NGOs	0.65	1.00
	Private - NGOs	15.44	0.044*
Choice	Private - MoH	16.48	0.000*
	Private - UNRWA	14.88	0.000*
	MoH - UNRWA	1.59	1.00
Overall responsiveness	UNRWA - MoH	2.54	0.000*
	Private - MoH	11.06	0.000*
	Private - MMS	10.70	0.001*
	Private - UNRWA	8.52	0.000*

4.8.5 Type of health providers – inpatient care

As shown in table (4.20), an independent t-test was conducted to examine whether there was a significant difference between the governmental and non-governmental inpatient healthcare providers with regard to the overall responsiveness of the health system. The results revealed that study participants who benefited from governmental hospitals reported a lower level of responsiveness (83.56%) than participants who benefited from non-governmental hospitals (87.64%) (T= 3.912, Sig.= 0.000). These findings are also reasonable due to the aforementioned reasons for outpatient care.

Table (4.20): Differences in the level of responsiveness among types of healthcare providers in terms of inpatient care services.

Responsiveness score		T	Sig.
Governmental hospitals	83.56%	3.912	0.000*
Non-governmental hospitals "NGO and private"	87.64%		

Chapter 5

Conclusion and Recommendations

5.1 Conclusion

Responsiveness of the health system is the aspects related to the way individuals are treated and the environment in which they are treated. It is considered as a standard to assess health system performance. Responsive health systems contribute to better health outcomes as they anticipate and adapt to existing and future health needs. It has seven dimensions as articulated by the WHO; the seven dimensions are dignity, autonomy, confidentiality, prompt attention, social support, basic amenities, and choices of providers. The responsiveness of the healthcare system of Gaza governorate was assessed in this study by using mixed methods study. Quantitative method by a responsiveness module of the World Health Survey (WHS) questionnaire collected throughout household interviewed surveys. Qualitative method by using focus group discussions to collect data from healthcare system beneficiaries on their experiences related to non-health aspects of the healthcare services.

The quantitative findings of this study were collected from 53.5% males and 47.5% females, the mean age of the study population was 49.35 years. With regards to marital status at the time of data collection, the majority of the study population were married. As for academic qualifications, nearly half of the study population were bachelor's degree level or higher. The distribution of employment status by gender revealed that 38.4% of males were employed compared to 26.3% of females. On the other side, nearly half of males out of the study population were unemployed, while about two-thirds of females were unemployed at the time of data collection. With regards to monthly income, majority of participants have an average monthly income under the poverty line.

In general terms, the overall responsiveness level was very good. The best evaluated domain was access to social support based on participants' experiences regarding their interaction with the health system, followed by confidentiality, dignity, quality of basic amenities and prompt attention, whilst, autonomy and choice of health provider were showed weakness areas in the health system.

Capturing participants' preference of domains, researcher tried to figure out the domains the participants perceive as the most important aspects of the health system responsiveness. The first suggestion for most of the study participants was dignity followed by prompt attention, meanwhile, choice and quality of basic amenities were suggested as the least important. Findings of the domains' importance assist policy makers to understand which improvements of health system responsiveness to prioritize.

Comparing the findings of domains' scores in outpatient care and inpatient care. The best performing domains in outpatient care were confidentiality and dignity, while access to social support and dignity domains scored the best in inpatient care. Quality of basic amenities and Autonomy were reported better in outpatient than in outpatient care with differences of 15.78% and 10.27% respectively. However, Dignity was reported better in inpatient care than in outpatient care.

Concerning the level of responsiveness domains for outpatient care services. The performance was best for the domains of confidentiality and dignity. The participants' reported the lowest percentage of responsiveness was for the domain of Choice. Regarding the level of responsiveness domains for inpatient care services. The performance was reported the best for the domains of access to social support and dignity. The participants' reported the lowest percentage of responsiveness was for the domain of choice.

The inferential analysis showed interesting results that reflected the relationship between study variables and participants' characteristics. It was found that females were reported to be treated in a dignified manner more than males and are more likely to have access to social support during hospitalization periods than males. Moreover, participants aged from 46 to 60 years have a statistically higher score of quality of basic amenities than participants aged 61 years and more. This finding can be attributed to that, in general, older people would suffer from more complicated illnesses, which result in greater demands on a health system to be responsive.

Participants with a low level of education reported a higher level of responsiveness than those with higher level of education. This may be attributed generally to the lower expectations that patients with a low level of education might have and thus results in a better assessment of responsiveness.

Participants who attended private clinics scored their ability to reach health provider of choice statistically higher than participants who attended MoH and UNRWA centers. Participants who attended MoH clinics were less likely to express that they received prompt attention than participants who attended private clinics and less than UNRWA attendants. The differences were statistically significant.

From study participants' points of view, the overall responsiveness level in Private clinics is statistically higher than that in MoH clinics and statistically higher than that in UNRWA clinics. On the other hand, MoH clinic attendants reported less responsiveness level than that in UNRWA clinics. Study participants who benefited from governmental hospitals reported a lower level of responsiveness than participants who benefited from non-governmental hospitals. These results can be considered reasonable. Private clinics, where the number of patients is significantly less than that for other service providers, ensure the

ability to provide a higher level of quality of health and non-health services and thus achieving higher patient satisfaction. On contrary, the huge number of beneficiaries, in light of the scarcity of resources, staff burnout and crisis of paying salaries to governmental health sector employees, contribute to the lower level of responsiveness.

5.2 Recommendations

5.2.1 General recommendations:

- Providing training to policy makers, health managers and health care providers in responsiveness concept and domains is essential.
- Raising community awareness towards humans' rights especially in health aspects.
- Enhancing capacity building of health staff based on best practices with regards to domains of responsiveness.
- Strengthening the monitoring system within health care system in order to ensure that the health system responsiveness is achieved in a constant and systematic manner.
- Dignity and prompt attention domains were considered as the most important domains for people of Gaza governorate; thus, the policy makers may focus on these domains in order to ameliorate the perceived responsiveness of healthcare services.
- Enhancing the delivery of health care services based on best practices that preserve patients' involvement in process of deciding treatment plans.
- Working towards improving responsiveness through less resource-dependent domains such as dignity, autonomy, and confidentiality.
- As the type of provider was a main contributor to responsiveness and service users, it sounds that health policy should concentrate on provider performance.

5.2.2 Recommendation for further studies:

- National study to assess the health system responsiveness in the Gaza Strip is needed.
- As responsiveness is highlighted as a health system goal, there is a need to conduct studies that monitor the performance of health system in responsiveness and the effects of interventions on it.
- Conduct research studies to assess the health system responsiveness using key informants' surveys.
- There is a need to conduct studies to assess if there are other aspects affecting perceived responsiveness of the health system.
- Considering that the Gaza Strip has a low-income population using governmental services more on one hand, and gave lower scores to governmental services responsiveness on the other hand, further studies are needed on the equity aspects of service use and responsiveness.

