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**Evaluation of the Quality of Reproductive Health  
Services in Jabalia Woman's Health Centre:  
Client's Perspective**

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**Evaluation of the Quality of Reproductive Health Services in  
Jabalia Woman's Health Centre: Client's Perspective**

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Jerusalem – Palestine

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## **Dedication**

*To my uncle Maher & his wife Samira for their grateful support*

*To my husband for his help & encouragement*

*To my sisters for their support*

*To my parents for their love*

*To my aunt Samira*

*To my daughter*

*Without their effort & support, this work could not have been done*

***Mariam Shaqura***

## **Declaration**

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

Signed.....

Mariam Mohammed Shaqura

Date : November, 2008

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## Abstract

*Recent research considers client's perspectives about the services they receive as an essential part of understanding and assessing quality of care. Clients' perceptions are shaped by their cultural values, previous experiences, perceptions of the role of the health system, and interactions with providers. To provide high-quality care, providers must understand and respect their clients' needs, attitudes, and concerns since they leads to improved client satisfaction, continuous and sustainable use of services, and health improvement. This study aims to evaluate the quality of reproductive health services in Jabalia Woman's Health Centre from client's perspective and to provide recommendations for improving the quality of the services provided.*

*This study is a cross sectional for women who received reproductive health and physiotherapy services in Woman's Health Center at the time of data collection and showing acceptance to participate in the research. The study evaluates services provided at the centre, which include clinic services (antenatal, ultrasound, family planning, gynecological check and health counseling), physiotherapy services and counseling services which include psychological, social and legal counseling. An exit interview questionnaire was developed which concentrated on quality domains from client's perspective about services provided at Woman's Health Centre Jabalia. A total of 342 clients were chosen according to the eligibility criteria and they were invited for an interview to complete the questionnaire. The respondents are 304 clients and response rate was 88.8%. The total instrument reliability test (Cronbach's Alpha) was (0.766, 0.690, and 0.774) in clinic, physiotherapy and counseling services respectively. Also Split Half result (0.795, 0.825, 0.940) in clinic, physiotherapy and counseling services respectively. Correlation coefficient was used to measure construct validity for each domain of questionnaire with the total score of items.*

*The study main domains are: Competence, consultation, interpersonal relations and communications, accessibility, drug and supplies availability, physical infrastructure and general satisfaction. The study revealed that the client's perspective ranged from low to high perspectives and satisfaction. It ranged from 51% -98.2% in all services. In clinic service, high perspective levels were found with provider competency, service provider consultation, interpersonal relations and communications, accessibility and general satisfaction. Moderate level of perspective was found with drug and supplies availability. Low level was found with physical infrastructure.*

*In physiotherapy services, high perspectives levels were found with provider competency, service provider consultation, interpersonal relations and communications, accessibility and general satisfaction. Low perspective level was found with physical infrastructure and supplies availability. While in counseling services, high perspectives levels were found with interpersonal relations and communications and accessibility. Moderate level of perspective was found with provider competency, service provider consultation, physical infrastructure and general satisfaction.*

*In clinic services, findings showed that there was no statistical significant difference between age, employment status and income with regard to overall perspectives. But there is significant difference between client's education level and overall perspectives.*

*In physiotherapy services, the results revealed that there was statistical significant difference between age, educational level, employment status and income with regard to overall perspectives.*

*In counseling services, the results revealed that there was no statistical significant difference between age, educational level, employment status and income with regard to overall perspectives.*

*The study revealed that improvement in the infrastructure, providing drugs and supplies needed to quality services are important, counseling training courses are also vital. Furthermore, managers, board of directors and responsible could use the study findings to improve clients perspectives regarding reproductive health services provided and enhance more positive perspectives toward centre services.*

## ملخص الدراسة

### تقييم جودة خدمات الصحة الإنجابية المقدمة في مركز صحة المرأة- جباليا من وجهة نظر المنتفع

ترى البحوث التي أجريت مؤخرا أن وجهات نظر المنتفعين حول جودة الخدمات التي يتلقونها جزءا أساسيا من فهم وتقييم نوعية الرعاية المقدمة لهم. وجهات نظر المنتفعين هي التصورات التي شكلتها قيمهم الثقافية، وتجاربهم السابقة، وتصوراتهم عن دور النظام الصحي، والتفاعل مع مقدمي الخدمات. لتوفير خدمات الرعاية العالية الجودة، يجب على مقدمي الخدمات فهم واحترام احتياجات منتفعيها، ومواقفهم، واهتماماتهم لأنه يؤدي إلى تحسين رضا المنتفعين، واستمرار الاستخدام المستدام للخدمات، وتحسين الصحة. تهدف هذه الدراسة إلى تقييم جودة خدمات الصحة الإنجابية المقدمة في مركز صحة المرأة-جباليا من وجهة نظر المنتفعة وتقديم توصيات لتحسين نوعية الخدمات المقدمة.

الدراسة مقطعية التصميم وأعدت للنساء اللاتي حصلن على خدمات الصحة الإنجابية في مركز صحة المرأة في ذلك الوقت من جمع البيانات، وتبين قبولهن للمشاركة في البحث. الدراسة تقيم الخدمات المقدمة في المركز والتي تشمل خدمات العيادة (رعاية الحوامل، الألتراساوند، تنظيم الأسرة، الكشف النسائي والمشورة الصحية)، خدمات العلاج الطبيعي وخدمات المشورة والتي تشمل تقديم المشورة النفسية والاجتماعية والمشورة القانونية. لقد تم إعداد استبانة ركزت على وجهات نظر المنتفعين حول جودة الخدمات المقدمة في مركز صحة المرأة جباليا وتكونت من 5 محاور أساسية للتقييم واعتمدت مقياس ليكرت الخماسي (غير موافق بشدة - غير موافق - غير متأكد - موافق - موافق بشدة). لقد تم اختيار 342 منتفعة وفقا لمعايير الأهلية وطلب منهن مقابلة لتعبئة الاستبيان. وكان معدل الاستجابة 88.8 % (304 منتفعة). ودرجة ثبات الاستبيان ككل كانت حسب عامل اختيار كرونباخ (Cronbach's) تساوي (0.766، 0.690، 0.774) في خدمات العيادة، العلاج الطبيعي وخدمات المشورة على التوالي. أيضا حسب نتيجة نصف سبليت (Split Half) كانت درجة الثبات (0.795، 0.825، 0.940) في خدمات العيادة، العلاج الطبيعي وخدمات المشورة على التوالي. واستخدم معامل الارتباط بيرسون لقياس صدق الاستبانة وتبين وجود علاقة ذات دلالة إحصائية بين فقرات الاستبانة والبعد وبين البعد والأبعاد الأخرى للاستبانة.

استخلصت الدراسة الأبعاد الرئيسية التي شكلت إطارا لوجهات نظر المنتفعين حول جودة الخدمات المقدمة وهي: كفاءة مقدم الخدمة، خدمات المشورة، العلاقات والاتصال، سهولة الوصول لتلقي الخدمة، توفر العلاج والمستلزمات، البنية التحتية وتجهيزات المركز والرضا العام. وكشفت الدراسة عن أن وجهات نظر المنتفعين تتراوح بين 51 % و 98.2 % في جميع الخدمات. وقد كانت هناك اختلافات فيما يتعلق بمستوى تصور عوامل وجهات النظر والرضا باختلاف الخدمة التي تم الحصول عليها. في خدمات العيادة وجد أن التصور كان إيجابيا وعاليا بخصوص كفاءة مقدم الخدمة، خدمات المشورة، العلاقات والاتصال، سهولة الوصول للخدمة و الرضا العام. وكان متوسطا في بعد توفر العلاج والمستلزمات وكان أقل تصور فيما يتعلق بالبنية التحتية وتجهيزات المركز.

في خدمات العلاج الطبيعي كانت وجهات النظر ايجابية فيما يتعلق بكفاءة مقدم الخدمة، خدمات المشورة، العلاقات والاتصال، سهولة الوصول للخدمة و الرضا العام. وكان قليلا في توفر العلاج والمستلزمات والبنية التحتية المركز.

بينما في خدمات المشورة كانت وجهات النظر ايجابية في العلاقات والاتصال وسهولة الوصول للخدمة. وكانت متوسطة في كفاءة مقدم الخدمة، خدمات المشورة، البنية التحتية والرضا العام.

أظهرت نتائج المنتفعات من خدمات العيادة أنه لا يوجد علاقة ذات دلالة إحصائية بين العمر، الوظيفة والدخل فيما يتعلق بوجهات نظر المنتفعات بينما يوجد علاقة ذات دلالة إحصائية بين وجهات نظر المنتفعات والمستوى التعليمي.

بينما وضحت نتائج المنتفعات من خدمات العلاج الطبيعي أنه يوجد علاقة ذات دلالة إحصائية بين العمر، الوظيفة، الدخل والمستوى التعليمي فيما يتعلق بوجهات نظر المنتفعات تجاه جودة الخدمة المقدمة في المركز.

أما بالنسبة لخدمات المشورة فقد أوضحت النتائج أنه لا يوجد علاقة ذات دلالة إحصائية بين العمر، الوظيفة، الدخل والمستوى التعليمي ووجهات نظر المنتفعات تجاه جودة الخدمة المقدمة في المركز.

وكشفت الدراسة أن تحسين البنية التحتية للمركز، توفير الأدوية والمستلزمات الضرورية لتقديم الخدمة، وتقديم دورات تدريبية في المشورة وفن الاتصال من العوامل الضرورية لتحسين وجهات نظر المنتفعات، لذلك من الضروري مراعاتها من قبل المسؤولين وصناع القرار. وعلاوة على ذلك، يستطيع المسؤولون استخدام نتائج الدراسة لتعزيز وجهات النظر الايجابية وتحسين وجهات نظر المنتفعات تجاه جودة خدمات الصحة الإنجابية المقدمة في المركز.

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## Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANOVA	Analysis of variance
CBR	Crude Birth Rate
CDR	Crude Death Rate
COPE	Client-Oriented, Provider Efficient
EGH	European Gaza Hospital
EMCDD	European Monitoring Centre for Drugs and Drug Addiction
GNP	Gross National Product
GS	Gaza Strip
ICPD	International Conference on Population and Development
IEC	Information, education and communication
MDGs	Millennium Development Goals
MOH	Ministry of Health
NHP	National Health Plan
NGO's	Non Governmental Organizations
NIS	New Israel Sheqel
OPT	Occupied Palestinian Territories
PCBS	Palestinian Central Bureau of Statistic
PHC	Primary Health Care
QAP	Quality Assurance Project
RCS	Red Crescent Society for Gaza Strip
RH	Reproductive Health
SPSS	Statistical Package for Social Science
STDs	Sexual Transmitted Diseases.
TAMI	Training, Accounting and Management Institution
UNDPC	The United Nations International Drug Control Programme
WB	West Bank
WHCJ	Woman's Health Centre Jabalia
WHO	World Health Organization
UNDP	United Nations Development Program

UNFPA

United Nations Population Fund

UNRWA

United Nations Relief and Works Agency

# *Chapter One*

## *Introduction*

# **Chapter 1**

## **Introduction**

### **1.1 Background**

The researchers defined evaluation in different ways, but evaluation mainly concerned with the following: Trochim (2006), defined evaluation as the systematic assessment of the worth or merit of some object. Evaluation is the systematic acquisition and assessment of information to provide useful feedback about some object (Trochim,2006). Evaluation is a part of a continuing management process consisting of planning, implementation, and evaluation; ideally with each following the other in a continuous cycle until successful completion of the activity (Thakore, 2006).

Evaluation is an important tool the organization can use to demonstrate its accountability, improve its performance, increase its abilities for obtaining funds or future planning, and fulfill the organizational objectives. By communicating the results of the evaluation, the organization can inform its staff, board of directors, service users, funders, the public, or other stakeholders about the benefits and effectiveness of organization's services and programs. Although there are many benefits in conducting evaluation, it will be a waste of organization's resources if the evaluation results are not used ( Zarinpoush, 2006).

The generic goal of most evaluations is to provide "useful feedback" to a variety of audiences including sponsors, donors, client-groups, administrators, staff, and other relevant constituencies. Recent years have witnessed growing interest in evaluation of health services and social service programs from client's perspective in which this provides a personal and unique view of the perceived effectiveness of a clinic's services (World Health Organization, The United Nations International Drug Control Programme and European Monitoring Centre for Drugs and Drug Addiction, (WHO, UNCPD, EMCDDA, 2000). The client is a priority in all facilities, and forms the core of the programs to be continued and sustained. In client-centered health care, clients are considered the experts on their own personal circumstances and wants (Nicholas, Heiby and Hatzell, 1991). Reproductive health is a crucial part of general health and a central feature of human development. It is a reflection of health during childhood, and crucial during adolescence

and adulthood, sets the stage for health beyond the reproductive years for both women and men, and affects the health of the next generation. Reproductive health is a universal concern, but is of special importance for women particularly during the reproductive years (World Bank, 1995). Reproductive health is a complete physical, mental and social wellbeing and not merely the absence of disease or infirmity in all matters relating to the reproductive health system and to its functions and processes (ICPD, 1994).

The multi-dimensional nature of quality services suggests that some aspects of quality perceived as important by professionals may not necessarily be of equal value or of any importance to clients. Thus, in order to design the best client-satisfaction practices to improve the quality reproductive health services, there is a need to understand client perceptions of quality of care (Daniel and Kabira, 2000)

Before assessment can begin we must decide how quality is to be defined and that depends on whether one assesses only the performance of practitioners or also the contributions of patients and of the health care system; on how broadly health and responsibility for health are defined; on whether the maximally effective or optimally effective care is sought; and on whether individual or social preferences define the optimum. We also need detailed information about the causal linkages among the structural attributes of the settings in which care occurs, the processes of care, and the outcomes of care. Specifying the components or outcomes of care to be sampled, formulating the appropriate criteria and standards, and obtaining the necessary information are the steps that follow. Though we know much about assessing quality, much remains to be known (Donabedian, 1988).

Quality is "The totality of features and characteristics of a product or service that bears on its ability to meet a stated or implied need" (Shouroki, 2007).

An essential factor to consider when analyzing the quality of care of health facilities is the perspective of the client. For clients and communities, quality care is something that meets their perceived needs. Since a client's needs often differ, their personal satisfaction ultimately depends on the perception, attitude and expectations of each individual (Brawley, 2000).

Different studies were conducted on quality of reproductive health services from client's perspective and different dimensions were emerged in different health settings. From

related literature and past studies the researcher found that the most important dimensions of quality for the client are:

*Provider competency* which reflects the concern of clients about the qualifications and training of service providers, conducting proper examination, identify the problem and prescribe treatment.

*Service provider consultation* refers to clients concerns with the provider consultation through taking regular counseling from health provider, spend more time listening to their problem, explain the examination and procedures, explain the treatment, give clear instruction about medication, give clients the opportunity to ask questions and provide a referral if necessary (Brawley, 2000).