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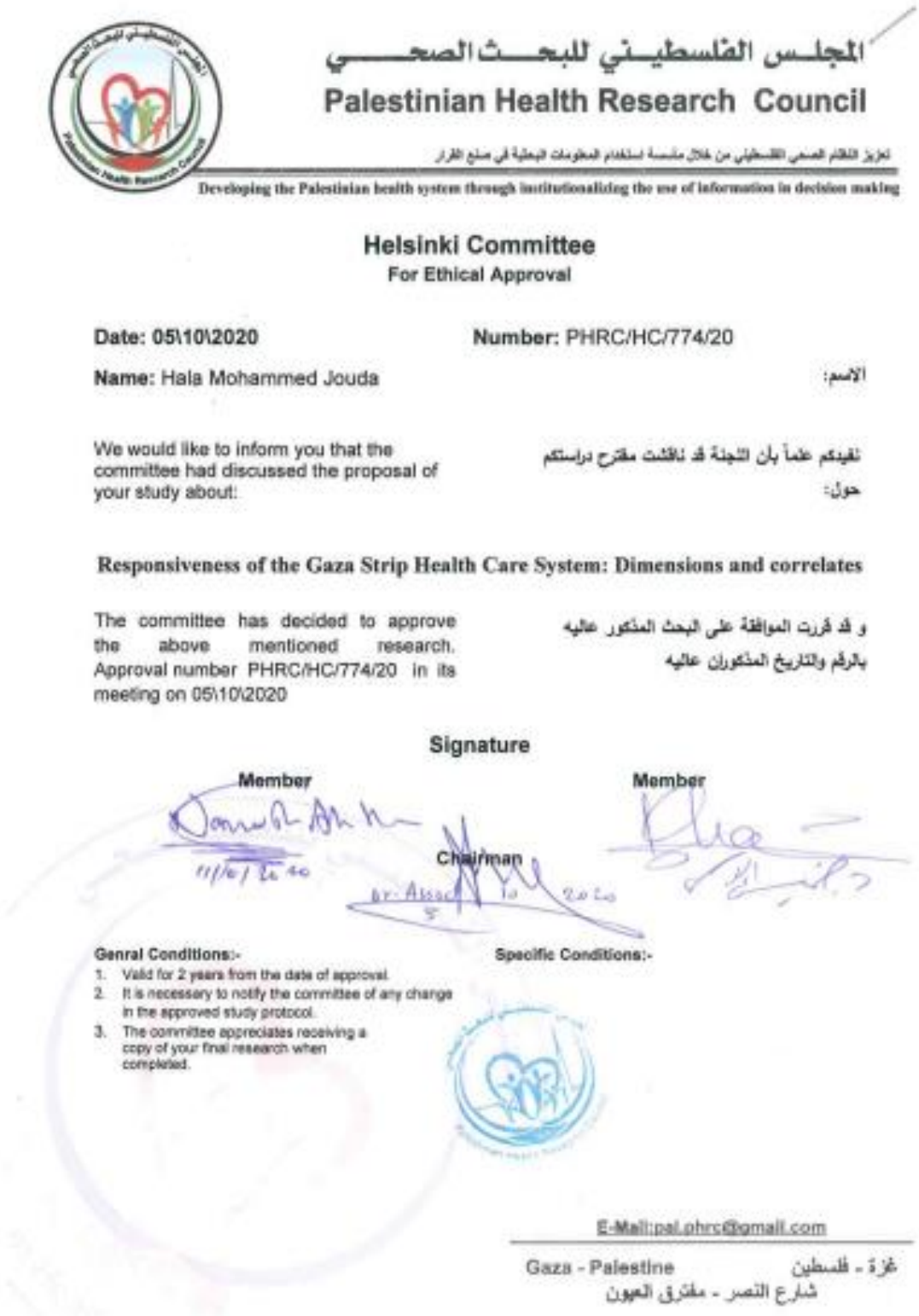
Annexes

Annex (1): Helsinki Committee Research Approval



المجلس الفلسطيني للبحث الصحي
Palestinian Health Research Council

تعزيز النظام الصحي الفلسطيني من خلال مأسسة استخدام المعلومات البحثية في صنع القرار
Developing the Palestinian health system through institutionalizing the use of information in decision making

Helsinki Committee
For Ethical Approval

Date: 05\10\2020 **Number:** PHRC/HC/774/20

Name: Hala Mohammed Jouda الاسم:

We would like to inform you that the committee had discussed the proposal of your study about: نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:

Responsiveness of the Gaza Strip Health Care System: Dimensions and correlates

The committee has decided to approve the above mentioned research. Approval number PHRC/HC/774/20 in its meeting on 05\10\2020 و قد قررت الموافقة على البحث المذكور عاليه بالرقم والتاريخ المذكوران عاليه

Signature

Member **Chairman** **Member**

Genral Conditions:-
1. Valid for 2 years from the date of approval.
2. It is necessary to notify the committee of any change in the approved study protocol.
3. The committee appreciates receiving a copy of your final research when completed.

Specific Conditions:-

E-Mail:pal.phrc@gmail.com
Gaza - Palestine غزة - فلسطين
شارع النصر - مفترق العيون

Annex (2): Official letter of approval from Ministry of Interior

STATE OF PALESTINE
Ministry of Interior & National Security
Minister Office

دولـــة فلســـطـين
وزارة الداخلية والأمن الوطني
مكتب الوزير

وزارة الداخلية ـ مكتب الوزير
18-11-2020
صادر رقم/ 13851

التاريخ: 03 ربيع ثاني 1442هـ
18 نوفمبر 2020م

إفـــــادة

لمن يهمـــه الأمـــر

تفيد وزارة الداخلية والأمن الوطني بأنه لا مانع لديها من تسهيل مهام باحثة دراسات عليا بالإضافة إلى اثنين من المساعدين لجمع البيانات اللازمة بالخصوص، وذلك لإجراء دراسة حول قياس مدى استجابة النظام الصحي في قطاع غزة لتوقعات المستفيدين بخصوص الخدمات غير الصحية المقدمة مثل(الكرامة، المحافظة على المعلومات الخاصة بالمرضى، اختيار مزود الخدمة، الانتباه السريع، الاستقلال والحرية، جودة البيئة المحيطة).

وهم حسب البيانات التالية:

م	الاسم	عنوان استبانة البحث
1	هالة محمد جودة	استجابة النظام الصحي في قطاع غزة (الأبعاد والارتباطات)
2	ربيع أحمد ربيع عوض	جامعي البيانات
3	محمد خليل ربيع عبد ربه	جامعي البيانات

وزارة الداخلية والأمن الوطني

Annex (3): Time framework

Activity	2020						2021			
	7	8	9	10	11	12	1	2	3	4
Review literature and study tools										
Tools' validation and piloting										
Data collection										
Data entry										
Data analysis										
Report writing										
Dissemination										

Annex (4): Eleven quarters in Gaza Governorate

المحافظة	اسم التجمع	رمز التجمع	رقم التجمع	عنوان الموقع
غزة	مخيم الشاطىء	602775	1	امتدادحميد مقابل الزنط
	غزة	602825	2	عمر المختار
	غزة	602825	3	شارع الجندى المجهول
	غزة	602825	4	غزة - شارع سوق معسكر الشاطئ
	غزة	602825	5	سوق البسطات
	غزة	602825	6	شارع محمد بهادر
	غزة	602825	7	الشعف بالقرب من مسجد جعفر
	غزة	602825	8	شارع المسكة خلف شركة اسليم اخوان
	غزة	602825	9	المغربي
	غزة	602825	10	الرشيد الاعلى
	جحر الديك	603045	11	شارع ابراج الهدى

Annex (5): Sample Calculation

Sample size calculator

What margin of error can you accept? 5% is a common choice	5 %	The margin of error is the amount of error that you can tolerate. If 90% of respondents answer *yes*, while 10% answer *no*, you may be able to tolerate a larger amount of error than if the respondents are split 50-50 or 45-55. Lower margin of error requires a larger sample size.
What confidence level do you need? Typical choices are 90%, 95%, or 99%	95 %	The confidence level is the amount of uncertainty you can tolerate. Suppose that you have 20 yes-no questions in your survey. With a confidence level of 95%, you would expect that for one of the questions (1 in 20), the percentage of people who answer *yes* would be more than the margin of error away from the true answer. The true answer is the percentage you would get if you exhaustively interviewed everyone. Higher confidence level requires a larger sample size.
What is the population size? If you don't know, use 20000	678669	How many people are there to choose your random sample from? The sample size doesn't change much for populations larger than 20,000.
What is the response distribution? Leave this as 50%	50 %	For each question, what do you expect the results will be? If the sample is skewed highly one way or the other,the population probably is, too. If you don't know, use 50%, which gives the largest sample size. See below under **More information** if this is confusing.
Your recommended sample size is	**384**	This is the minimum recommended size of your survey. If you create a sample of this many people and get responses from everyone, you're more likely to get a correct answer than you would from a large sample where only a small percentage of the sample responds to your survey.

Annex (6): The questionnaire consent form.

بسم الله الرحمن الرحيم

الموافقة على إجراء استبيان حول دراسة:

تقييم استجابة النظام الصحي في قطاع غزة لتوقعات المرضى للخدمات غير الصحية

أنا الباحثة: هالة محمد عبد القادر جودة، طالبة في برنامج ماجستير الصحة العامة في جامعة القدس، أقوم بعمل بحث علمي وهو جزء من دراستي في الجامعة يهدف إلى تقييم استجابة النظام الصحي في قطاع غزة من حيث الخدمات غير الصحية المقدمة للمرضى.

هناك خيارات للإجابة عن كل سؤال، الرجاء اختيار الإجابة الأقرب إليك ولتجربتك الواقعية، مع العلم أنه لا توجد إجابات خاطئة و إجابات صحيحة.

المشاركة في هذا البحث تطوعية ولك الحق في الانسحاب متى تشاء مع التأكيد على سرية المعلومات.

الاستبيان قد يستغرق حوالي 15 دقيقة.

أقدر عالياً مشاركتك في البحث.

وتفضلوا بقبول جزيل الشكر

Annex (7) The questionnaire in Arabic version

استبيان لقياس استجابة النظام الصحي في قطاع غزة

Serial Number……

القسم الأول: معلومات عامة		
1.1	العمر بالسنوات:	
1.2	الجنس :	1.ذكر 2. انثى
1.3	الحالة الاجتماعية:	1. أعزب/ عزباء 2.متزوج/ة 3.مطلق/ة 4.أرمل/ة 5.غير ذلك
1.4	مكان السكن:	
1.5	نوع المواطنة:	لاجئ 2. مواطن
1.6	مستوى التعليم:	1. أمي 2.أساسي 3.توجيهي 4.دبلوم 5.بكالوريوس 6.ماجستير 7.دكتوراة
1.7	الوضع المهني الحالي:	أعمل بشكل دائم 2.أعمل بشكل جزئي/مؤقت 3.بطالة 4.متقاعد 5.متطوع 6.لا أعمل
1.8	مستوى دخل الأسرة :	1.أقل من 1974 شيقل 2. 1974-2470 شيقل 3. أكثر من 2470 شيقل
1.9	عدد أفراد الأسرة:	
1.10	هل تعاني من اي إعاقة ؟	1. نعم 2. لا
1.11	إذا الإجابة نعم، حدد نوع الإعاقة	1.حركية 2. بصرية 3. سمعية 4.عقلية 5. غير ذلك حدد_____
1.12	بشكل عام كيف تقيم صحتك:	1. جيدة جدا 2. جيدة 3. معتدلة 4. سيئة 5. سيئة جداً
1.13	هل تعاني من مرض مزمن:	نعم 2. لا

القسم الثاني: العناية في المراكز الصحية (العيادات) Outpatient		
.2	هل تلقيت أي رعاية صحية خلال الإثني عشر شهرًا الماضية؟	
	نعم (تابع)	لا (انتقل الى س49)
.3	هل تلقيت أي رعاية صحية في عيادة صحية خارجية أو هل قام أحد الأطباء أو من يعملون في مجال الصحة	

	بزيارتك في المترل خلال الاثني عشر شهرًا الماضية ؟ (عيادة صحية خارجية تعني عيادة طبيب، عيادة رعاية أولية، عيادة خارجية للمستشفى أو أي رعاية صحية بحيث لم يتم البيات)				
	نعم (تابع)	لا (انتقل الى س33)			
.4	هل كانت معظم رعايتك الصحية خلال الإثني عشر شهرًا الماضية في مركز صحي أم ان أحد الأطباء أو من يعملون في مجال الصحة زارك في المترل ؟				
	معظمها في مركز صحي	معظمها من طبيب أو من يعملون في مجال الصحة في المنزل	من الاثنين معاً بالتساوي		
.5	ما هو المركز الصحي الذي تذهب إليه عادة عند احتياجك للرعاية الصحية؟				
	اسم المركز	مركز صحي حكومي (وزارة الصحة) مركز صحي حكومي (خدمات طبية عسكرية) مركز صحي غير حكومي (وكالة) مركز صحي غير حكومي (أهلي) مركز صحي غير حكومي (خاص)			
.6	متى كانت آخر مرة تلقيت فيها الرعاية الصحية؟				
	خلال الثلاثين يومًا الماضية	خلال الثلاثة أشهر الماضية	خلال الستة أشهر الماضية	ما بين 6-12 شهراً الماضية	لا أذكر
.7	كم مرة زرت المركز الصحي خلال الإثني عشر شهرا الماضية؟				
	مرة	مرتين	ثلاث مرات	أربع مرات	أكثر من أربع مرات
.8	الى اي مدى كنت تحصل على الرعاية الصحية عند الاحتياج اليها، خلال الإثني عشرة شهرًا الماضية؟				
	دائماً	غالباً	عادةً	نادراً	أبداً
.9	كم كان الوقت الذي عليك أن تنتظره من بدء احتياجك للرعاية الصحية وحتى الوقت الذي حصلت فيه على هذه الرعاية، خلال الإثني عشر شهرًا الماضية؟				
	____ دقائق	____ ساعات	____ أيام	____ أسابيع	____ أشهر
.10	هل احتجت لأي فحوصات مخبرية أو تصويرية، خلال الإثني عشر شهرًا الماضية؟				
	نعم (تابع)	لا (انتقل الى س12)			
.11	بشكل عام كم كان عليك أن تنتظر قبل الحصول على هذه الفحوصات المخبرية أو التصويرية ؟				
	في نفس اليوم	1-2 يوم	3-5 أيام	6-10 أيام	أكثر من 10 أيام
.12	بشكل عام، كيف تقيم تجربتك في سرعة الحصول على الرعاية الصحية، خلال الإثني عشر شهرًا الماضية؟				
	جيدة جداً	جيدة	معتدلة	سيئة	سيئة جداً