*Interpersonal relations and communications* refers to interaction between client and health provider which include trust, respect, confidentiality, courtesy, responsiveness, empathy, effective listening and communication between providers and clients (Quality Assurance Project, 2007).

*Accessibility* means the degree to which client facilitated to receive services from the centre includes easiness to reach the centre, provider's availability, service availability, proper waiting time and cost of service. *Drugs and supplies availability* which is very important to provide quality services.

*Physical infrastructure* which includes running water and electricity available, cleanliness and sanitation (examination rooms, toilets), privacy and comfort through plenty of seats in waiting room and adequate space to maintain client confidentiality (Brawely, 2000).

Lastly, *general satisfaction* domain which is "a summary of psychological state that results from the confirmation or non confirmation of expectations when compared with perception of a discrete episode of contact with an organization. Satisfaction is of short duration and contributes to the formation of attitude over-time " (Oliver, 1981).

This study was conducted to evaluate the quality of reproductive health services of Woman's Health Center from client's perspective, because it has not been evaluated since it's establishment, except one evaluation done for adolescence counseling services only in 2006 by TAMI and UNFPA.

In addition to registered decreased clients numbers benefited from the services and complains of some clients regarding such issues like availability of services, communications and others; which motivates the researcher to do the study to provide suggestions to policy makers in order to improve quality of services provided to clients in

the centre, and increase utilization of services to contribute to improving reproductive health for women and all family.

## **1.2 Statement of the problem**

Client's satisfaction is considered very important indicator for evaluation of the quality of reproductive health services. To provide high-quality care, providers must understand and respect the client's needs, attitudes, and concerns. These client perceptions are in turn affected by personal, social, and cultural factors. Research highlights the benefits of addressing client's perspective on quality of care, since it leads to improved client satisfaction, continued and sustained use of services, and improved health outcomes. Good care helps individuals and couples meet their reproductive health needs safely and effectively (Bruce, 1990). The Program of Action of the 1994 International Conference on Population and Development (ICPD) in Cairo called for more attention to the quality of care. It urged a client-centered approach to the delivery of family planning and other reproductive health services (ICPD, 1994).

In Palestine, there are few studies regarding quality improvement in reproductive health services from client's perspective. Thus, the study was conducted to evaluate the quality of reproductive health services in Jabalia woman's Health Centre from client's perspective. Therefore the results may be adopted and based in quality health care system.

## **1.3 Significance of the study**

Quality improvement is getting more attention nowadays by health care organizations all over the world. This means that the consumer of reproductive health services need to be cared by giving chance to speak about their perception and how they are valuing the way they conducted services to enhance proper participation and empowerment of clients.

ICPD (1994) focused on quality of reproductive health services because during reproductive age, women may get pregnant, miscarriage, give birth all these take their role on women's health, make them more susceptible to illness and health related problems which make it very essential to study quality of reproductive health services to save mother's lives. Everyone has the right to enjoy reproductive health, which encompasses

key areas; that every child is wanted, every birth is safe, every young person is free of HIV and every girl and woman is treated with dignity and respect (UNFPA, 2007).

Patient satisfaction is a strong influencing factor in determining whether a person seeks medical advice, complies with treatments and maintains a relationship with the provider/health facility. Ultimately, the dimensions of quality that relate to client satisfaction affect the health and well being of the community (Brawley, 2000).

Far from being a luxury, improving quality of care can be a cost-effective means for achieving the ultimate goal of better reproductive and sexual health . If clients are not treated with respect, they may not use the available services. Or they may have poor outcomes (UNFPA, 2005).

Gaps between theory and practice, the delivery of services and quality of care provided which contributes significantly to women's ill health motivate the researcher to study this topic. Moreover, few studies in Palestine regarding quality of reproductive health from client's perspective motivates the researcher to focus and highlight the importance of evaluation of service quality, and client satisfaction regarding reproductive health services for improvement of the health and quality of the women's life during all stages of their life span. In addition, client's perspective studies are seen as an important way for obtaining a wealth of information about the dimensions of quality related to reproductive health and exploring variables influencing client's satisfaction.

The research will identify areas of quality health care services that are particularly important to the client and use this information as a basis for recommendations for client perspective standards. As the researcher is a director of WHCJ, the results of the study will help in improving quality of care provided and discover areas of strength to enhance it, and areas of weakness to treat it. Also the findings of the study will help in preparing actual plan based on scientific needs and results. Additionally, to provide suggestions to policy makers to adopt it in order to improve quality of services provided to clients in Gaza. Also this research will give chance to other researchers to do further studies mainly in quality field. Therefore, the results may be adopted and based in quality health care system.

## **1.4 Aim of study**

The aim of this study is to evaluate the quality of reproductive health services in Jabalia Woman's Health Center from client's perspective. The study explores the main domains of quality as perceived by clients attending the center to identify strength and weakness points affected client's satisfaction.

## **1.5 Objectives of the study**

1. To explore the main constructs of client's perspective towards quality of reproductive health services in Jabalia Woman's Health Center.
2. To assess client's satisfaction regarding reproductive health services in Jabalia Woman's Health Center.
3. To identify the relationships between selected demographic, socio-economic and organizational factors with respect to client's perspective toward quality of reproductive health services in Jabalia Woman's Health Center .
4. To provide suggestions for decision makers to improve reproductive health services quality in Jabalia Woman's Health Center .

## **1.6 Research questions**

*This study addresses the following questions:*

1. What are the clients' perspectives toward technical competence of providers of reproductive health services in Jabalia Woman's Health Center?
2. What are the client's perspectives toward interpersonal relations with providers of reproductive health services in Jabalia Woman's Health Center?
3. What are the clients' perspectives regarding accessibility of reproductive health services in Jabalia Woman's Health Center?
4. What are the clients' perspectives toward amenities of reproductive health services in Jabalia Woman's Health Center?
5. Are the clients generally satisfied with reproductive health services provided in Jabalia Woman's Health Centre?

6. Are there significant differences in perspectives of clients attending clinics, physiotherapy and counseling with regard to selected demographic and socio-economic variables such as age, educational level, economical state and employment status?
7. Are there significant differences in client's perspectives with regard to selected organizational variables such as waiting time and consultation time?
8. What are the suggestions to improve reproductive health services quality in Jabalia Woman's Health Center?

## **1.7 Context of the study**

To establish a good understanding of health care system and services in Palestine, the researcher presented background information on Palestine, mainly Gaza Strip, that gives an idea about the situation of Palestinian and their health status which can serve the study.

### **1.7.1 Demographic context**

Palestine is located on the eastern coast of the Mediterranean Sea. It is bordered by Lebanon on the north, by Syria and Jordan on the East, the Gulf of Aqaba on the South and by Egypt and the Mediterranean Sea on the West (MOH, 1999a) (Annex 1).

Gaza Strip is a narrow piece of land lying on the coast of the Mediterranean Sea. It is 50 km long and 5-12 km wide with an area of 365 square kilometer and constitutes 6.1 % of the total area of the Palestinian Territory land. G.S contains five provinces ; North Gaza, Gaza, Middle-Zone, Khan-Younis and Rafah. There are four towns, eight refugee camps and fourteen villages (PCBS, 2006) (Annex 2). G.S is a very crowded place, the number of population is 1,416,539 (37% of total population which constitutes 3,761,646), around 19.3% of the population resides in North Gaza, 35% in Gaza City, 14.5% in Mid Zone, 19.4% in Khanyounis, and 11% in Rafah district. The population density is 3,881 inhabitants per square kilometer (PCBS, 2008).

Regarding age structure, 48.8 % of the total population in G.S is under 15 years. Age from 15-64 years constitute 49.9 % of the total population and 2.6% of the population

are 65 years and over. Proportion of population aged 60 years and above is 4.4% of total population (Annex 3) (PCBS, 2008).

The crude birth rate in G.S dropped from 4.7 in 1997 to 3.8 in 2005. MOH has reported that crude death rate in Palestine declined from 4.8 deaths per 1000 population in 1997 to 2.8/1000 population in 2005 (3.1 GS and 2.1WB) (MOH, 2005).

According to United Nation Relief and Work Agency (UNRWA) registration statistics, the total registered refugee's population in Gaza Strip was 986,034 in the year 2005, which constituted 68% of total population in G.S. (UNRWA, 2005).

### **1.7.2 Socio-political context**

The unstable political situation influences the socioeconomic status. The Palestinian economy refers to the economy of the Palestinian territories, including the West Bank, East Jerusalem and the Gaza strip. Recent geopolitical events have severely damaged the economy of the territories. Unemployment rate in age 15 year and above is 29.7; two-thirds of Palestinians are living below the poverty line (PCBS, 2008). The Palestinian economy was affected by two main factors during the year 2006. Firstly, continues deterioration of the social and economic situation due to the Israeli measures in the Palestinian Territory erupted at the outbreak of the second Intifada late September 2000. The second factor is the changes in the policy of the donor community took place after the legislative elections of January 25th 2006, and the forming of the new government. As of the beginning of the second quarter 2006, three main measures (actions) affected the Palestinian economy:

- 1- Stopping the transfer of tax revenues that Israel collects in behalf of the Palestinian National Authority (PNA), which forms about 60% of the PNA revenues.
- 2- Decline in the budgetary financial supports provided by the donors (As budget support, relief), which estimated by \$US 13 million per month.
- 3- Inability to transfer financial assistance from other Arab countries to the Palestinian Government (PCBS, 2006).

The data indicates high dependency ratio in Palestine, the ratio declined from 114.5 in 1997 to 108.5 in Gaza in 2004 which is high. This means that the economically dependent part on the productive part is very high. The dependency ratio tells us how many young

people (under 16) and older people (over 64) depend on people of working age (16 to 64). The Gross National product (GNP) was 5,545 million US\$ in 1999 and decreased to 3,720 million US\$ in 2004 (MOH, 2005).

Population growth problem affects socioeconomic development of individual and community, MOH has reported that population natural increase rate 2.5 in 2005 in Palestine (3.1% GS and 2.1% WB) (MOH, 2005).

Education is a major concern for Palestinians. 92.4% in G.S of the total population are literate from age 15 and over (UNDP, 2006). Crude marriage rate in Palestine was 7.7 marriage/1000 population and crude divorce rate is 1.1/1000 population (MOH, 2004).

### **1.7.3 Health care system context**

#### **Before 1994**

Prior to the Israeli occupation in 1967, Gaza was administered by Egypt, while the West Bank and East Jerusalem were administered by Jordan. Health institutions in each area operated independently from each other. Between 1967 and 1994, these areas were both administered by the Israeli Occupying Forces. Gaza and the West Bank had separate chief medical officers and administrative structures, and they continued to follow different protocols in certain health policy areas while many aspects of health policy were standardized for both the West Bank and Gaza (Schoenbaum, Afifi, and Richard, 2005).

#### **Transfer to the Palestinian Authority**

Following the Oslo Agreement in 1993, Israel and the Palestinians negotiated the transfer of responsibility of health services and health policy from Israeli Administration to the newly formed PA. The Palestinian health system is commonly described as consisting of four sectors : the government sector, led by the MOH, the private sector, the NGO sector, and the sector run by UNRWA. The MOH serves as the principal administrative. The MOH manages public health services and delivery of primary, secondary, and tertiary care in government facilities (Schoenbaum, Afifi, and Richard, 2005).

### **1.7.4 Health Indices**

The vital statistics are very important to be highlighted.

Infant Mortality Rate (IMR) is one of the main health indicators that reflect the health status in the country. In 2005 It was 20.8/1000 live births. Additionally, early neonatal death (< 6 days) is (9.4/1000 infant) which constituted about 45% of infant mortality in 2005. Late neonatal deaths (7-27days) is 4.7/1000 live births which constitute 23% of infant deaths. Post neonatal mortality accounted for about half of the total infant death (6.6/1000) in 2005. Mortality at this age is primarily related to environmental causes such as infectious diseases and accidents which may be preventable (MOH, 2005).

### **Women health context**

Palestinian women have a fundamental right to enjoy the highest possible levels of health and quality of life. The Ministry of Health works together with the UNRWA and NGO's toward the improvement of health and quality of the women's life during all stages of their life span.

Female population between 15-49 years old represent 22.3% of total population and 45.1% from the total number of females, female still have the higher average life expectancy at birth, is 73.1 years while and 71.7 years for males (MOH, 2005). Total fertility rate is declining to 4.6 per woman in 2004 while it was 6 births per woman in 1997 (MOH, 2004).

### **Family planning services**

Family planning works to enable people to make informed choices about their reproductive health and well being. It safeguards individual health and improves the quality of life for women, husband and their children. According to Demographic and Health Survey in 2004 conducted by PCBS, the contraceptive prevalence rate in Palestine was 50.6% (55.1% WB and 43%GS) (PCBS, 2004).

### **Antenatal, delivery and postnatal care services**

In Palestine 4 sectors provides maternal care MOH, UNRWA, NGOs, and private doctors.

MOH reported that more than 96.5% of women aged (15-49) receive antenatal care in Palestine, with 5.5 visits paid by pregnant women. In UNRWA, it was reported at 7.6 visits per pregnant in G.S (MOH, 2005). According to MOH report, about 96.8% of births took place in health institutions and 3.2 % in homes. About 83.9% of deliveries are vaginal, and 16.1% are caesarean deliveries. In G.S, total number of beneficiaries of home visits program was 1950 women in 2005. The total number of women who receive postnatal care in UNRWA clinics was 30,920 women, 98.4% out of total live births (MOH, 2005).

### **Anemia among women**

WHO define anemia as Hb of less than 11 gm/dl, Percentage of anemia among pregnant women registered in MOH was 38.5% while among those registered in UNRWA was 35.7% in G.S. Ferrous sulfate and folic acid as a tonic is distributed for pregnant women and children under 3 years in MOH and UNRWA centers free of charge (MOH, 2005).

### **Breast cancer**

Among Palestinian females, breast cancer was the first leading cause of cancer deaths(21.1%) with a mortality rate of 5.2 per 100,000 females (MOH, 2005).

### **Breastfeeding**

Percentage of breastfeeding is high 95.6% in Palestine. Mean duration of breastfeeding is 10.9 months (PCBS, 2004).

### **Maternal Mortality Ratio**

The maternal mortality ratio per 100,000 live births among women aged (15-49)was 7.7 per 100,000 live births in Palestine. In 2005 only 8 maternal deaths were reported (7 GSand1WB). Globally, 70% of all maternal deaths are caused by just 5 factors: hemorrhage, infection, unsafe abortion, high blood pressure and obstructed labor (MOH, 2005).

## 1.8 Operational definitions

**Evaluation:** is defined as "the systematic acquisition and assessment of information to provide useful feedback about some object" (Trochim, 2006).