.13	خلال الإثني عشرة شهرًا الماضية عندما احتجت الى رعاية صحية، الى أي مدى كان الطبيب، الممرضة أو غيرهم ممن يتعاملون في مجال الصحة يعاملونك باحترام؟				
	دائماً	غالباً	عادةً	نادراً	أبداً
.14	خلال الإثني عشر شهرًا الماضية الى أي مدى قام الموظفون في المركز مثل موظفة الإستقبال أو أي موظفون آخرون بمعاملتك باحترام؟				
	دائماً	غالباً	عادةً	نادراً	أبداً
.15	خلال الإثني عشر شهرًا الماضية، الى أي مدى قام الأطباء، الممرضون أو أي أشخاص آخرين ممن يتعاملون في مجال الصحة بالإستماع إليك بعناية؟				
	دائماً	غالباً	عادةً	نادراً	أبداً
.16	خلال الإثني عشر شهرًا الماضية الى أي مدى تمت فحوصاتك الجسمية ومعالجتك بحيث تم احترام خصوصيتك (اغلاق غرفة الفحص، وجود ستارة حول السرير، تغطيتك بشرشف مناسب)؟				
	دائماً	غالباً	عادةً	نادراً	أبداً
.17	بشكل عام، الى أي مدى تقيم تجربتك في مراكز العناية الصحية بخصوص الاحترام لكرامتك خلال الإثني عشر شهرًا الماضية؟				
	جيدة جدا	جيدة	معتدلة	سيئة	سيئة جدا
.18	خلال الإثني عشر شهرًا الماضية، الى أي مدى قام الأطباء، الممرضون أو أي أشخاص آخرين ممن يتعاملون في مجال الصحة بشرح الأمور بطريقة مفهومة لك؟				
	دائماً	غالباً	عادةً	نادراً	أبداً
.19	خلال الإثني عشر شهرًا الماضية، الى أي مدى قام الأطباء، الممرضون أو أي أشخاص آخرين ممن يتعاملون في مجال الصحة بمنحك الوقت للإستفسار عن مشكلتك الصحية أو عن علاجك؟				
	دائماً	غالباً	عادةً	نادراً	أبداً
.20	خلال الإثني عشر شهرًا الماضية وعندما ذهبت الى مركز العناية الصحية هل تم إتخاذ أي قرارات بشأن صحتك ومعالجتك (مثل إعطاءك دواءً) أو القيام بالفحوصات؟				
	نعم (تابع)			لا (انتقل إلى س22)	
.21	خلال الإثني عشر شهرًا الماضية، الى أي مدى قام الأطباء، الممرضون أو أي أشخاص آخرين ممن يتعاملون في مجال الصحة بمشاركتك في اتخاذ القرار بشأن العناية بك والمعالجة والفحوصات؟				
	دائماً	غالباً	عادةً	نادراً	أبداً
.22	خلال الإثني عشر شهرًا الماضية، الى أي مدى قام الأطباء، الممرضون أو أي أشخاص آخرين ممن يتعاملون في مجال الصحة بطلب الإذن منك قبل البدء بالمعالجة والفحوصات؟				
	دائماً	غالباً	عادةً	نادراً	أبداً
.23	بشكل عام، كيف تقيم مدى مشاركتك حسب ما تريد في اتخاذ القرارات بشأن رعايتك أو معالجتك خلال الإثني عشر شهرًا الماضية؟				

	جيد جداً	جيد	متوسط	سيء	سيئ جداً
.24	خلال الإثني عشر شهرًا الماضية، الى أي مدى كانت محادثاتك مع الأطباء، الممرضون أو أي أشخاص آخرين ممن يتعاملون في مجال الصحة تتصف بالسرية والخصوصية بحيث أن الأشخاص الآخرين الذين لم تردهم أن يسمعوا الحوار لم يتمكنوا من سماع شيء؟				
	دائماً	غالباً	عادةً	نادراً	أبداً
.25	خلال الإثني عشر شهرًا الماضية الى أي مدى قام الأطباء، الممرضون أو أي أشخاص آخرين ممن يتعاملون في مجال الصحة بالحفاظ الى سرية المعلومات الخاصة بك؟بمعني أنه لم يتم إطلاع أي شخص لا ترغب به على حالتك الصحية؟				
	دائماً	غالباً	عادةً	نادراً	أبداً
.26	بشكل عام كيف تقيم طريقة المركز الصحي في الإبقاء على سرية المعلومات الخاصة بك خلال الإثني عشر شهرًا الماضية؟				
	جيد جداً	جيد	متوسط	سيء	سيئ جداً
.27	ما حجم المشاكل التي واجهتها في الحصول على طبيب، ممرض أو أي شخص آخر ممن يتعاملون في مجال الصحة من اختيارك، خلال الإثني عشر شهرًا الماضية ؟				
	لا يوجد مشاكل	مشاكل بسيطة	مشاكل متوسطة	مشاكل كبيرة	مشاكل كبيرة جداً
.28	خلال الإثني عشر شهرًا الماضية ماحجم المشاكل التي واجهتها في اختيار مركز صحي آخر للذهاب إليه غير المركز الذي اعتدت عليه؟				
	لا يوجد مشاكل	مشاكل بسيطة	مشاكل متوسطة	مشاكل كبيرة	لا ينطبق لم يجرب من قبل
.29	بشكل عام، كيف تقيم مدى مقدرتك على استخدام مركز صحي أو طبيب، ممرض أو أي شخص آخر ممن يتعاملون في مجال الصحة بحيث يكون من اختيارك أنت خلال الإثني عشر شهرًا الماضية؟				
	جيد جداً	جيد	متوسط	سيء	سيئ جداً
.30	كيف تقيم جودة غرفة الإنتظار مثل: المساحة المتوفرة والمقاعد والهواء النظيف للمركز الصحي خلال الإثني عشر شهرا الماضية؟				
	جيد جداً	جيد	متوسط	سيء	لا ينطبق تمت الزيارة في المنزل
.31	كيف تقيم نظافة المكان بما يشمل نظافة دورة المياه (المرحاض) للمركز الصحي خلال الإثني عشر شهرا الماضية ؟				
	جيد جداً	جيد	متوسط	سيء	لا ينطبق تمت الزيارة في المنزل
.32	بشكل عام، كيف تقيم محيط المكان، مثلاً المساحة المتوفرة، المقاعد، الهواء النقي والنظافة للمركز الصحي خلال الإثني عشر شهرا الماضية ؟				
	جيد جداً	جيد	متوسط	سيء	لا ينطبق تمت الزيارة في المنزل

القسم الثالث: العناية في داخل المستشفيات Inpatient						
.33	هل بقيت ليلة على الأقل في إحدى المستشفيات خلال الإثني عشر شهرًا الماضية؟					
	نعم (تابع)				لا (انتقل س49)	
.34	ما هو اسم المستشفى الذي قضيت ليله فيه مؤخرًا؟					
	اسم المستشفى:				حكومي (وزارة الصحة) حكومي (خدمات عسكرية) غير حكومي (أهلي) غير حكومي (خاص)	
.35	هل حصلت على الخدمة الصحية في المستشفى فورًا عندما طلبت ذلك؟					
	نعم				لا	
.36	ما مدى حصولك وفي كل مرة على الرعاية الطبية من الطبيب والممرضين بالسرعة التي أردتها خلال وجودك بالمستشفى؟					
	دائماً	غالباً	عادةً	نادراً	أبداً	
.37	بشكل عام، كيف تقيم تجربتك في سرعة الحصول على رعاية الصحية من المستشفى خلال الإثني عشر شهرًا الماضية؟					
	جيد جداً	جيد	متوسط	سيء	سيئ جداً	
.38	بشكل عام، الى أي مدى تقيم تجربتك في المستشفى بخصوص الاحترام لكرامتك؟					
	جيد جداً	جيد	متوسط	سيء	سيئ جداً	
.39	بشكل عام، كيف تقيم مدى مشاركتك في اتخاذ القرار بشأن رعايتك أو معالجتك حسب ما تريد وذلك عندما كنت في المستشفى؟					
	جيد جداً	جيد	متوسط	سيء	سيئ جداً	
.40	بشكل عام كيف تقيم المستشفى من ناحية الحفاظ على سرية المعلومات الشخصية الخاصة بك؟					
	جيد جداً	جيد	متوسط	سيء	سيئ جداً	
.41	بشكل عام، كيف تقيم مدى مقدرتك على الذهاب إلى مستشفى للعناية الصحية من اختيارك أنت خلال الإثني عشر شهرًا الماضية؟					
	جيد جداً	جيد	متوسط	سيء	سيئ جداً	
.42	بشكل عام، كيف تقيم مدى جودة محيط المكان مثل: المساحة المتوفرة، المقاعد، الهواء النقي و النظافة في المستشفى؟					
	جيد جداً	جيد	متوسط	سيء	سيئ جداً	
.43	خلال فترة وجودك في المستشفى ما مدى حجم المشكلة التي واجهتها في الحصول على وجبات طعام صالحة للأكل وصحية؟					

	لا يوجد مشاكل	مشاكل بسيطة	مشاكل متوسطة	مشاكل كبيرة	مشاكل كبيرة جدا
44.	خلال فترة وجودك في المستشفى ما مدى حجم المشكلة التي واجهتها في اقناع المستشفى بالسماح لعائلتك وأصدقائك بزيارتك ؟				
	لا يوجد مشاكل	مشاكل بسيطة	مشاكل متوسطة	مشاكل كبيرة	مشاكل كبيرة جدا
45.	خلال فترة وجودك في المستشفى ما مدى حجم المشكلة التي واجهتها في اقناع المستشفى بالسماح لعائلتك وأصدقائك بالإهتمام باحتياجاتك الشخصية، مثل أن يحضروا لك أكلك المفضل أو صابونك المفضل ...الخ؟				
	لا يوجد مشاكل	مشاكل بسيطة	مشاكل متوسطة	مشاكل كبيرة	مشاكل كبيرة جدا
46.	خلال فترة وجودك في المستشفى ما حجم المشكلة التي واجهتها في حال وجودها في اقناع المستشفى بالسماح لك بممارسة الشعائر أو الطقوس الدينية إذا أردت ذلك؟				
	لا يوجد مشاكل	مشاكل بسيطة	مشاكل متوسطة	مشاكل كبيرة	مشاكل كبيرة جدا
47.	بشكل عام، كيف تقيم مدى سماح المستشفى لك بالتواصل مع الأهل والأصدقاء وأن تستمر في ممارسة النشاطات الإجتماعية و/أو الشعائر الدينية خلال فترة إقامتك في المستشفى؟				
	جيد جداً	جيد	متوسط	سيء	سيئ جداً
48.	رجاء أجب ب "نعم" أو "لا" على الأسئلة التالية: خلال الإثني عشر شهرًا الماضية، هل تمت معاملتك بطريقة سيئة من قبل المراكز الصحية أو المستشفيات في بلدك بسبب: (تحقق من كافة الإجابات التي تنبطق)				
	نعم	لا	السبب		
			الجنسية		
			منطقة السكن		
			عدم وجود تأمين خاص		
			جزء من مجموعة عرقية		
			اللون		
			الجنس		
			اللغة		
			الدين		
			المعتقدات السياسية		
			الحالة الصحية		
			عدم كفاية الأموال		
			غيرها (حدد.....)		
49.	خلال الإثني عشر شهرًا الماضية هل حصل وأن احتجت الى خدمة صحية ولكنك لم تحصل عليها لأنك لا تستطيع تحمل النفقات؟				
	نعم	لا			
50. رجاء اقرأ البطاقات التالية. تصف هذه البطاقات بعضًا من مختلف الطرق التي تظهر فيها مراكز العناية الصحية في بلدك الإحترام للناس وتجعلهم مركز اهتمامها. بالتفكير فيما هو مكتوب على هذه البطاقات وفي النظام الصحي ككل، أي منها تجده أكثر أهمية بالنسبة لك وأي منها هو الأقل أهمية؟					

الكرامة	سرية المعلومات
• أن يتم إظهار الاحترام. • أن يتم الفحص الطبي مع الحفاظ على الخصوصية والسرية. • أن يستمع لك الطبيب أو الشخص المعالج بعناية .	• الحفاظ على سرية المعلومات الطبية المتعلقة بالمريض • أن تتم المحادثة مع الأطباء، الممرضون، أو من يعملون في مجال الصحة بطريقة لا يسمعكم فيها الأشخاص الآخرون حولكم ممن لا ترغب في أن يستمعوا لكم
الإختيار	**الإنتباه السريع**
• أن تكون قادرًا على اختيار الطبيب أو الممرض أو شخص آخر يقوم عادة بالعناية الطبية بك • أن تكون قادرًا على الذهاب الى مركز صحي آخر إذا أردت ذلك	• أن يكون المركز الطبي على بعد مسافة معقولة من بيتك وأن يكون الوقت المستغرق للوصول الى المركز الطبي معقولاً أيضًا • الحصول على عناية طبية سريعة في حالات الطوارئ • أن يكون وقت الإنتظار قصيرًا للمواعيد و الإستشارات، إضافة الى الإنتهاء من الفحص الطبي بسرعة • أن تكون قوائم الإنتظار للحالات الجراحية غير الطارئة قصيرة
الإستقلال والحرية	**البيئة المحيطة (محيط المكان ككل)**
• أن يقوم الطبيب أو الشخص المعالج بشرح الامور بطريقة مفهومة لك • أن يتم منحك الوقت الكافي لتطرح الأسئلة • أن تتم مشاركتك في تقرير العناية الطبية أو العلاج في حال أردت ذلك • أن يقوم الطبيب أو الشخص المعالج بالإستئذان منك قبل بدء العلاج أو الفحص	• توفر مساحة كافية، مقاعد وهواء نقي في غرفة الإنتظار • أن يكون المكان نظيفًا (بما في ذلك الحمام) • أن يكون الطعام صحيًا وصالحًا للأكل
الدعم الإجتماعي	
• أن يتم السماح بزيارة الأقارب والأصدقاء • أن يتم السماح لك بتلقي الطعام والهدايا الأخرى من الأقارب • أن يسمح لك بممارسة الشعائر و الطقوس الدينية	