**Quality:** "The totality of features and characteristics of a product or service that bears on its ability to meet a stated or implied need" (Shouroki, 2007).

**Reproductive health:**"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes "(UNFPA, 2004).

**Client's perspective:** Client's perspective is defined in this study, as patient's experience, views and opinions about the centre services they received. Views and perceptions used in the same position.

*In this study an instrument was developed and contained the following domains to achieve the aim of the study.*

- **Provider competence:** the researcher view that provider competence from clients point of view is to identify problem, conduct a proper examination and prescribe treatment.
- **Service provider consultation:** includes regular counseling, spend more time listening to the client's problem; explain examination and give chance to ask.
- **Accessibility:** The degree to which client is facilitated to receive services from the center, which including easiness to reach, provider and service availability, easiness to get services, waiting time and cost of services.
- **Interpersonal relations and communications:** the interaction between the health providers and clients which include welcoming the client, trust, respect,

confidentiality, courtesy, responsiveness, empathy, effective listening and communication between providers and clients.

- **Amenities:** include drug and supplies availability physical infrastructure and comfort such as cleanliness, running water, seats, sanitation, and space for waiting, curtains and beds for check.
- **General satisfaction:** "a summary of psychological state that results from the confirmation or non confirmation of expectations when compared with perception of a discrete episode of contact with an organization. Satisfaction is of short duration and contributes to the formation of attitude over-time "(Oliver, 1981).

### **1.9 Red Crescent Society for Gaza Strip (RCS)**

The RCS for Gaza Strip is an independent NGO concerned with democracy, development and relief work. It provides health, cultural, educational and humanitarian services to all needy citizens in Gaza Strip. It was due to the need of national institutions that would address the daily needs of the Palestinians that resulted from the Israeli occupation territories in June 1967. Thus, eleven Palestinian personalities, decided to found a society under the title of the Red Crescent Society of Gaza Strip. The Society was licensed in 1969 and permitted operating in the first of January 1972.

The RCS vision is to improve the health, educational, cultural and human conditions of GS population. The General Assembly of the society is comprised of the bulk of its members, and it convenes on regular basis once a year. The Board of Directors is selected by the General Assembly biannually and it consists of 11 members. The society has more than one centre which are Dr. Haider Abdul Shafi Centre, Abassan Medical Centre, and Woman's Health Centre-Jabalia. (RCS, 2007)

#### **Woman's Health Centre – Jabalia (WHCJ)**

WHC-J is a NGO established since 1998, by two partner organizations. Red Crescent Society for Gaza Strip (RCS), and the Italian Association for Women in Development (AIDOS) aiming at the creation of a Women's Center for health care, physiotherapy services, psychosocial assistance, legal counseling and community education in Jabalia

Refugee Camp in the north governorate of Gaza, with financial support from Italian government through UNFPA.

The center was created as a response to the Palestinian women's needs, as assessed by a study conducted by the UNDP. Operationally, since October 1999, Jabalia Women's Health Center has pioneered women's comprehensive and preventative care in Palestine. Emphasis is placed on the inter-relation between the social, psychological and physiological with particular attention to individual and collective aspects, prevention and care, information and education.

Women of the camp, besides receiving individual primary gynecological health care, are provided with information and services in family planning, birth spacing, self breast examination, prevention of sexually transmitted diseases, and antenatal and postnatal care. Different parallel services which comprise individual and group psychological services, legal counseling, and social services for women. The psychosocial counselors deal with different problems like unemployment, poverty, depression, divorce, behavioral problems and others through providing individual and group counseling, psychodrama and debriefing in addition to awareness sessions. Physiotherapy services include gymnastics, antenatal exercises for pregnant women, and postnatal exercises after delivery to prevent any complication and strengthen the body muscles. In addition to physiotherapy sessions for women who complain from musculoskeletal problems. Physical well-being of women is an essential element of their sexual and reproductive life, in addition to men involvement in reproductive health. Finally, a series of health workshops, training seminars, and outreach programs are conducted in the center and throughout Jabalia refugee camp and the northern governorate, focusing on topics that have been requested by the women themselves (WHCJ, 2006).

The project's underlying approach is that of women's empowerment, which is achieved by enabling women to have access to knowledge on how their bodies function, to gain control over their bodies, to know what to do in cases of domestic violence, meet and exchange experiences with other women, attending workshops and seminars that focus on building self-esteem, upgrading their knowledge about their rights, and having access to audiovisual and printed material.

The Center's activity is consistent with the Palestinian National Health Plan, which adopted a comprehensive approach to women's health, with focus on reproductive health.

The centre serve women of all age groups, including adolescents and menopause, with a special focus on marginalized and underprivileged sectors of Jabalia camp, in addition it serves men because they are essential partners in decision making in terms of reproductive health choices and for a healthy and balanced family. Also it serves children in need for psychosocial counseling and nutritional support.

All the activities planned for the attainment of project objectives involve a combination of individual and group consultation, community-based workshops, home-visits and formal training courses.

Staff of the center is 23 members as following: Director, accountant, secretary, receptionist, 3 health educators, 1 nurse, 1 midwife, physician, and lab. Technician, 2 social worker, physiotherapist, dentist, 2 psychologists, 1 lawyer, 2 male counselor, 1 volunteer, guard, cleaner.

The project was able to maintain a wider network of NGOs such as; Ministry of Health "MOH", UNRWA, UNFPA, UNDP, Al-Mezan Centre for Human Right and Gaza Community Mental Health Program.

The center provides nearly 5000 consultation annually. These include new and return users. The administration mainly focused on high quality services, through providing services according to protocols that prepared by UNFPA and MOH, regular follow up, monitoring and evaluating, building capacity of the staff and make free space to client's to express their needs , perceptions and complains if available (WHCJ , 2006).

*Chapter Two*  
*Literature Review*

## **Chapter 2**

### **Literature Review**

This chapter reviews the literature that clarifies different issues related to client's perspective. It begins with the evaluation concept, and then it presents benefits, types and approaches of evaluation. Furthermore, it identifies the uses of evaluation findings and clients satisfaction evaluation. Also, the chapter clarifies reproductive health concept, development of RH concept and components of reproductive health. Further, it provides brief idea about reproductive health in Palestine. RH in Islam is mentioned also. After that, it reviews quality and reproductive health, approaches of quality and Islamic point of view regarding quality. Lastly, it presents related studies conducted in different health care settings and summarizes the main dimensions of quality in reproductive health from client's perspective.

#### **2.1 Conceptual Framework**

To evaluate and improve the quality of services provided, it is important to hear client's voices and explore their needs, expectations and perspectives regarding the services they received. The center staff needs to identify factors which influence client's perspectives regarding reproductive health services. Several studies were conducted to explore client's perspective regarding quality of health services provided in different health settings (For more details see Annex 4). The literature review helps the researcher to take the following domains of quality that affect client's perspectives.

Brawley, (2000) reviewed 17 articles and academic health studies, Brawley, found that the most important dimensions of quality for the client are the following: provider competency, service provider consultation, interpersonal relations and communications, accessibility, physical infrastructure, drug and supplies availability and general satisfaction.

##### **1. Technical Competence**

###### **a. Provider Competence**

The Quality of Reproductive Healthcare Study (DISH, 1999) discovered that clients often expected facilities to have well qualified medical doctors and laboratory technicians.

Specifically, clients wanted providers to conduct a proper examination, identify the problem and prescribe treatment. Clients wanted providers to conduct a proper examination, identify the problem and prescribe treatment.

#### **b. Service Provider Consultation**

Clients concerns with the provider consultation when evaluating the quality of RH services. Clients expect to receive regular counseling from health providers who are expected to spend more time listening to their problems ,explain the examination and procedures, explain the treatment , give clear instruction about medication, give clients the opportunity to ask questions and provide a referral if necessary (Nshakira, and others, 1996).

### **2. Interpersonal relations and communication**

Interpersonal relations are one of the most important issues for clients' perception of quality. The interpersonal relations and communication refers to interaction between client and health provider which include trust, respect, confidentiality, courtesy, responsiveness, empathy, effective listening and communication between providers and clients.

### **3. Accessibility**

Clients would like to have increased access to health workers clients would like to have increased access to health workers. In particular, clients are looking for punctuality, shorter waiting periods at the facility, and willingness to be served at any time. (Nshakira et. al., 1996). The researcher defined it in this study as the degree to which client is facilitated to receive services from the centre including easiness to reach the centre, providers availability, service availability, short waiting time and cost of service.

#### **a. Provider and service availability**

Clients would like to have increased access to health providers and service. In particular, clients are looking for willingness to serve them at any time which encourage them return back to the health centre (Nshakira and others, 1996).

### **b. Proper waiting time**

The clients respect punctuality and shorter waiting times at the centre; clients identified long waiting times as a concern (Snow, 2000). Villar, and Bergsjo, (2000) cited that, in developing countries antenatal care programs are often poorly implemented and clinical visits can be irregular with long waiting times and poor feedback to the women.

### **c. Cost of Services**

It is no surprise that many clients believe that health services should be provided free or that fees charged should be reasonable. Costs, including fees for transportation, services, and supplies, can be another barrier to care ( Nshakira et. al., 1996).

## **4. Amenities**

### **a. Infrastructure and comfort**

Clients typically noted the following concerns for quality of the facility building in good repair running water & electricity available cleanliness and sanitation (examination rooms, toilets/latrines) privacy and comfort through plenty of seats in waiting room to accommodate clients, adequate space to maintain client confidentiality (curtains or private rooms/areas) and beds (Brawley, 2000).

### **b. Drug and proper equipment availability**

Clients believe drugs are necessary for treatment. Users often think that receiving drugs means receiving treatment. Many users will choose a health facility where they expect to find drugs all the time. Clients believe a health facility with good quality service must be equipped with diagnostic equipment, blood testing equipment and laboratory equipment.

## **5. General satisfaction**

Patient satisfaction has become a frequently researched outcome measure of the quality of health care delivery. Clients' satisfaction is an important indicator of service quality. Because clients' satisfaction influences their behavior. Client satisfaction may influence whether clients seek care, follow the provider's instructions on correct use, return to the provider and recommend services

Client satisfaction depends not only on service quality but also on clients' expectations; clients are satisfied when services meet or exceed their expectations (Thompson, and Sunol, 1995).

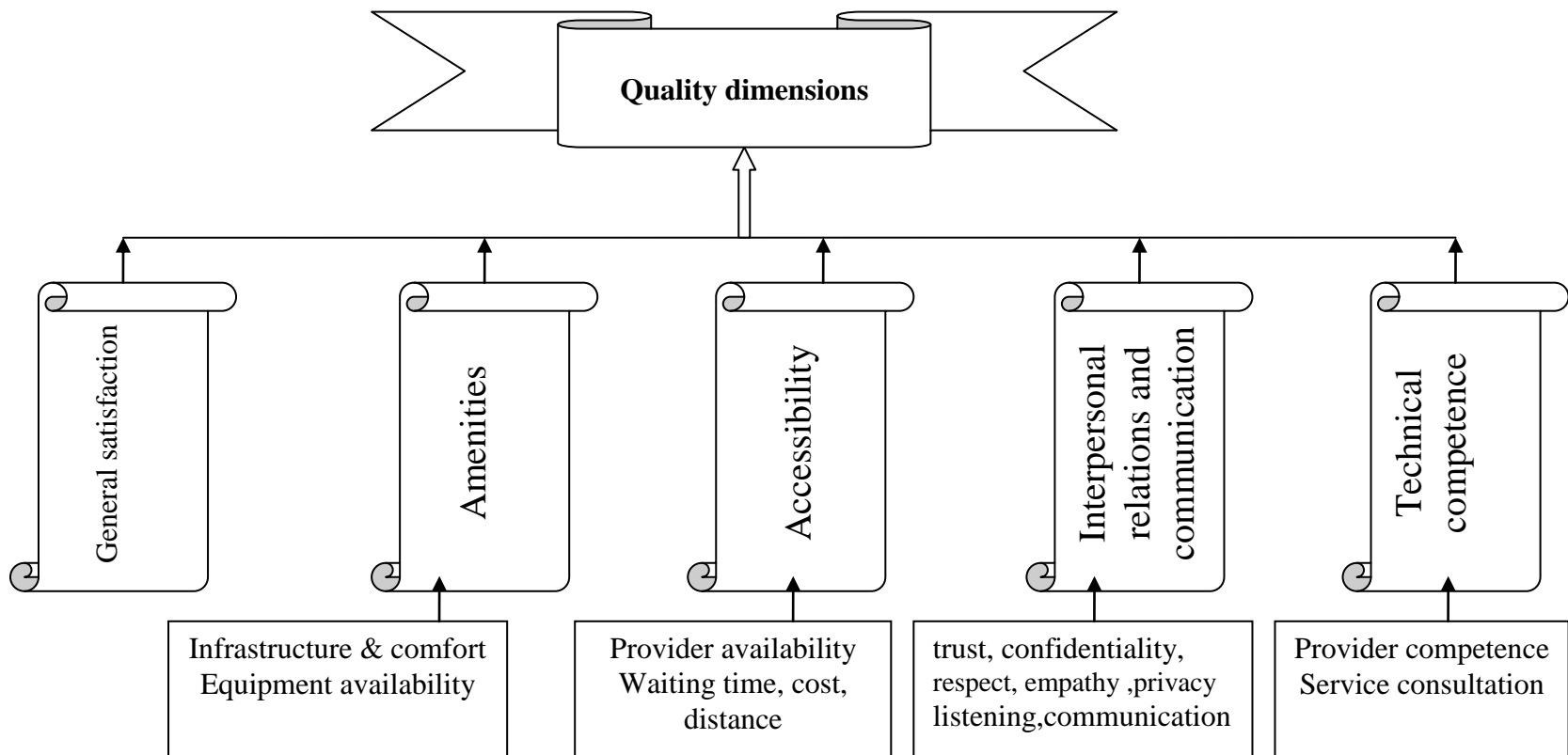


Figure 2.1: Diagram illustrates quality dimensions from client's perspective in reproductive health services

Many people think of evaluation as taking place once at the end of a program to prove to a funder that it worked or failed. But Evaluation should be used as an ongoing management and learning tool to improve an organization's effectiveness. Program evaluation conducted regularly can improve the management and effectiveness of organization and its programs. Well-run organizations and effective programs are those that can demonstrate the achievement of results (Martinez, 2005).

## **2.2. Evaluation in health care**

### **2.2.1 Evaluation concept**

Evaluation is defined in different ways as follows: Evaluation is about using monitoring and other information you collect to make judgments about your project. It is also about using the information to make changes and improvements (Charities Evaluation Services, 2008).

Evaluation refers to a periodic process of gathering data and then analyzing or ordering it in such a way that the resulting information can be used to determine whether your organization or program is effectively carrying out planned activities, and the extent to which it is achieving its stated objectives and anticipated results ( Martinez, 2005).