الأكثر أهمية ..... **الأقل أهمية .....**

Annex (8) The questionnaire in English version

Questionnaire to assess the responsiveness of health system in Gaza Governorate

Serial Number ……

Part 1: General information		
1.1	Age:	……. Years
1.2	Gender:	1. Male 2. Female
1.3	Marital status:	1. Single 2. Married 3. Divorced 4. Widowed 5. other
1.4	Place:	
1.5	Refugee status:	1. Refugee 2. Non-refugees
1.6	Education:	1. Illiterate 2. Preparatory 3. General secondary 4. Diploma 5. Bachelor 6. Master degree
1.7	Working status:	1. Full time job 2. Part time job 3. Volunteer 4. Retired 5. Unemployed
1.8	Monthly income:	1. less than 1974 shekl 2. 1974-2470 shekl 3. more than 2470 shekl
1.9	Family members:	
1.10	Do you suffer from disability?	1. Yes 2. No
1.11	If yes, specify:	1. mobility 2. Visual 3. Hearing 4. Mental 5. Other, specify_____
1.12	In general, how would you rate your health?	1. Very good 2. Good 3. Moderate 4. Bad 5. Very bad
1.13	Do you suffer from any NCDs?	1. Yes 2. No

Part 2: Care in health centers (Clinics) (Outpatient services)		
2.	Have you received any health care in the last 12 months?	
	1. Yes 2. No (Go to Q49)	
3.	In the last 12 months, did you get any health care at an outpatient health facility or did a health care provider visit you at home? (An outpatient health facility is a doctor's consulting room, a clinic or a hospital outpatient unit-any place outside your home where you did not stay overnight.)	
	1. Yes 2. No (Go to Q33)	
4.	In the last 12 months, did you get most of your health care at a health facility or most from a health provider who visited you in your home?	
	1. Mostly at a health facility 2. Mostly from a health provider in my home 3. Equally from both	
5.	What is the health center you usually go to when you need medical care?	
	Name of health center……..	1. Governmental health center (MoH) 2. Governmental health center (MMS) 3. UNRWA 4. NGOs 5. Private
6.	When was your last (most recent) visit to a health facility or provider? Was it…	
	1. In the last 30 days? 2. In the last 3 months? 3. In the last 6 months?	

	4. Between 6 months and 12 months ago? 5. Don't remember
7.	In the last 12 months, how many times did you visit the health center?
	1. Once 2. Twice 3. Three times 4. Four times 5. More than four times
8.	In the last 12 months, when you wanted care, how often did you get care as soon as you wanted?
	1. Always 2. Often 3. Usually 4. Sometimes 5. Never
9.	In the last 12 months, how long did you usually have to wait from the time that you wanted care to the time that you received care?
	_____minutes _____hours _____days _____weeks _____months
10.	In the last 12 months, have you needed any laboratory tests or examinations? Some examples of these tests or special examinations are blood tests, scans or X-rays.
	1. Yes 2. No (Go to Q12)
11.	Generally, how long did you have to wait before you could get the laboratory tests or examinations done?
	1. Got them the same day 2. 1-2 days 3. 3-5 days 4. 6-10 days

	5. More than 10 days
12.	Now, overall, how would you rate your experience of getting prompt attention at the health services in the last 12 months?
	1. Very good 2. Good 3. Moderate 4. Bad 5. Very bad
13.	In the last 12 months, when you sought health care, how often did doctors, nurses or other health care providers treat you with respect?
	1. Always 2. Often 3. Usually 4. Sometimes 5. Never
14.	In the last 12 months, how often did the office staff, such as receptionists or clerks there, treat you with respect?
	1. Always 2. Often 3. Usually 4. Sometimes 5. Never
15.	In the last 12 months, how often did doctors, nurses or other health care providers listen carefully to you?
	1. Always 2. Often 3. Usually 4. Sometimes 5. Never
16.	In the last 12 months, how often were your physical examinations and treatments done in a way that your privacy was respected (close the examination room, a curtain around the bed, suitable cover)?
	1. Always 2. Often 3. Usually 4. Sometimes 5. Never
17.	Now, overall, how would you rate your experience of being treated with dignity at the health services in the last 12 months?
	1. Very good 2. Good 3. Moderate 4. Bad 5. Very bad
18.	In the last 12 months, how often did doctors, nurses or other health care providers, explain things in a way you could understand?
	1. Always 2. Often 3. Usually 4. Sometimes 5. Never
19.	In the last 12 months, how often did doctors, nurses, or other health care providers give you time to ask questions about your health problem or treatment?

	1. Always 2. Often 3. Usually 4. Sometimes 5. Never
20.	In the last 12 months, when you went for health care, were any decisions made about your care, treatment (giving you drugs, for example) or tests?
	1. Yes 2. No (Go to Q22)
21.	In the last 12 months, how often did doctors, nurses or other health care providers involve you as much as you wanted to be in deciding about the care, treatment or tests?
	1. Always 2. Often 3. Usually 4. Sometimes 5. Never
22.	In the last 12 months, how often did doctors, nurses or other health care providers ask your permission before starting the treatment or tests?
	1. Always 2. Often 3. Usually 4. Sometimes 5. Never
23.	Now, overall, how would you rate your experience of getting involved in making decisions about your care or treatment as much as you wanted in the last 12 months?
	1. Very good 2. Good 3. Moderate 4. Bad 5. Very bad
24.	In the last 12 months, how often were talks with your doctor, nurse or other health care provider done privately so other people who you did not want to hear could not overhear what was said?
	1. Always 2. Often 3. Usually 4. Sometimes 5. Never
25.	In the last 12 months, how often did your doctor, nurse or other health care provider keep your personal information confidential? This means that anyone whom you did not want informed could not find out about your medical conditions.
	1. Always 2. Often 3. Usually 4. Sometimes 5. Never
26.	Now, overall, how would you rate your experience of the way the health services

	kept information about you confidential in the last 12 months?
	1. Very good 2. Good 3. Moderate 4. Bad 5. Very bad
27.	Over the last 12 months, with the doctors, nurses and other health care providers available to you how big a problem, if any, was it to get a health care provider you were happy with?
	1. No problem 2. Mild problem 3. Moderate problem 4. Severe problem 5. Extreme problem
28.	Over the last 12 months, how big a problem, if any, was it to get to use other health services other than the one you usually went to?
	1. No problem 2. Mild problem 3. Moderate problem 4. Severe problem 5. Not applicable – never tried
29.	Now, overall, how would you rate your experience of being able to use a health care provider or service of your choice over the last 12 months?
	1. Very good 2. Good 3. Moderate 4. Bad 5. Very bad
30.	Thinking about the places you visited for health care in the last 12 months, how would you rate the basic quality of the waiting room, for example, space, seating and fresh air?
	1. Very good 2. Good 3. Moderate 4. Bad 5. Not applicable – visited at home