Program evaluation in health care is the systematic collection and analysis of information about some or all aspects of a health service program to guide judgments or decisions about that program. Health care services are often evaluated to decide how to improve a program or whether it should be continued. Decisions should be based on a comprehensive evaluation (Lee, Pui-Mun, Khong, PohWah, Ghista, and Dhanjoo, 2006)

Planning, implementing, and reporting evaluations can have many practical benefits if the process produces credible results. Planning evaluations before programs are implemented can increase the impact of programs by revealing objectives that have no planned activities and those with insufficient program depth to bring about desired change. Targeted revisions in these areas can increase the possibility for impact to occur. Implementing evaluations can identify ineffective programs and thus permit reallocation of valuable resources to new needs and/or to effective programs. Reporting evaluation results can increase citizen interest and awareness of programs and indicate that public resources are being used wisely (Smith, Barber, and Walker, 1984).

### **2.2.2 Benefits of evaluation**

Evaluation measures performance and provides tangible evidence that is putting resources into programs that benefit residents. Evaluation demonstrates program benefits to funding sources and to the community. Additionally, this information can be used to attract other potential funders. Agencies also often require programs to measure performance or provide information on program results, service quality, and customer satisfaction. Evaluation can help improve program's effectiveness. Another benefit of conducting a program evaluation is that the findings will help you improve program (Knowledge, Responsibility Achievement Corporation,1997).

### **2.2.3 Major Types of Program Evaluation**

#### **Goals-Based Evaluation**

Often programs are established to meet one or more specific goals. These goals are often described in the original program plans. Goal-based evaluations are evaluating the extent to which programs are meeting predetermined goals or objectives (Carter, 2000).

#### **Process-Based Evaluations**

Process-based evaluations are geared to fully understanding how a program works and how does it produce that results. These evaluations are useful if programs are long-standing and have changed over the years, employees or customers report a large number of complaints about the program.

#### **Outcomes-Based Evaluation**

Program evaluation with an outcomes focus is increasingly important for nonprofits and asked for by funders. An outcomes-based evaluation facilitates asking if an organization is really doing the right program activities to bring about the outcomes to be needed by your clients. Outcomes are benefits to clients from participation in the program (Carter, 2000).

### **2.2.4 Evaluation steps**

Evaluation must be carefully planned and carried out in a systematic manner by following several basic steps:

**Step 1:** Assemble an evaluation team. Planning and implementing evaluation should be a team effort. Even if you hire an outside consultant to help, you and your staff need to remain full partners in the evaluation effort.

**Step 2:** Prepare for the evaluation. This includes deciding what to evaluate, building a model of your program, and stating your objectives in measurable terms.

**Step 3:** Develop an evaluation plan. An evaluation plan is a blueprint or a map of an evaluation. It details the design and methods that will be used to conduct the evaluation and analyze the findings.

**Step 4:** Collect evaluation information. Once an evaluation plan is completed, you are ready to begin collecting information. This will require selecting and/or developing information collection procedures and instruments.

**Step 5:** Analyze your evaluation information. After evaluation information is collected, it must be organized in a way that allows you to analyze it.

**Step 6:** Prepare the evaluation report. The evaluation report should be a comprehensive document that describes the program in addition to providing the results of the implementation and outcome analysis. The report also should include an interpretation of the results for understanding program effectiveness (KRA Corporation, 1997).

### **2.2.5 Methods to Collect Information**

There are different methods used for collecting data during evaluations: Questionnaires, surveys and checklists are used when needed to quickly and easily get information from people in a non threatening way. Interviews used when we want to fully understand someone's impressions or experiences. Documentation review used to gather accurate information about how a program actually operates, particularly about processes. Observation used to gather accurate information about how a program actually operates, particularly about processes. Focus groups to explore a topic in depth through group discussion. Case studies used to fully understand or depict client's experiences in a program, and conduct comprehensive examination through cross comparison of cases (Carter, 2000).

### **2.2.6 Uses of Evaluation Findings**

1- Improving a program: Specific findings might be used to identify strengths and weaknesses of a program or provide strategies for continuous improvement. Findings could lead to strategies that would help staff manage more effectively, improve

organizational culture or systems, or improve staff interactions and relationships with clients.

2- Determining how effective a program is: in cases where the primary purpose of evaluation is to assess the effectiveness of the program, evaluation findings should support decisions around accountability and quality control.

3- Generating new knowledge: Focusing evaluation questions on how and why programs work, for whom and in what circumstances provide important findings and create new knowledge. (KRA Corporation, 1997)

### **2.2.7 A client satisfaction evaluation**

Client satisfaction evaluation provides an excellent opportunity to involve clients in the process of evaluation. Client's satisfaction evaluations can address the reliability of services, the assurance that services are provided in a consistent and dependable manner, the responsiveness of services or the willingness of providers to meet clients' needs, the courtesy of providers and the security of services. The assessment of client satisfaction adds an important consumer perspective to evaluations. Client satisfaction evaluation can be viewed as an opportunity to consult with clients about their experiences in a programme. Client satisfaction ratings have been criticized as indicators of the quality of human services (WHO, UNDCP and EMCDD, 2000).

### **2.2.8 An Example of Evaluation conducted at WHC-J**

Training, Accounting, and management Institute with fund from UNFPA in 2006 conducted an evaluation for the counseling services of the centre. This was clearly evidenced by the outcomes of the conducted evaluation through meeting the management, staff, reviewing reports and focus group discussion. The staff was able to introduce other services as legal and psychological counseling to the beneficiaries upon their visits to seek RH medical care at the center .

At the focus groups, young women stated that, they found comprehensive package of services that covered most of their needs at the same place (e.g. medical treatment, family planning, physiotherapy and sport, legal and psychosocial counseling, awareness lectures and meetings with specialized people in reproductive health, legal and social aspects).

Progress reports showed that the number of women who received legal and psychological counseling increased in Jabalia since August 2005 associated with the start of legal and psychosocial counseling (TAMI, 2006).

Young refugee women expressed that they found solutions for legal and psychosocial problems, they had and that the staff in the center gave them special care. They feel they belong to the center as they can always resort to the center to meet their needs. Young women suffering reproductive health problems stated they received good medical care at the center, they often had the right diagnosis by the staff, and they also get the laboratory tests and physiotherapy at fairly low prices which they could afford.

Despite the project provides the service of counseling and those who might require further treatment or/and follow up are referred to other specialized partner NGOs. It was noted that the referral system is a one way referral system that does not allow for feed back from the specialized NGOs. Moreover, regarding measures for dealing with the young women exposed to gender based and domestic violence, it has been noted that the project has no documented measures and all the related measures are about increasing self assertiveness and awareness for self protection. The project was able to maintain a wider network of NGOs . TAMI recommended the following to improve the achievements:

- Support such initiative as counseling through media and broadcast channels as they are very effective in widening the outreach spectrum to most of the refugee women especially the adolescents.
- The referring process shall be done officially between the centers and other partner NGOs to maintain such network in promoting human and reproductive rights.
- Regarding the domestic violence, it is recommended that the centers should hold workshops for males who are the usual imposer of violence towards women and children.
- In order to increase the demand on legal counseling in Jabalia it is important to maximize the out reach and promote the services of the center better through the home visits and attract the young women to seek legal counseling.

Through all the reviews and interviews conducted, it was obvious that the activities of the project had great impact on the beneficiaries (TAMI, 2006).

## **2.3 An Overview of Reproductive Health**

Reproductive health is fundamental to the social and economic development of communities and nations and is at the core of human development (UNFPA, 2004). Every member in the society needs reproductive health services from infancy to old ages to be able to live in optimal state of health and away from physical, social and psychological suffers. Before International Conference of Population and Development, reproductive health concept passed through many processes beginning from birth control which is the main population field focus reaching reproductive health as a holistic concept (ICPD, 1994).

### **2.3.1 Development of the concept of reproductive health:**

The right to plan the size and spacing of the family was originally agreed at the International Conference on Human Rights in Teheran in 1968. At the World Population Conference held in Bucharest in 1974, the right was formulated that: All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so; the responsibility of couples and individuals in the exercise of this right takes into account the needs of their living and future children, and their responsibilities towards the community (UNFPA, 1999).

The 1994 International Conference on Population and Development (ICPD) articulated a bold new vision about the relationships between population, development and individual well-being. At the ICPD, 179 governments adopted a forward-looking, The ICPD Programme of Action, sometimes referred to as the Cairo Consensus, was remarkable in its recognition that reproductive health and rights, as well as women's empowerment and gender equality, are cornerstones of population and development programmes. The Consensus is rooted in principles of human rights and respect for national sovereignty and various religious and cultural backgrounds (ICPD, 1994).

The 1995 Fourth World Conference on Women in Beijing reinforced the importance of women's rights and empowerment. The Platform for Action is an agenda for women's empowerment. It aims at removing all the obstacles to women's active participation in all spheres of public and private life through a full and equal share in economic, social, cultural and political decision-making. Equality between women and men is a matter of human rights and a condition for social justice and is also a necessary and fundamental prerequisite for equality, development and peace (Beijing Conference, 1999).

In 1999, the UN General Assembly convened a special session, ICPD+5, to review progress towards meeting the ICPD goals. The review revealed that greater urgency was needed to achieve the Programme of Action, especially in the areas of education and literacy, reproductive health care and unmet need for contraception, maternal mortality reduction and HIV/AIDS (Germain, 2000).

In 2000, 189 Member States agreed to help the world's poorest countries significantly progress towards a better life for their people by the year 2015. A framework for progress consisting of eight Millennium Development Goals (MDGs) was derived from the Millennium Declaration adopted by these world leaders. (United Nations Millennium Declaration, 2000). At the 2005 World Summit, the largest-ever gathering of world leaders reaffirmed the need to keep gender equality, HIV/AIDS and reproductive health at the top of the development agenda. The high-level commitment to achieve universal access to reproductive health by 2015, promote gender equality and end discrimination against women represents the culmination of more than a decade of advocacy since the 1994 Cairo Consensus ( World Summit Outcome, 2005).

The WHCJ mainly work on providing comprehensive package of reproductive health through providing antenatal care, postnatal care, informed choice in choosing the method of family planning and give the couple the right decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so. The staff works hardly toward recognition of reproductive rights, as well as women's empowerment and gender equality through awareness sessions about gender based violence, gender roles, women's rights and others. Also providing psychosocial and legal counseling and help women to take decisions in many issues in life with participation with males. So the centre also integrate male involvement program into the services provided and enhance the concept of male participation in reproductive health issues.

## **Health and the Millennium Development Goals**

In September 2000, the largest-ever gathering of Heads of State ushered in the new millennium by adopting the Millennium Declaration. The Declaration, endorsed by 189 countries, was then translated into a roadmap setting out goals to be reached by 2015.

The eight Millennium Development Goals (MDGs) build on agreements made at United Nations conferences in the 1990s and represent commitments to reduce poverty and hunger, and to tackle ill-health, gender inequality, lack of education, lack of access to clean water and environmental degradation. Eighth MDGs aims at eradicating extreme poverty and hunger, achieve universal primary education, promote gender equality and empower women, reduce child mortality, improve maternal health, combat HIV/AIDS, malaria and other diseases, ensure environmental sustainability and develop a global partnership for development (WHO, 2007).

It is clear from above conferences that the RH concept passed through stages since 1968 which focused on birth control and limiting the number of population until the ICPD in Cairo in 1994 the concept transferred from birth control and family planning to reproductive health package including gender and women empowerment which considered to be a comprehensive concept.

Ensuring universal access to reproductive health information and services through promoting gender equality and empowerment of women, reducing child mortality, improving maternal health, combating HIV/AIDS and voluntary family planning, are essential goals in Millennium Declaration.

### **2.3.2 Definition of reproductive health**

ICPD Programme of Action defined reproductive health as a holistic concept as "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (ICPD, 1994).

### **2.3.3 Components of Reproductive Health**

Reproductive health is a vast subject in medical and health sciences that deals with a variety of topics like pregnancy, adolescent reproductive health, cervical cancer prevention, contraceptive methods and family planning, gender and sexual health, harmful and health practices, HIV/AIDS, infertility, men and reproductive health, older women, reproductive tract infections, and safe motherhood. Other topics covered include maternal and newborn health, abortion, STDs, breast and pelvic exams, infection prevention, women's reproductive health, impotence etc. Information education and communication (IEC) is another subject treated in reproductive health (RHO, 2008). The ICPD affirmed the need to ensure access, declaring: "All countries should strive to make accessible through the primary health care system, reproductive health care to all individuals of appropriate ages as soon as possible and no later than 2015." (WHO and UNFPA, 2003)

The researcher viewed that reproductive health is essential for every one life and concern for both women and men, at all age stages to keep physical , social and psychological wellbeing to pass safely through age stages.

A comprehensive package of reproductive health services should be integrated and coordinated with each other, with other primary health care services, and with other sectors. Reproductive health services should also be concerned with women's and men's health throughout the life span, and not just concentrated on episodes of pregnancy or contraception (National Health care Quality Report, 2006).

#### **A full sexual and reproductive health package includes:**

- Family planning/birth spacing services
- Antenatal care, skilled attendance at delivery, and postnatal care
- Management of obstetric and neonatal complications and emergencies
- Prevention of abortion and management of complications resulting from unsafe abortion
- Prevention and treatment of reproductive tract infections and sexually transmitted infections including HIV/AIDS
- Early diagnosis and treatment for breast and cervical cancer
- Promotion, education and support for exclusive breast feeding

- Prevention and appropriate treatment of sub-fertility and infertility
- Active discouragement of wrong ways of cutting.
- Adolescent sexual and reproductive health
- Prevention and management of gender-based violence (UNFPA, 2007).

Some authors found that physiotherapy as related to women's health in particular antenatal, postnatal and pelvic floor exercises consider as a complementary service to reproductive health package and have a great way to build physical competence and confidence while developing self-esteem and improving physical and mental health.

### **2.3.4 Reproductive health in Palestine**

In 1995 the Women's Health and Development Directorate was created, which at the time mainly focused on family planning. The Ministry of Health developed the "National Unified Reproductive Health Guidelines and Protocol" with UNFPA support. The basic idea was to integrate comprehensive reproductive health services into all primary health care services (Bosmans, and others, 2008).

In addition to concern of non governmental organizations with reproductive health services like Palestinian Family Planning and Protection Association, Red Crescent Society, Palestinian Medical Relief Committee and other since that time. So reproductive and sexual health is a component of overall health, throughout the life cycle, for both men and women. The critical importance of reproductive health to development was recently considered as priority in national planning. World decision makers integrate it into national strategies, Palestine leaders are one of those concerned with women health. So National Health Plan 1999-2003 goals stress on improvement of women health by reduction of preventable mortality and morbidity and increase women's community participation.

#### **The Palestinian National Health Plan (1999-2003) addresses some issues, including:**

- Reduce maternal mortality by 30% by 2003.
- Decrease high risk pregnancies by 30% by 2003 from its existing level of 11.5%.
- Increase 10% per year of prenatal care and 7% postnatal care by 2003.
- Measure the mortality rate among women due to breast cancer by 2000, and achieve a 25% reduction in the rate by 2003.

- Reduce morbidity related to pregnancy and childbirth, reproductive tract infections, STDs and other chronic disease by 30% by 2003.
- Introduction of counseling for family planning and screening of some cancers (namely, cervical and breast) in 50% health facilities.
- Increase modern contraceptive prevalence by 25%.
- Integrate reproductive health and family planning in the primary and secondary health care levels.
- Improve quality of care, overall, but especially in regard to technical skills and satisfaction for service received.
- Promote community outreach programs to expand reproductive health services.
- Increase awareness of the population on reproductive health issues through mass media and interpersonal and community channels of communication (NHP, 1999-2003).

To achieve the national goals, health facilities need high quality services to satisfy client's needs, community needs and enhance health level of all. RH services are integrated into MOH, UNRWA, NGOs in different Palestine governorates, the responsible worked hardly in increase access to these services to all Palestinians to achieve NHP goals and improving women's health, family health and society health at all.

### **2.3.5 Reproductive Health in Islam**

Reproductive health is an area of medical and health sciences which covers sex, child and maternal health, contraception and family planning. Clearly, reproductive health is of great importance to both the existence and sustenance of mankind. Muslims claim that Islam is not only a religion but also a complete way of life (Shawkani, and Al Qurtubi, 1993).

The basis of their claim is the following verse of the Glorious Qur'an. Nothing have we omitted from the Book (Al Ana'm 6/38). According to leading exegetes (*mufasirrun*) like Shawkani and Qurtubi this verse refers to the comprehensiveness of the Qur'an. It leaves nothing undiscussed even though such discussions may be concise in some cases and detailed in others (Imam, 2005).

This part will focus on Islamic provisions on reproductive health as obtained from the Qur'an, Hadith and Ijma. Reproductive health topics found in this part include sexuality, pregnancy, breastfeeding, family planning and contraceptives and abortion.

## **Sexuality and Islam**

Sexuality can be commendable and condemnable in Islam. It is commendable when performed within the ambits of the Islamic law, in other words in a legal relation. On the contrary when it is performed outside wedlock it becomes condemnable and punishable. The Qur'an considers lovemaking and child bearing as signs among other signs of the Divine existence. In that regard Allah says: And among His Signs is that He created for you mates from among yourselves; that ye may dwell in tranquility with them, and He has put love and mercy between your hearts. Verily in that are Signs for those who reflect. (Al Room 30/21). Love means sexual intercourse and the mercy, points to product of that intercourse which is a child. The Qur'an goes further to state that husbands and wives should make love whenever In fact sexual desire, pleasure and satisfaction are legitimate rights of both spouses (Muslimentents, 2007).

Sexual intercourse is forbidden during menstruation; post natal course, serious sickness that may be aggravated by sexual intercourse and in the fasting time in the month of Ramadan. The basis for the prohibition of sex during menstruation is this verse of the Qur'an: They ask thee about women courses: Say they are a hurt. So keep away from women in their courses and do not approach them until they are clean. But when they have purified themselves ye may approach them in any manner, time or place ordained for you by Allah. For Allah loves those who turn to him constantly and he loves those who keep themselves pure and clean (Al Baqara 2/222) (Ibn Kathir, 2008).

## **Pregnancy and Islam**

The Qur'an for example describes conception in a number of its chapters and verses. Man we did create from a quintessence (of clay). Then we placed him as a drop of sperm in a place of rest firmly fixed. Then we made the sperm into a clot of congealed blood; then of that clot we made a (fetal) lump; then we made out of that lump bones and clothed the bones with flesh; then we developed out of it another creature. So blessed be Allah the best to create. (Al Mo'menon 23/14) (Al Tabari, 2008).

Though none of the verses give duration of each stage of the fetal development, the Hadith provides it in this report. Verily the creation of any one of you takes place when he is assembled in his mother's womb. For forty days (he is) a drop, then he becomes a clot in the same way and then in the same way a mass. The minimum gestation in Islam is six

months. The carrying of a child to his weaning is (a period of) thirty months. (Al Ahqaf 46/15) This verse deals with pregnancy and suckling without details about the duration of each of them.

### **Breast-feeding in Islam**

Breastfeeding is found in the Qur'an. It is found that the maximum period of breast-feeding is two years for parents who wish to complete the weaning of their children. Should a lesser period be chosen Islam does not object to such a decision if doing so will not constitute any hardship to the any of the parents and their children. The mother shall give suck to her offspring for two whole years, if the father desires to complete the term. But he shall bear the cost of their food and clothing on equitable terms (Al Baqara 2/233) (Al Tabari, 2008).

### **Islamic Provisions on Family Planning and Contraceptives**

Closely linked with breast-feeding is family planning. From the above cited verses of the holy Qur'an, that is, those on fetal development and breast feeding, it is clear that the least gap between a delivery and the other is six months in case the previous child is not weaned before another pregnancy. Where a complete weaning period is observed, no new child may be born until after the 30 months of the previous child. In that case the gap between the two deliveries will be two and a half years. This gap we believe has been prescribed to ensure qualitative health for the mother and her baby. The oldest method known in Islam is the withdrawal method (azl) approved by the prophet when the reports of its practice got to him. The hadith reads thus: We used to perform azl (withdrawal or coitus interrupts) during the time of the Prophet (Imam, 2005).

Since most "modern" methods of birth control have the same aim as the withdrawal method to frustrate the attempt of the sperm to fertilize the egg we can by analogy assume that modern birth control is also permissible. Other methods of birth control are called "irreversible" methods, and include vasectomy, tubal ligation and hysterectomy; Islamic scholars usually say that such irreversible methods of contraception are forbidden (Ebrahim, 1992).

## **Adolescence and Islam**

Islam encourages child rearing in the manner described in the following hadith: "Leave him free for seven years, discipline him for seven, and be his companion for seven". Instruction between 7-14 years of age determines how the person will move towards the right guiding principles by focusing on the inner person, the natural elements of his personality, until adolescence comes along in the fourteenth year, or thereabouts. Islam provides guidelines to correct adolescent misconduct and to protect it from the pitfalls Islam has imbued the child with self-confidence, be it male or female, by giving him/her the right to be an independent and legally recognized entity. When the child reaches the age of mental maturity, when he can conduct his own affairs, Islam relieves him from his guardianship: "And test the orphans until, at adulthood, if you see maturity in them, then give them their property" (Al-Nisa 4/6), the guardianship of the elders is removed from a mentally mature boy or girl (Fadlalah, 2008).

## **Gender and Islam**

"The Women," is one of the longest chapters in the Quran. It deals with many of the rights and responsibilities of women, rights that were first available to western women only a few decades ago, and some that still aren't (Al Nisa 4/34). The theme of this Sura is to defend women's rights, and countering injustice and oppression of women (Alaykum, 2008).

The concept of gender equality in Islam is stressed by the non-superiority of either sex over the other. It came at a time when it was necessary to elevate the demeaned status of women and grant them rights equal to those of men.

## **Abortion in Islam**

Basically, Islam considers life as a sacred gift from God Almighty. No one is allowed to take or stop the life of anyone else except by way of justice or according to the Islamic law. Thus, the Holy Quran says: "Kill not your children for fear of want; it is we who provide sustenance for them as well as for you; for verily killing them is a great sin. (Al Isra' 17/31). What should we understand from this verse? First of all, it is a grave sin to take the life of children for fear of want as was the habit during that period. Neither is it

allowed to do so for any other reason unless a great evil is caused by the presence of the fetus that may cause the death of the mother (Al Ashi, 2008).

The abortion of a formed fetus after 120 days from the day of fertilization, is considered a criminal offense and prohibited by all Islamic legal schools. Exceptions to this prohibition however include situations where the mother's life was in danger, where the pregnancy is harming an already suckling child, or where the fetus is expected to be deformed (Shaikh, 2003).

The researcher comments that the above information examined reproductive health from the Islamic point of view. Islam pays attention to reproductive health issues allowed in religion because Islam respects the person as a human being, and forbids some of it like abortion and free sexual relations.

### **2.3.6 Reproductive health and quality**

There is greater recognition of the need to understand perceptions of quality from the perspective of clients who are the users of the services. Recent research considers client's perspective on the services they receive an essential part of understanding and assessing quality of care (Williams et. al., 2000). Clients' perceptions are shaped by their cultural values, previous experiences, perceptions of the role of the health system, and interactions with providers. Their perceptions affect how clients view the risks and benefits of care (Kelley and Boucar, 2000).

Quality of care is a complex matter and is not easy to measure or define because it involves a wide range of important key issues. Prominent among these is the human factor both in terms of receivers and providers of services. This makes it difficult to measure the feelings and the degree of the receivers' satisfaction as well as whether the providers treat the receivers with dignity and give the best professional care. The quality of care is also directly, or indirectly, related to service effectiveness, environment, management, leadership, resources as well as sustainability ( Western Pacific Region, 2001).

### **2.3.6.1 What Is Quality in reproductive health?**

Perhaps the simplest definition of quality is inspired by the work of W. Edwards Deming, a pioneer of the quality movement in industry. There are a number of well-known quality definitions: "the totality of features and characteristics of a product or service that bears on its ability to meet a stated or implied need", "conformance to requirement", "fitness for use", "the degree of conformance to a standard", "user satisfaction" (Shouroki, 2007). Other definition is "Satisfying the client's wishes" (Western Pacific Region, 2001). Also Quality can refer to the technical quality of care, to nontechnical aspects of service delivery such as clients' waiting time and staff's attitudes, and to programmatic elements such as policies, infrastructure, access, and management (Bruce,1990; Bongaarts and Bruce, 1995)

In health care and family planning this means offering a range of services that are safe and effective and that satisfy clients' needs and wants (Blumenfeld,1993). Quality in health care and family planning has been defined in many ways (Blumenthal,1996). From a public health perspective, quality means offering the greatest health benefits, with the least health risks, to the greatest number of people, given the available resources (Humber,1994).

Katoanga (1999) defines quality reproductive health care as: "accessing of gender sensitive, safe and affordable integrated RH services of acceptable standards and environment that satisfy the clients' needs to be provided by appropriately trained and caring service providers and efficient managers." Katoanga based this definition on working experience and it aims to encompass most of the issues that contribute to quality of care: satisfaction of the client, roles of service providers and managers, availability, accessibility, affordability and acceptability of services, technical issues such as: the technical competence of the service providers, non-technical issues such as the favorable attitude (caring) of the service provider, safety of the services, need for the services to be gender sensitive and user friendly, the need for integration.

Quality of care is a multidimensional issue that may be defined and measured differently, according to stakeholders' priorities.

-Clients, whose perception of quality may be influenced by social and cultural concerns, place significant emphasis on the human aspects of care.

-Providers usually stress the need for technical competency, as well as infrastructure and logistical support from their institution.

-Policymakers and donors are concerned with cost, efficiency, and outcomes for health investment as a whole (Creel, Sass, and Yinger, 2002).

Quality of care means that the needs of the clients in the context of their personal life should be the major determinant of the behavior of the providers and the goal of the programs. Quality of care can be focused as a right of the client. Ten rights of family planning clients have been outlined by International Planned Parenthood Federation as follows: Rights to: information, access, choice, safety, privacy, confidentiality, dignity, comfort, continuity, and opinion. A strategy for quality of care cannot be realistic without recognizing that providers have their own needs which can be outlined as: training, information infrastructure, supplies, guidance, back-up, respect, encouragement, feedback, and self-expression. When fulfilling the rights of the clients and needs of the service providers, both technical and human aspects should be taken into account (Huezo and Diaz, 1993).

#### **2.3.6.2 The Broad Benefits of Investing in Reproductive Health**

The full value of investing in reproductive health services has been underestimated, as its wide range of benefits has been largely unrecognized. The direct medical benefits of preventing unintended pregnancies, improving maternal health and preventing, diagnosing and treating sexually transmitted infections including HIV/AIDS are well-known; however, the economic and social benefits are real, even if they are more difficult to measure (Cohen, 2004).

To provide high-quality care, providers must understand and respect their clients' needs, attitudes, and concerns. These client perceptions are in turn affected by personal, social, and cultural factors. Research highlights the benefits of addressing client perspectives on quality of care, since it leads to improved client satisfaction, continued and sustained use of services, and improved health outcomes (Bertrand et al. 1995, Kols and Sherman 1998, Vera 1993).

A change in providers' attitudes or reorganization of service delivery can improve quality at relatively little cost, without additional staff or equipment (Hull, 1996). Also, Quality

can avoid unnecessary costs by preventing injuries, infections, and unwanted pregnancies, good-quality care eliminates costly follow-ups to treat clients who have been harmed (Faundes, 1996). In Oyo State, Nigeria, for example, lapses in counseling, screening, and infection prevention sent many IUD clients back to clinics to have side effects explained, infections treated with antibiotics and pain relievers, and expelled IUDs reinserted (Quality Assurance Project, 1992).

In addition, improving quality can attract more clients, help programs raise revenue, and attract donor support. Offering good-quality services allows some programs to charge or raise user fees (Alderman, and Lavy, 1996). Moreover, providers derive greater personal and professional satisfaction from their job when they can offer good-quality care and can feel their work is valuable (Kols, and Sherman, 1998).

The researcher convinced that quality applies to everything in life. It offers many benefits. Good care attracts, satisfies, and keeps clients by offering them the services, supplies, information, and emotional support they need to meet their reproductive goals. Poor services also can lead to incorrect, inconsistent, or discontinued services.

### **2.3.6.3 Expanding the Scope of Quality of Care in reproductive health**

The value of the client's perspective on family planning services was increasingly recognized during the 1980s. A framework published by Judith Bruce in 1990, together with measurement and assessment tools developed by Anrudh Jain, has been especially influential in focusing attention on the clients' perspective. This model, widely known as the Bruce-Jain framework, includes six elements of quality of care in family planning service delivery: Choice of methods, information given to clients, technical competence, interpersonal relations, and mechanisms to encourage continuity, and appropriate constellation of services (Bruce, 1990).

Creel, Sass, and Yinger, (2002) said that since the development of the Bruce-Jain framework, health care specialists have suggested several changes to broaden or modify the definition of quality of care, including the following options:

Extending the framework to other aspects of reproductive health services, such as prevention and treatment of sexually transmitted infections (STIs); provision of maternal

health services, including post-abortion care; and screening, counseling, and referral services for victims of violence (Mora et al. 1993). Paying more attention to the health structures that can improve quality of care, such as follow-up and continuity mechanisms (AbouZahr et al. 1996). Considering gender relations, both in the population served and between providers and clients (AbouZahr et al. 1996). Adding formal standards for quality of care, such as treatment protocols and clinical practice guidelines developed by ministries of health, professional organizations, or the facility itself (Brown et al. 2000). In addition to Considering clients' access to family planning and reproductive health services, including the distance clients must travel to reach services, the costs of services, the attitudes of providers, and unnecessary eligibility requirements that exclude clients based on age, marital status, or gender (Bertrand, et al., 1995).