31.	Thinking about the places you visited for health care over the last 12 months, how would you rate the cleanliness of the place including toilets?
	1. Very good 2. Good 3. Moderate 4. Bad 5. Not applicable – visited at home
32.	Now, overall, how would you rate the quality of the surroundings, for example, space, seating, fresh air and cleanliness of the health services you visited in the last 12 months?
	1. Very good 2. Good 3. Moderate 4. Bad 5. Not applicable – visited at home

Part 3: Care in hospitals (Inpatient services)		
33.	Have you stayed overnight in hospital in the last 12 months?	
	1. Yes 2. No (Go to Q49)	
34.	What was the name of the hospital you stayed in most recently?	
	Hospital name…….	1. Governmental (MoH) 2. Governmental (MMS) 3. NGO 4. Private
35.	Did you get your hospital care as soon as you wanted?	
	1. Yes 2. No	
36.	When you were in the hospital, how often did you get attention from doctors and nurses as quickly as you wanted?	
	1. Always 2. Often 3. Usually 4. Sometimes 5. Never	
37.	Now, overall, how would you rate your experience of getting prompt attention at	

	the hospital in the last 12 months?
	1. Very good 2. Good 3. Moderate 4. Bad 5. Very bad
38.	Overall, how would you rate your experience of being treated with dignity at the hospital?
	1. Very good 2. Good 3. Moderate 4. Bad 5. Very bad
39.	Overall, how would you rate your experience of getting involved in making decisions about your care or treatment as much as you wanted when you were in hospital?
	1. Very good 2. Good 3. Moderate 4. Bad 5. Very bad
40.	Overall, how would you rate your experience of the way the hospital kept personal information about you confidential?
	1. Very good 2. Good 3. Moderate 4. Bad 5. Very bad
41.	Overall, how would you rate your experience of being able to use a hospital of your choice over the last 12 months?
	1. Very good 2. Good 3. Moderate 4. Bad 5. Very bad
42.	Overall, how would you rate the quality of the surroundings, for example, space, seating, fresh air and cleanliness of the hospital?
	1. Very good 2. Good 3. Moderate 4. Bad 5. Very bad
43.	When you stayed in a hospital, how big a problem, if any, was it to have healthy and edible food?
	1. No problem 2. Mild problem 3. Moderate problem 4. Severe problem 5. Extreme problem

44.	When you stayed in a hospital, how big a problem, if any, was it to get the hospital to allow your family and friends to visit you?
	1. No problem 2. Mild problem 3. Moderate problem 4. Severe problem 5. Extreme problem
45.	When you stayed in a hospital, how big a problem, if any, was it to get the hospital to allow your family and friends to take care of your personal needs, such as bringing you your favorite food, soap etc..?
	1. No problem 2. Mild problem 3. Moderate problem 4. Severe problem 5. Extreme problem
46.	During your stay in the hospital, how big a problem, if any, was it to have the hospital allow you to practice religious or traditional observances if you wanted to?
	1. No problem 2. Mild problem 3. Moderate problem 4. Severe problem 5. Extreme problem
47.	Now, overall, how would you rate your experience of how the hospital allowed you to interact with family, friends and to continue your social and/ or religious

	customs during your stay over?		
	1. Very good 2. Good 3. Moderate 4. Bad 5. Very bad		
48.	Please check with either a yes or no for each question. In the last 12 months were you treated badly by health centers or hospitals in your country because of your: (Check all that apply)		
	Yes	No	reason
			Nationality
			place
			Lack of private insurance
			Ethnicity
			Color
			Sex
			Language
			Religion
			Political/other beliefs
			Health status
			Lack of wealth or money
			Other (specify)_____
49	In the last 12 months, did you ever not seek health care because you could not afford it?		
	1. Yes 2. No		

50. Read the cards below. These provide descriptions of some different ways the health care services in your country show respect for people and make them the center of care.

Thinking about what is on these cards and about the whole health system, which is the most important and the least important to you?

DIGNITY • being shown respect • having physical examinations conducted in privacy • having the provider listen to you carefully	**CONFIDENTIALITY OF INFORMATION** • having your medical history kept confidential • having talks with health providers done so that other people who you don't want to have hear you can't overhear you
CHOICE • being able to choose your doctor or nurse or other person usually providing your health care • being able to go to another place for health care if you want to	**PROMPT ATTENTION** • having a reasonable distance and travel time • from your home to the health care provider • getting fast care in emergencies • having short waiting times for appointments and consultations, and getting tests done quickly • having short waiting lists for non-emergency surgery
AUTONOMY • having the provider explain things so you can understand • having time to ask questions • being involved in deciding on your care or treatment if you want to • having the provider ask your permission before starting treatments or tests	**SURROUNDINGS OR ENVIRONMENT** • having enough space, seating and fresh air in the waiting rooms • having a clean facility (including clean toilets) • having healthy and edible food
SOCIAL SUPPORT • being allowed to be visited by relatives and friends • being allowed the provision of food and other gifts by relatives • being allowed freedom of religious practices	

Most important _____ least important _____

Annex (9): Focus groups interviews questions.

Focus Groups interviews questions

1. In your perspective, to what extent did you think you were treated with dignity at the health services in the last 12 months?

Probing questions

- Respect
- Concern
- Listen to you carefully

2. How would you rate your experience of getting prompt attention at the health services in the last 12 months?

Probing questions

- Getting fast care in emergencies
- Short waiting lists

3. In your perspective, to what extent did you think you were getting involved in making decisions about your care or treatment as much as you wanted in the last 12 months?

Probing questions

- Provided with information
- Consulted on preference
- Patient consent

4. How would you rate your experience of the way the health services kept information about you confidential in the last 12 months?

Probing questions

- Privacy "others can't overhear consultation"
- Patient information/medical records confidentiality

5. How do you evaluate your experience of being able to use a health care provider or service of your choice over the last 12 months?

Probing questions

- Choose health institution
- Choose health provider

6. What do you think about the quality of the surroundings, for example, space, seating, fresh air and cleanliness of the health services you visited in the last 12 months?