Improving quality of care for clients means understanding their cultural values, previous experiences, and perceptions of the role of the health system, and then bringing reproductive health service providers and the community together to map out a shared vision of quality. Similarly, enhancing quality of care for providers requires identifying their motivations, addressing their needs and helping them to better understand. All of these modifications supplement the basic Bruce-Jain framework, placing the client at the center of the concept of quality of care, while also emphasizing the importance of technical standards and of increasing access to information and services (Creel, Sass, and Yinger, 2002).

#### **2.3.6.4 Some of Quality approaches in health**

Modern approaches to quality in health care often are represented as a triangle, All three points of the triangle' quality design, quality control, and quality improvement are essential, interrelated, and mutually reinforcing components of quality assurance.

**Quality design** is a planning process. The design process defines the organization's mission, including its clients and services. It allocates resources and sets the standards for service delivery.

**Quality control** consists of the monitoring, supervision, and evaluation that ensure every worker and every work unit meet those standards and consistently deliver good-quality services.

**Quality improvement** aims to increase quality and raise standards by continually solving problems and improving processes (Juran, 1992).

### **COPE Approach**

Client-oriented, provider- efficient Approach is a relatively simple process for improving quality in health services. COPE is cost-effective and does not involve large investments of time because some activities may be conducted while staff carries out their routine work. It is also results-oriented (COPE, 2008). COPE offers guidance for providers to assess their services, interview patients, and examine the time that they spend at clinics. This gives staff a better understanding of patients' perspectives, and enables them to develop a plan of action to improve quality. The approach empowers providers to have more control over their activities and resources, and motivates staff to identify their own training needs (IDS, 2007).

### **Client-Centered approach**

A client- centered approach to providing high-quality health care as basic human rights has emerged as a critical element of family planning and reproductive health programs. It has been promoted by local stakeholders, such as women's health organizations and affirmed at international conferences such as 1994 International Conference on Population and Development.

Interventions designed to overcome access barriers have focused on empowering clients and communities to demand high-quality services and on improving clients' attitudes toward receiving care. A client-centered approach helps clients identify, demand, and receive the acceptable waiting times and convenient clinic hours can help clients obtain the services they need (Creel, Sass, and Yinger, 2002).

Adopting a client-centered approach often requires a shift in attitudes. Even while trying to deliver good-quality services, most service providers and other staff members have assumed that they, as health care experts, know what is best for clients. An orientation to the client recognizes that clients' concerns and preferences also are valid and important ( Kols, and Sherman, 1998 ).

Putting clients first is key to improving the quality of health and family planning services. Planners, managers, and providers can design and offer services that both meet medical

standards and treat clients as they want to be treated. Clients are the experts on their own personal circumstances and wants. Many health care organizations, like many private businesses, historically have seen clients as passive recipients of services or products (Morgan, and Murgatroyd, 1994). In client-centered health care, clients are considered first and foremost at every point in the planning, implementation, and evaluation of service delivery (Edmunds, Strachan, and Vriesendorp, 1987).

The researcher found that improving quality of care for clients means understanding their values, previous experiences, and perceptions to ensure that clients receive the care that they deserve. To provide high-quality care, providers must understand and respect their clients' needs, attitudes and concerns which will lead to client satisfaction and sustainability of services and improved health outcome.

#### **2.3.6.5 Quality in Islam**

Islam, as a widespread religion, has a set of goals and values encompassing all aspects of human life, including social, economic and political issues .

Muslims are demanded to undertake diligent perfect work in every age and in every country to fill earth with life and further people's lives and their way of life. The Holy Qur'an came to elucidate for people that they are vicegerents of this earth; It is a vicegerency based in essence on excellent workmanship, perfection, and creativity and free from chaos.

The religion of Islam is most certainly quality in full scope and in its wholeness with its tenets and laws. Why should not Islam be the top of perfection in quality and creativity The Holy Qur'an ascertains quality and creativity in the quranic verse, he merely says, "Be," and there it is.(Al-Baqarah 2/117) (Wazzan, and Al Umairi, 2008).

The Prophet (peace and blessings of God be upon him) says: Allah loves someone who when works, he performs it exceptionally"

#### **Islamic Excellence Model (FACT)**

The model is fundamentally based on a short part of the holly Quran which has summarized all of Quranic cognitions and includes a comprehensive and complete program for human excellence. The main components in FACT model are:

- **Faith:** at the first stage for an organization, it is necessary to establish and clarify some overall spirit. It includes ideology, values, philosophy, approach, vision, mission, it seems that the responsibility of this phase is by the leaders.
- **Acting right:** at the second step it is required to determine our needful plans, projects, activities and functions with respect to the organizational faith. This phase covers some part of manager's functions such as: planning and organizing.
- **Commending to the truth:** then it is intransitive to monitor the processes and give kind of feedback to the organizational sections or people. This stage includes: controlling, training, feedback, revision.
- **Tolerating:** during the process of excellence management you should have some patience and also advise the staff for it .Islam is a comprehensive religion that govern all aspects of life. Excellence is goal-oriented process, in Islam, the most important goal of life is prosperity and the holly Quran claims that it has all programs needed for achieving the prosperity (Shouroki, 2007).

The researcher shows that recent studies consider client's perspective on a service is an important indicator in evaluating quality of care, so to provide high quality care, providers must understand and respect clients' attitudes and concerns. Further more, the researcher believes that quality approached focused on clients to be at first and priority when talking about quality and improving health services.

### **2.3.7 Dimensions of quality in reproductive health from client's perspectives**

Several studies reviewed dimensions of quality in reproductive health from client's perspective, each study has it's own concerns regarding domain of quality, some researchers focused on interpersonal relations, others focused on technical competence, others on accessibility or both, the following studies showed the domains of quality that were studied by different researchers in different health facilities around the world.

Gangopadhay, and Das, (1993) conducted a research to evaluate the quality of family planning services in India from the user's perspective to find out the causes of the failure of the National Family Welfare Programme. Researchers found that the respondents were mainly from the low-income, underprivileged group. About 85 per cent of the respondents were receiving services from the family planning centre of nearby hospitals, 10 per cent

from private doctors and the rest (5%) from other government hospitals. A third of the respondents reported that they received poor quality of counseling and their fears and doubts were not addressed. Private practitioners were preferred because they offer better information and counseling. The findings depict the need to develop an IEC programme to increase the awareness of the benefits of child spacing. They also reveal that the service providers should be sensitive to the clients' needs and help them make an informed choice.

The meaning of quality of care for the women who receive reproductive health services at a family planning and maternal and infant care clinic in Santiago, Chile, was examined to describe the clinic's service from the women's point of view. The women defined high quality of care as "being treated like a human being." Among specific elements of care they identified were cleanliness, promptness and availability of service, time made available for consultation, learning opportunities for themselves and their partners, and cordial treatment. Clients' view of quality of care must be supplemented by professional judgments about how well services meet clients' needs. But the client's view is determinant if improvements are to result in greater acceptance and sustained use of the services offered. The issues identified by the clients involve only minor costs for the clinic (Vera1993).

Koenig, Hossain, and Whittaker, (1997) made a report opens with an overview of the development of the concept of "quality of health care" and attempts to identify appropriate research methodologies to define and measure quality of care indicators. The present study uses longitudinal data collected after May 1989 via interviews with 7829 women in rural Bangladesh to describe the influence of quality of care on contraceptive behavior. The analysis provided compelling evidence of the important effect of quality of care on contraceptive behavior. Clients were more likely to continue contraceptive usage if they perceived a high quality of care from field workers. Higher standards of care were also associated with a 27% increase in subsequent adoption of contraception by non users. It was also found that the absolute number of contraceptive methods offered to a client may not be as important as the degree of trust developed between the field worker and the client. The findings also indicate that significant improvements are needed in the quality of care provided by field workers. Only half of the ever-visited respondents received acceptable standards of care, only 25% welcomed a return visit, and only a minority had positive views of services provided through government clinics.

A more recent study in Peru, however, suggests that quality of services does matter to levels of contraceptive use in an area. Unintended pregnancies were twice as common among women in areas with poor-quality services as among women in areas with adequate services 22% versus 11%. Quality was rated on a combination of eight indicators including contraceptive choice, provider bias, provider training, information to clients, and privacy (Mensch, 1997).

Bender and Santander (1999) assessing quality of health care In Bolivia, used a cross-sectional design to systematically select women for an initial interview. The survey included a section with questions assessing four aspects of quality: access, technical management, interpersonal relationships and continuity. One hundred women were interviewed. Findings showed that women provided objective responses about ease of access to the health clinic. While 90% reported that it was easy to walk to the health clinic, making scheduled visits. Women, responding to the survey, indicated that they were treated respectfully by the nurse and physician in the survey instrument, women reported good continuity in terms of having a repeat visit and seeing the same physician during the last two visits. The researchers concluded that "Quality of health services is important to both providers and users".

A qualitative study conducted at an inner-city sexually transmitted disease (STD) clinic in Johannesburg, South Africa, in 1994-96 produced numerous recommendations for improving the quality of STD care. In-depth interviews with STD clients revealed a high degree of satisfaction with the technical quality of services provided; however, these men and women expressed a strongly internalized sense of shame that was exacerbated by the lack of anonymity and confidentiality in the clinic. Improvements in service quality require managerial interventions to improve staff morale and thus staff client relations through a process model involving clients, the community, front-line staff, and supervisors. Such a model should encourage team building, dialogue, active listening skills, and promotion of empathy, participatory data gathering, collective problem solving, vision building, and supportive supervision (Oskowitz, Schneider, and Hlatshwayo, 1997).

Moreover, Studies have shown that improving the quality of reproductive health services increases contraceptive use. Studies in Bangladesh, Senegal, and Tanzania showed that women's contraceptive use was higher in areas where clients felt that they were receiving

good care than it was in areas with lower-quality health facilities (Koenig, et. al., 1997, Mroz, et. al., 1999, Speizer, and Bollen, 2000).

Al Hindi, (2000) assessed the level of satisfaction with radiology services in Gaza Strip and explored dimensions related to client's satisfaction including organizational culture, continuity and affordability, availability, interaction and communication, attitude and perception, comfort and privacy and approach of care. Cross sectional design with a systematic randomized sample was used and a standardized structures questionnaire was developed. Sample was 410 clients and response rate was 78.04%. Study findings showed that clients reported a relatively high degree of satisfaction with radiology services 82.5%.

Mousa, (2000) conducted a study about client's satisfaction with the family planning services at Ministry of Health (MOH) , United Nations Relief and Work Agency (UNRWA) in Gaza Strip. Client model home visit interview was developed, 377 clients were interviewed and response rate was 87.3%. The over all satisfaction level of the family planning services was 72%. The major five satisfaction domains recognized by the study were attitude and expectation, information and counseling, communication and interaction, interpersonal relationship, mechanism of care and delivery of care. The high satisfaction level was found with the information and communication process. The least level of satisfaction was with communication and interaction. Clients attending UNRA clinics were more satisfied than clients attending MOH clinics.

William, Schutt-Aine, and Cuca, (2000) conducted a study to measure family planning service quality through client satisfaction exit interviews , because of the widely recognized importance of quality of care in the provision of family planning and sexual and reproductive health services. From 1993 through 1996, 89 surveys of more than 15,000 clients were conducted in eight Latin American and Caribbean countries. Results shown that the areas of quality that most often received more than 5% negative response from clients (termed negative response cases) were waiting time (mentioned in 70% of surveys, with a mean dissatisfaction level of 20%), ease of reaching the clinic (in 54%, with an average dissatisfaction level of 12%) and price of services (47% and 10%, respectively). Using the survey results, participating family planning associations made changes to improve quality in these areas, ranging from improving appointment systems to relocating to implementing sliding fee scales. Results from 16 subsequent follow-up surveys showed

a decline in each country in the number of negative response cases, as well as in the mean level of dissatisfaction. For example, in Brazil, the mean number of negative response cases per survey declined from 2.7 to 2.2, and the mean level of dissatisfaction among them fell from 19% to 11%. The researchers concluded that these kinds of improvements will be necessary if service providers hope to become more sustainable and if they are to help clients meet their reproductive health needs (William, Schutt-Aine, Cuca, 2000).

Another study conducted by Jaynelle, and Marianne, (2001) found in a study of multiple perspectives on quality in women's health care that quality is an illusive concept with different meanings to different people. Providers often define quality in terms of patient outcomes, professional standards of practice, predetermined criteria used to measure quality, and even subjective opinion. Patients describe quality in terms of the interpersonal aspects of care, how well they were treated, and the responsiveness of the provider to their needs. This qualitative study using a semi-structured interview defined quality from the perspectives of patients, physicians, nurses, and payers associated with a hospital-based women's service line, and how the attributes of quality varied among the multiple groups. The study also described how stakeholders become aware of quality and how they determined a hospital's quality. From the findings of the study, a conceptual framework of quality in women's health was developed.

RamaRao, Lacuesta, and Costello, (2003) conducted Interviews in 1997–1998 with 1,728 new family planning users who had sought services to show whether quality of family planning care influences continued use of contraception, the results showed that the quality of care received at the time a woman adopted a contraceptive method influenced her contraceptive use at follow-up, after adjustment for the effects of background characteristics. Furthermore, use increased steadily with quality. The predicted probabilities of contraceptive use were 55% for low-quality care, 62% for medium-quality care and 67% for high-quality care. They concluded that a focus on quality improvement would benefit both programs and users.

Abu Salleek, (2004) conducted a study to assess the level of clients' satisfaction with nursing care provided at selected hospital in Gaza Strip, and explored six dimensions of satisfaction with nursing care; information and interaction, availability/attentiveness and

openness, comfort and environment, nurses' skills and professionalism, organizational culture, counseling and advancing.

Abu Harbeed, (2004) conducted a study about women's satisfaction with antenatal care services in Gaza Strip; the study conceptually used eight dimensions of satisfaction. Women's satisfaction was measured through using specific exit interview. The response rate was 92.8% and the sample was 504 women. The findings revealed that the level of satisfaction represented with provider competence was 89.5%, infrastructure was 82%, drug availability was 79.5%, general satisfaction was 89.5%, and overall satisfaction was 79.3%. The study revealed that some variables influencing satisfaction include age, educational level, employment status, service provided, waiting time, health provider manners and type of health sectors.

A study was conducted by Jakka, (2004) reveals that clean office, job knowledge, respect for client, and clarity of regulations were the most important dimensions determining the quality services in the surveyed institutions. While Chowdhary, and Prakash, ( 2007) found that service quality dimensions are tangibility, reliability, assurance, empathy and responsiveness .

One study conducted to develop a reliable and valid scale to measure in-patient and outpatient perceptions of quality in India and to identify aspects of perceived quality which have large effects on patient satisfaction. Rao et. al., (2006) founded that internal consistency, validity, and factor structure of the scale are evaluated. The association between patient satisfaction and perceived quality dimensions is examined.

The results showed that A 16-item scale having good reliability and validity is developed. Five dimensions of perceived quality are identified medicine availability, medical information, staff behavior, doctor behavior, and hospital infrastructure. Patient perceptions of quality at public health facilities are slightly better than neutral. Multivariate regression analysis results indicate that for out-patients, doctor behavior has the largest effect on general patient satisfaction followed by medicine availability, hospital infrastructure, staff behavior, and medical information. For in-patients, staff behavior has the largest effect followed by doctor behavior, medicine availability, medical information, and hospital infrastructure. (Rao et. al., 2006)

Zineldin, (2006) conducted a survey aimed to examine the major factors affecting patients' perception of cumulative satisfaction and to address the question whether patients in Egypt and Jordan evaluate quality of health care similarly or differently. A conceptual model including behavioral dimensions of patient-physician relationships and patient satisfaction has been developed. This study concerns three hospitals in Egypt and Jordan. Zineldin Findings are hospital C has above-average total and dimensional qualities and patients are the most satisfied in accordance with all dimensions of services. Hospitals A and B have under-average total qualities as the majority of patients are not satisfied with services. Comparing hospitals A and B, in the majority of dimensions, the quality in hospital B is higher than in hospital A. Patients' satisfaction with different service quality dimensions is correlated with their willingness to recommend the hospital to others. In Practical implications; the result can be used by the hospitals to reengineer and redesign creatively their quality management processes and the future direction of their more effective health-care quality strategies. This study argues that a patient's satisfaction is a cumulative construct, summing satisfaction with five different qualities (5Qs) of the hospital: quality of object, processes, infrastructure, interaction, and atmosphere.

Zaky, et. al., (2007) conducted a study to assess the quality of reproductive health services using client satisfaction exit interviews among three groups of primary health care units run by the Ministry of Health and Population of Egypt. The results showed that reproductive health beneficiaries at the units implementing the new health sector reform program were more satisfied with the quality of services. Still there were various areas where clients showed significant dissatisfaction, such as waiting time, interior furnishings, cleanliness of the units and consultation time. The study showed that the staff of these units did not provide a conducive social environment as other interventions did. A significant proportion of women expressed their intention to go to private physicians owing to their flexible working hours and variety specializations.

Al Haj, (2008) conducted a study about perception of hospitalized patients about the services provided at the European Gaza Hospital. An exit interviewed questionnaire was developed and 375 patients chosen with response rate 88.8%. The study extracted six factors that constituted a frame for patients' perceptions about the services which are meeting expectation, hospital culture, hotel services, respect and privacy, approach of care, information and communication. The study revealed that the European Gaza Hospital

patients were moderately satisfied which ranged from 73% to 83% in general. The study revealed that improvement in hotel services and hospital culture are considered important factors to improve the patients' perception. Furthermore, health managers could use the study findings to target patient groups at risk of having lower perception about the hospital services.

(Annex 4) summarize related studies to conclude dimensions of quality from client's perspective.

### **2.2.8 Dimensions of quality from client's perspective**

Quality Assurance Project, (2007) found that the following nine **dimensions of quality** have been developed from the technical literature on quality and synthesize ideas from

***Technical performance:*** The degree to which the tasks carried out by health workers and facilities meet expectations of technical quality (i.e., adhere to standards)

***Access to services:*** The degree to which healthcare services are unrestricted by geographic, economic, social, organizational, or linguistic barriers.

***Effectiveness of care:*** The degree to which desired results of care are achieved

***Efficiency of service delivery:*** The ratio of the outputs of services to the associated costs of producing those services

***Interpersonal relations:*** Trust, respect, confidentiality, courtesy, responsiveness, empathy, effective listening, and communication between providers and clients

***Continuity of services:*** Delivery of care by the same healthcare provider throughout the course of care (when appropriate) and appropriate and timely referral and communication

***Safety:*** The degree to which the risks of injury, infection are minimized

***Physical infrastructure and comfort:*** The physical appearance of the facility, cleanliness, comfort, privacy, and other aspects that are important to clients

***Choice:*** As appropriate and feasible, client choice of provider, insurance plan, or treatment (QAP, 2007).

Quality of service refers to the quality of both the transaction and the outcome of the service. It is a multi-dimensional concept. An honest portrait of client satisfaction implies that variation for each of the major dimensions has been measured. According to Zeithaml et al. (1990), the ten most common dimensions cited by clients in judging quality are:

- Tangibles: Appearance of physical facilities, equipment, personnel, and communication materials.
- Reliability: Ability to perform as promised, dependably and accurately.
- Responsiveness: Willingness to help clients and provide prompt service.
- Competence: Possession of the required skills and knowledge to perform the service.
- Courtesy: Politeness, respect, consideration and friendliness of contact personnel.
- Credibility: Trustworthiness, believability, honesty of the provider.
- Security: Freedom from danger, risk or doubt.
- Access: Approachability and ease of contact.
- Communication: Keeping customers informed in language they can understand and listening to them.
- Understanding the Client: Making the effort to know clients and their needs (Zeithaml, et. al., 1990).

Brawley, (2000) found in his literature review regarding the client's perspective and quality health care services that the most **important dimensions of quality for the client are technical competence, interpersonal relations, accessibility and amenities.**

The goal of Brawley literature review which involved an analysis of 17 articles and academic studies was to identify areas of quality health care services that are particularly important to the client and use this information as a basis for recommendations for client perspective standards. So dimensions of quality from client's perspective as following:

## **Technical Competence**

### A. Provider Competence/Training

The literature suggests that clients are particularly concerned about the qualifications and training of service providers. Clients wanted providers to conduct a proper examination, identify the problem and prescribe treatment. Clients recommended that the facilities maintain an adequate number of staff to satisfy demand and to eliminate the policy of delegating responsibility to less qualified colleagues. Clients judge technical competence by whether their needs are met or their problems are resolved (Creel, Sass, and Yinger, 2002).

Clients say that they value service providers' technical competence, as well as privacy and confidentiality. Clients' definitions of competence do not always coincide with technical definitions of quality. In Zambia, clients based their judgment on how thoroughly they were examined (Ndulo et al., 1995).

#### B- Service Provider Consultation

Many studies cited clients who felt disappointed that the provider did not spend more time with them to discuss the problem and treatment. Clients thought providers should spend more time listening to their problem, explain the examination/procedure, explain the treatment, give clear instructions about medications, give clients the opportunity to ask questions and provide a referral if necessary.

Studies find that good services encourage people to continue using contraception when they want to avoid pregnancy. In China, for example, women were far more likely to continue using injectable contraceptives when they had been thoroughly counseled on how the method works and its side effects. Only 11% of women receiving good counseling had dropped out at one year compared with 42% of women receiving limited counseling. (Johns Hopkins School of Public Health, 1998)

#### **Interpersonal Relations and Communication**

The interpersonal relationship between a client and the provider is reported by many authors to be one of the most important issues for clients' perception of quality. Specifically, clients prefer a service provider who gives a warm welcome, acts friendly and polite, shows respect and treats clients as a "human being", is sympathetic, acts fair, is humble, communicates well in a language the client understands, pays attention to the client, expresses or demonstrates a commitment to their work and assures clients of confidentiality (Brawley, 2000).

A study conducted to assess user expectations and degree of client satisfaction and quality of health care provided in Rural Bangladesh, the researchers found that the most powerful predictor for client satisfaction with the government services was provider behavior, especially respect and politeness., the second most powerful predictor was respect for privacy, reduction in waiting time on average of 30 minutes was more important to clients in addition to consultation time with 75% of clients being satisfied (Aldana, Piechulek, and Al-Sabir, 2001).

The researcher finds that providers must treat clients with respect, be responsive to their needs and avoid judgmental attitudes. In addition, services should be provided in ways that ensure respect for privacy, confidentiality and freedom of choice, and that ensure equity of care to all groups. Client-centered care requires providers to respect a clients' point of view, encourage clients to discuss their needs, provide the appropriate medical information to the client and assist them in making decisions rather than telling them what to do (Kim et. al., 2000).

Numerous studies cited low client satisfaction of quality of care because of poor attitudes from health workers. In the Philippines, among family planning clients in Bukidnon Province, women were more likely to continue using their method if they thought the provider was friendly, if they were satisfied with services, and if they had been told about the advantages and side effects of several methods (Sealza, 1994).

In Bangladesh rural women were asked whether field workers serving them were responsive, sensitive to their need for privacy, dependable, sympathetic, and informative. Women who felt they received good care, as judged by their answers to these questions, were 27% more likely to adopt a family planning method and 72% more likely to continue using a method for up to 30 months than women who felt they had received poor care (Lei, et. al., 1996).

Studies find that women are more likely to seek out and continue using family planning services if they receive respectful and friendly treatment ( Williams et al., 2000). Modes of speech are important to clients (Matamala, 1998). In one study in Zaire, most women who were asked about the two best qualities for a nurse first mentioned qualities related to communication style, such as respect and attentiveness, and second listed technical qualities (Haddad, and Fournier, 1995). Clients feel more comfortable if providers respect their privacy during counseling sessions, examinations, and procedures. In a qualitative study in Chile, between 30 percent and 50 percent of female patients reported a lack of privacy during gynecological examinations. One woman commented: "There should be a curtain or a door. I don't want people to see my body" (Matamala, 1998).

### **Accessibility**

Reproductive health services should be available, accessible and acceptable to all who need them. Quality of care is closely linked to accessibility. Ensuring access to services

means making good-quality, affordable care available where and when convenient to the public. Access means more than the mere existence of a nearby health worker or facility. When a facility lacks properly trained staff, opens irregularly, suffers from supply shortages, charges high prices, or blocks care with unnecessary medical barriers, the community does not have adequate access to services (Bongaars, and Bruce, 1995).

#### A. Provider Availability/Waiting Time

Most of the literature suggests that clients would like to have increased access to health workers. In particular, clients are looking for a willingness to serve clients at any time of the day or night, even if the provider is not on duty, a larger number of providers available, punctuality and shorter waiting periods at the facility.

DISH, (1999) said that lack of providers at a health facility had a negative impact on clients' perception of quality. Since available providers were overwhelmed this often led to untrained providers delivering reproductive health services which in most cases were poorly handled.

Access to service is a vital but complex element of quality of care, since it determines whether a client even gets to the service provider. Studies identify distance and cost as being among the major factors that constrain women's ability to access services access is strongly influenced by clients' perception of quality (Creel, Sass, and Yinger, 2002).

Long waiting times and inconvenient clinic hours can prevent clients from obtaining the services they need. In both Malawi and Senegal, clients identified long waiting times as a concern (Snow, 2000).

Villar, and Bergsjö, (2000), cited that, in developing countries antenatal care program are often poorly implemented and clinical visits can be irregular with long waiting times and poor feedback to the women, the principles of underlying the new of ANC were care providers should make every effort to keep their appointments with women in order to reduce client' waiting time.

#### B. Cost of Services

It is no surprise that many clients believe that health services should be provided free or that fees charged should be reasonable.

Costs, including fees for transportation, services, and supplies, can be another barrier to care. In the 2000 Cambodia Demographic and Health Survey, women said that lack of money was the main obstruction to obtaining health care . In a study in China, one woman explained, “Of course when you are sick you should seek a doctor. But if you have no money, how can you talk about going to see a doctor? Money is the important thing. If you have money, you will go to see the doctor, even if there is no way to go but to walk” (Wong, et. al. 1996). Clients are generally more likely to use low-cost services. In Kenya, clients said that low costs and proximity of services were the two most important factors that attracted them to services (Ndhlovu, 1995).

Williams, Schutt-Aine, and Cuca, (2000) conducted a study to measure Family Planning Service Quality through Client Satisfaction Exit Interviews, the findings showed that The areas of quality that most often received more than 5% negative response from clients (termed negative response cases) were waiting time (mentioned in 70% of surveys, with a mean dissatisfaction level of 20%), ease of reaching the clinic (in 54%, with an average dissatisfaction level of 12%) and price of services (47% and 10%, respectively).

The perspective of clients in South Africa of the health service is described in the 1998 survey of 4 000 households. The survey shows that a low percentage of people, generally, believed that access (31%), availability of medicines (26%), waiting times (20%) and quality of the doctors (28%) had improved over the last four years. Africans perceived the greatest improvement. The reasons for not seeking treatment also related to access and affordability. Services were unavailable or inaccessible to 23% of respondents and 66% said they could not afford to seek medical attention. In the private sector, reduction of costs (accessibility) was the most common suggestion (36%) (Morris, 1999 ).

## **Amenities**

To date, most interventions to improve the quality of reproductive health services have focused on changing provider behavior and improving clinic infrastructure.

### A-Infrastructure

Clients typically noted the following concerns for quality of the facility building in good repair running water and electricity available cleanliness/sanitation (examination rooms, toilets/latrines) privacy/comfort through plenty of seats/mats in waiting room to

accommodate clients, adequate space to maintain client confidentiality (curtains or private rooms/areas) and beds (Brawley, 2000).

### B-Equipment/Supplies

#### 1-Availability of drugs

Ndulo, et. al, (1995) said that many studies show that patients equate availability of drugs with high quality services. In Kenya, one study reported that drug availability in the health facility had a positive impact on demand for services. Another study conducted by Opare, (1996) in the Tororo District also concluded that the availability of drugs in the rural health facilities brought satisfaction not only to the users, but also to the providers .

From the researcher experience, some clients believe drugs are necessary for treatment. Users often think that receiving drugs means receiving treatment. Therefore, a consultation without drugs is a waste of time. As a result, many users will choose a health facility where they expect to find drugs all the time, such as private clinics.

#### 2-Proper equipment available

Clients believe a health facility with good quality service must be equipped with diagnostic equipment, blood testing equipment and laboratory equipment. Other suggestions included operational equipment, ambulance, furniture, beds, mattresses and gloves (DISH, 1999).

### **General Satisfaction**

Clients are the experts on their own personal circumstances and wants (Morgan and Murgatroyd, 1994). Client satisfaction is one of the most important results of good-quality care, because clients' satisfaction influences their behavior. Client satisfaction may influence whether clients seek care, follow the provider's instructions on correct use, return to the provider and recommend services (Daley, 1996, Dimatteo, 1994).