Probing questions

- Having enough space, seating and fresh air in the waiting rooms
- Having a clean facility (including clean toilets)
- Having healthy and edible food

7. From your view, how would you rate your experience of how the hospital allowed you to interact with family, friends and to continue your social and/ or religious customs during your stay over?

Probing questions

- Visits by relatives and friends
- Religious practices

Annex (10): Focus groups interviews consent form

نموذج الموافقة

عزيزي/تي المشارك/ة

أنا الطالبة/ هالة محمد جودة، ملتحقة ببرنامج ماجستير الصحة العامة – تخصص إدارة صحية بجامعة القدس.

إنه ليسعدني أن تكون/ي أحد المشاركين في هذه الدراسة والتي تهدف إلى **قياس مدى استجابة النظام الصحي في قطاع غزة** من حيث الخدمات غير الصحية المقدمة للمرضى، مما بإمكانه لاحقاً أن يساهم في تحسين جودة هذه الخدمات.

هذه الدراسة جزء من متطلبات برنامج الماجستير – كلية الصحة العامة.

أخي / أختي المشارك/ة: سيقوم الباحث بإجراء جلسة مناقشة جماعية لمستفيدي النظام الصحي في قطاع غزة وفي حال أبديث الموافقة للمشاركة في هذه الدراسة عليك المشاركة في المناقشة والاجابة على الأسئلة المطروحة، مع العلم بما يلي:

- مشاركتك طوعية في هذه الدراسة ويحق لك القبول أو الرفض أو الانسحاب متى شئت.
- تستمر المناقشة حوالي ساعة تقريبا.
- لا توجد اجابات صحيحة أو اجابات خاطئة.
- سيتم تدوين ما يقال في النقاش
- لن يتم ذكر أي من أسماء المشاركين حفاظاً على السرية.

شكراً لتعاونكم

مع خالص الاحترام والتقدير

الباحثة: هالة محمد جودة

كلية الصحة العامة-جامعة القدس

Annex (11): Experts and professional consulted

1. Dr. Bassam Abu Hamad.

Associate Professor – Faculty of Public Health – Al-Quds University

2. Dr. Mohammed Al Kashef

Director of Palestine Medical Council

3. Dr. Yousef Al Jeesh

Professor Doctor – Islamic University of Gaza

4. Dr. Mahomoud Radwan.

Public Health Institute – World Health Organization

5. Dr. Midtkal Hassouna.

Health expert

عنوان الدراسة: استجابة النظام الصحي في قطاع غزة: الأبعاد والارتباطات

إعداد: هالة محمد جودة

إشراف: أ.د. يحيى عابد

ملخص الدراسة

تتمثل استجابة النظام الصحي في قدرة النظام الصحي على تلبية توقعات الناس بخصوص تفاعلهم مع النظام الصحي، بعيداً من توقعاتهم للتحسن في الحالة الصحية أو الرفاهية. يوجد للاستجابة سبعة أبعاد كما أوضحتها منظمة الصحة العالمية؛ الكرامة والاستقلالية والسرية والاهتمام الفوري والدعم الاجتماعي وجودة المرافق الأساسية وخيارات مقدمي الخدمات.

قامت الباحثة بتقييم استجابة نظام الرعاية الصحية باستخدام دراسة وصفية وتحليلية شاملة. تم جمع البيانات الكمية باستخدام استبيان من مسح الصحة العالمية من خلال مقابلة 409 شخص وتعبئة الاستبان معهم في البيوت. أما بالنسبة للبيانات النوعية فتم إجراء مجموعتين بؤريتين لجمع البيانات من المستفيدين من نظام الرعاية الصحية حول تجاربهم المتعلقة بالجوانب غير الصحية لخدمات الرعاية الصحية، كان مجتمع الدراسة عبارة عن سكان مدينة غزة الذين تتراوح أعمارهم من 18 عاماً وأكثر.

كان مستوى الاستجابة العامة جيدًا جدًا (84.99٪). كانت أفضل الأبعاد التي تم تقييمها هي الوصول إلى الدعم الاجتماعي (99.51٪) والسرية (98.61٪) بناءً على تجارب المشاركين فيما يتعلق بتفاعلهم مع النظام الصحي. أظهر كل من الاستقلالية (73.59٪) واختيار مقدم الرعاية الصحية (68.83٪) نقاط ضعف في النظام الصحي. أما بخصوص مدى أهمية الأبعاد للمشاركين، كان الاقتراح الأول لمعظم المشاركين في الدراسة هو الكرامة (22٪) ، يليه الاهتمام الفوري (20٪) ، وفي الوقت نفسه ، تم اقتراح الاختيار (5٪) وجودة المرافق الأساسية (11٪) على أنه الأقل أهمية. بالنسبة لمقارنة النتائج في الرعاية الأولية والرعاية الثانوية، تم تقييم جودة المرافق الأساسية والاستقلالية بشكل أفضل في العيادات الخارجية عنها في رعاية المرضى داخل المستشفيات مع وجود اختلافات بلغت 15.78٪ و 10.27٪ على التوالي. ومع ذلك ، تم الإبلاغ عن الكرامة بشكل أفضل في رعاية المرضى داخل المستشفيات منها في العيادات الخارجية (بنسبة 5.93٪). كانت نتائج البيانات النوعية تتشابه من النتائج الكمية لكل من جودة المرافق الأساسية والدعم الاجتماعي والاختيار والاستقلالية، بينما كانت أقل لكل من الكرامة والسرية وسرعة الاستجابة.

أظهرت النتائج أن الإناث يعاملن بطريقة كريمة أكثر من الرجال ومن المرجح أن يحصلن على الدعم الاجتماعي خلال فترات المكوث في المشفى أكثر من الذكور. علاوة على ذلك، يتمتع المشاركون الذين تتراوح أعمارهم بين 46 إلى 60 عامًا بدرجة أعلى في جودة المرافق الأساسية مقارنة بالمشاركين الذين تبلغ أعمارهم 61 عامًا وأكثر. أفاد المشاركون ذوو المستوى التعليمي المنخفض عن مستوى استجابة أعلى من أولئك الذين لديهم مستوى تعليمي أعلى. من وجهة نظر المشاركين في الدراسة، فإن مستوى الاستجابة العامة في العيادات الخاصة أعلى من عيادات وزارة الصحة وأعلى من عيادات الأونروا. من ناحية أخرى ، أفاد العاملون في عيادات وزارة الصحة بمستوى استجابة أقل من عيادات الأونروا. أفاد المشاركون في الدراسة الذين استفادوا من المستشفيات الحكومية عن مستوى استجابة أقل من المشاركين الذين استفادوا من المستشفيات غير الحكومية.

في النهاية تقترح الباحثة أنه يمكن تحسين استجابة النظام الصحي من خلال تنفيذ تدريبات لصانعي القرار والإداريين ومقدمي الرعاية الصحية في مفهوم الاستجابة وأبعادها ، أيضاً تقترح الباحثة العمل على تحسين الاستجابة من خلال التركيز على الأبعاد الأقل اعتمادًا على الموارد المالية مثل الكرامة والاستقلالية والسرية.