Client satisfaction measures the extent to which a client's expectations for good services are met. Thus, it is essential to distinguish clearly the two components of satisfaction; client expectations and the actual or perceived quality of the service offered. (Office of the Comptroller General, 1991)

Abu Harbeed, (2004) conducted a study to assess women's satisfaction with antenatal care services in G.S, findings showed that the women reports a high level of overall satisfaction with antenatal care services 79.3%. Another study in Gaza was conducted to investigate client's satisfaction with radiology services , the results reported 82.5% of the study were satisfied and 17.5% were dissatisfied.(Al Hindi, 2002). Client's satisfaction doesn't depend only on service quality but also on clients' expectations. Clients satisfy when services meet or exceed their expectations.

UNFPA conducted a research to evaluate reproductive health sub program in OPT; In exit interviews, only 11% and 2% of clients in the West Bank and Gaza reported being *not* satisfied at all with the services they received. However, in the group discussions, negative perceptions of the quality of services emerged. Knowledge questions showed that IEC messages needed to be more focused and clear, as only a third of the women questioned could identify correctly two danger signs necessitating immediate care in pregnancy; less than 10% were able to identify correctly the timing and frequency of breast examinations; and less than 20% were able to identify correctly a side effect of IUD use. (Birzeit University, 2006)

Daniel, and Kabira, (2000) conducted a study to examine client satisfaction in Tanzania by assessing whether clients: received their preferred contraceptive method; were counseled effectively; were treated with respect and dignity; and to what extent clients perceived they were offered services with easy access in an acceptable environment. Whereas access to well-equipped sites with trained staff is central to providing quality service, it does not guarantee client satisfaction and continued use of services. This study demonstrated that clients are looking for service sites where they can: easily obtain their preferred contraceptive method; have their perceptions of quality service honored; and are treated well with respect and dignity. Programs must pay attention to client satisfaction.

After literatures reviewed the information that concern quality of reproductive health from client's perspective , the reader can understand what behind those concepts and how they was measured in regard to health services. However, the methodology of research was built on this chapter to act the proper methods in achieving the accurate results and findings.

*Chapter Three*  
*Methodology*

## **Chapter 3**

### **Methodology**

This chapter presents the study methodology. The researcher starts with the selected study design, setting of the study, study population, how sample is calculated and selected, and eligibility criteria. Moreover, this chapter presents tools of data collection, pilot study and response rate. Furthermore, it demonstrates the analysis method, ethical consideration and limitation of the study.

#### **3.1 Study Design**

This study design is cross sectional design. It has been selected because it's useful for descriptive and analytical analysis of study constructs, like perspectives, perception, and satisfaction purposes. A cross sectional study is fast and can study a large number of patients at little cost or effort (Simon, 2008). It enables the researcher to meet the study objectives in a short time.

#### **3.2 The study Population**

The study population in this research was women of any age who received physiotherapy and reproductive health services in Woman's Health Center at the time of data collection from September to October 2008.

#### **3.3 Setting of the study**

The study was carried out in WHC-J. It is an NGO in the Gaza Strip, which provides reproductive health services for women of Northern Governorate.

#### **3.4 Sample Size**

The sample size was calculated by using the Epi-info program. To calculate the desired sample size the researcher proposed confidence interval 95% and P value 0.05. Based on above criteria the sample size is composed of 342 women selected from the target population (Annex 5).

### **3.5 Sampling Method**

According to WHC-J annual report of 2007, the centre provides comprehensive services of reproductive health, clinical services, physiotherapy services, psychological, social and legal counseling for 5000 clients yearly (WHC Annual Report, 2007)(Annex 6). Multistage sampling was used. Firstly, proportional sampling was used to select the number of sample from each service (Annex 7). Then systematic random sample was used to select the chosen sample for the study. Systematic sample is used primarily in this study for convenience and simplicity (Mark,1996). The researcher randomly starting figure and chose every second client enters the centre. Then those selected clients were asked to participate after they received reproductive health services.

### **3.6 Instrument**

Structured questionnaire was used in this study. The researcher constructed the questionnaire based on her review of the literature, her observation and personal experience in WHC-J.

The questionnaire is written in Arabic Language, the rest of questionnaire was developed mainly with close ended and few open ended questions to give any additional comments. The researcher constructed one questionnaire for all centre services , which contained 150 items that covered study domains. After piloting , it's cleared that each service needed separate part of the questionnaire so the following process took place.

The researchers constructed a questionnaire for data collection (from physiotherapy services, clinic services and counseling services). The questionnaire consisted of three parts and took approximately 15 minutes to complete. It's free from medical terms and jargons.

Part I : Included general information about the client visit, it consists of 11 items.

Part II : Explored the dimension of quality from client's perspectives as following:

**Clinic section** : Provider competence which is consisted from 9 items, 8 items covered service provider consultation, Interpersonal relations and communication dimension is covered with 14 items, Accessibility which contains providers' availability, proper waiting time, cost of services and distance to obtain the service is covered and consisted of 12 item, Amenities including availability of drugs and proper equipment is covered and

consisted of 7 items , physical infrastructure included 8 items and General women's satisfaction dimension is consisted from 10 items.

**Physiotherapy section:** Provider competence which is consisted from 7 items, 8 items covered service provider consultation, Interpersonal relations and communication dimension is covered with 13 items, Accessibility which contains providers' availability, proper waiting time, cost of services and distance to obtain the service is covered and consisted of 12 item, Amenities including availability of drugs and proper equipment is covered and consisted of 5 items , physical infrastructure included 12 items and General women's satisfaction dimension is consisted from 10 items.

**Counseling section:** Provider competence which is consisted from 7 items, 8 items covered service provider consultation, Interpersonal relations and communication dimension is covered with 14 items, Accessibility which contains providers' availability, proper waiting time, cost of services and distance to obtain the service is covered and consisted of 12 item, Amenities included physical infrastructure included 8 items and General women's satisfaction dimension is consisted from 10 items.

Part III: Nine items explored the requested information on demographic and socio-economic profile of the clients including age, educational level, financial status, employment status, residency place, and type of family .

In addition, to two open ended questions about obstacles that prevent providing quality services, other one asked about most three things admire the client. Other question about women recommendation to improve quality of services provided at the centre (Annex 8 for Arabic Version).

The questionnaire was developed mainly using Likert Scale format. Five-point Likert scales are most commonly used in various fields of research. With a five-point scale the points can be labeled, agree strongly, agree somewhat, neutral, disagree somewhat, disagree strongly (Sclove, 2001). The Likert technique presents a set of attitude statements. Subjects are asked to express agreement or disagreement of a five-point scale. Each degree of agreement is given a numerical value from one to five. Thus a total numerical value can be calculated from all the responses.

Open ended questionnaire encourage clients to express their views, opinions and add any comments they needed.

### **3.7 Piloting**

A pilot study was conducted on a small sample to test the questionnaire, response rate, validity and suitability of the questionnaire. Pilot study is smaller version of a larger study that is conducted to prepare for that study. A pilot study can involve pretesting a research tool, like a new data collection method. It can also be used to test an idea or hypothesis (Stachowia, 2008).

Pretest pilot was conducted with a sample of 60 clients from WHC-J, the interviewed questionnaire consumed 20 minute, and response rate is 88.8%. The researcher found some statements needed rephrasing and some words needed correction, some questions needed omitting. Validity and reliability of the questionnaire were analyzed. Results from the pilot study pointed that the questionnaire would meet the purpose of the study. Changes were taken into consideration. These subjects were excluded from the study.

### **3.8 Ethical Considerations**

- \* An official letter of approval to conduct the study was obtained from Helsinki Committee in Gaza Strip (Annex 9).
- \* An official letter of request was obtained from General Director of Red Crescent Society for Gaza Strip (Annex 10).
- \* Consent forms were obtained from all participants, which was attached with each questionnaire which included the purpose of the study and confidentiality of information and ensure their voluntary participation in the study ( Annex 11).
- \* The researcher explained to every participant in the study that participation is optional and that she could withdraw any time.
- \* Ethical concepts and respect for participants was considered.

### **3.9 Data collection**

The data was collected by the researcher and two assistants through exit interview. The client exit interview is a very important source of information, as it represents the voice and perspective of the client in determining the quality of RH services received .

The assistants were trained well on questionnaire items, how to interview the women and fill the questionnaire in the same way as the researcher. The questionnaire was administered by face to face interview. Informed consent was obtained. The researcher and assistants explained the purpose of the study to the women before starting the interview, the women who agreed to participate voluntarily were signed a consent form and was interviewed. The collected questionnaires (304) were checked for completeness and then coding prior to input onto the computer.

### **3.10 Data entry**

Over viewing the questionnaire is first step, prior to entry, then designed an entry model using the computer Software Statistical Package for Social Sciences (SPSS) version 11. Then the coded questionnaires were entered into the computer by the statistician. Data cleaning is done through checking out a number of the questionnaires and through exploring descriptive statistics frequencies for all variables. All suspected or missed values were checked by revising the available questionnaire.

### **3.11 Data Analysis**

Many different statistical tests were used in data analysis, through frequency of the study variables and description of the study population. Frequency Tabulation, Bar Chart and Pie Chart were used. Validity and reliability of the instrument were tested. Then advanced statistical analysis was conducted to explore the potential relationships between variables. Therefore an Independent t-test and One Way ANOVA test were carried out to investigate the relationship between the independent study variables with the total scores of client's perspectives.

### **3.12 Psychometric properties of the questionnaire**

#### **3.12.1 Validity**

Validity of an instrument is considered to be an important issue that has been discussed by many researchers. Validity is the extent to which a test measures what it claims to measure.

It is vital for a test to be valid in order for the results to be accurately applied and interpreted (Wagner, 2005).

When instrument measured what is supposed to measure, this considered to be of great importance for their reliability.

To accumulate evidence of validity, three different types of evidences are generally concerned: content related evidence, criteria related evidence, and construct related evidence. In this study, content and construct related evidence was accumulated as follows:

### **Content Validity**

Content Validity is based on the extent to which a measurement reflects the specific intended domain of content (Carmines, and Zeller, 1991).

Content validity conducted before data collection and measured by expert subjective estimates of the relevance, clarity and completeness. For that purpose the researcher sent the instrument including items, dimensions, operational definition, research questions and objectives to eight different experts including academics, and researchers in the field. Criteria of 80% acceptance among experts were used. A result, some questions were modified, others were omitted and the rest showed relevance. (See Annex 12, List of Experts).

Some researchers consider face validity which is concerned with how a measure or procedure appears. Does it seem like a reasonable way to gain the information the researchers are attempting to obtain? Does it seem well designed? Does it seem as though it will work reliably? Unlike content validity, face validity does not depend on established theories for support (Fink, 1995).

### **Construct Validity**

Construct validity seeks agreement between a theoretical concept and a specific measuring device or procedure. To understand whether a piece of research has construct validity, three steps should be followed. First, the theoretical relationships must be specified. Second, the empirical relationships between the measures of the concepts must be

examined. Third, the empirical evidence must be interpreted in terms of how it clarifies the construct validity of the particular measure being tested (Carmines, and Zeller, 1991).

The researcher evaluated the construct validity of this study by using person correlation to estimate relationship between items and total score of each dimension. Results showed significant difference between all items with the domains. (See Annex 13 for more details).

Then, the researcher estimated Person correlation between total score of each domain with the total scores of the instrument. (See Annex 14 for more details).

### **3.12.2 Reliability**

Reliability is the "consistency" or "repeatability" of measures. Reliability is the extent to which an experiment, test, or any measuring procedure yields the same result on repeated trials. A measure is reliable if it gives the same results each time the situation or the domain is measured. In internal consistency reliability estimation to use single measurement instrument administered to a group of people on one occasion to estimate reliability. In effect judge the reliability of the instrument by estimating how well the items that reflect the same construct yield similar results. We are looking at how consistent the results are for different items for the same construct within the measure (Trochim, 1996).

Analyzing latent constructs such as job satisfaction, or customer satisfaction requires instruments to accurately measure the constructs. Interrelated items may be summed to obtain an overall score for each participant. Cronbach's coefficient alpha estimates the reliability of this type of scale by determining the internal consistency of the test or the average correlation of items within the test (Cronbach, 1951).

The Split-Halves method is used to measure the internal consistency reliability of survey instruments (Statistics, 2004) (See Annex 15 for more detail)

The total instrument reliability test for the clinic services is 76% using Cronbach's Alpha and 79% using Split Half Reliability.

The total instrument reliability test for the physiotherapy services is 69% using Cronbach's Alpha and 82% using Split Half Reliability.

The total instrument reliability test for counseling services is 77% using Cronbach's Alpha and 94% using Split Half Reliability.

From the above evidence for validity and reliability, the researcher concluded that, the developed instrument has had high degree of validity and reliability.

### **3.13 Eligibility Criteria**

#### **- Inclusion Criteria**

- Women who received reproductive health services in Woman's Health Center at the time of data collection.

#### **- Exclusion Criteria**

- Any women who received care at time other than the time of data collection in other health setting, not registered in the center.
- Clients refused to participate

### **3.14 Response rate**

Response rate (also known as completion rate or return rate) in survey research refers to the ratio of number of people who answered the survey divided by the number of people in the sample. It is usually expressed in the form of a percentage.

According to eligibility criteria, the researcher selected 342 clients to participate in this study. The total number of 304 clients agrees to share in this research, which represented 88.8% of the study population and 38 clients refused to participate, which represent 11.2% of the population. The interviewing questionnaires usually result in higher rate of response rate ( Burns and Grove, 1997).

### **3.15 Difficulties that faced the researcher**

- Time limitation
- Electricity Problems
- The research studied all centre services as a comprehensive centre including physiotherapy services and counseling.

*Chapter Four*  
*Results and Discussions*

## Chapter 4

### Results

#### 4.1 Introduction

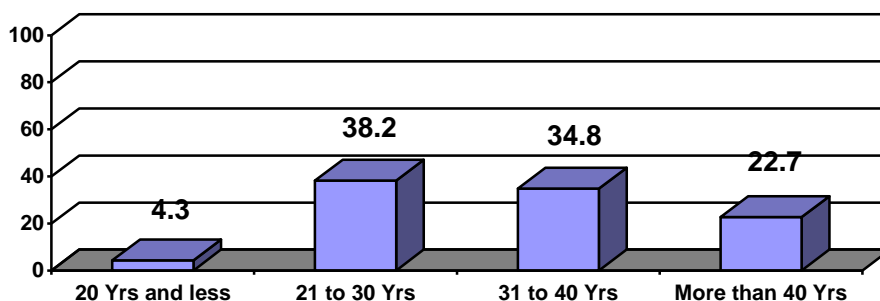
This chapter presents the results, interpretation and discussions of statistical analysis of the data. Descriptive analysis presents the demographic characteristics of the clients. Moreover, the differences between the selected variables and general perspectives scores were explored by using different analytical statistical tests as detailed below.

#### 4.2 Descriptive analysis

##### 4.2.1 Demographic and socio-economic characteristics

A sample of 304 clients included in the study showed different demographic and socio-economical profiles. Table 4.1 summarizes important variables that were found in this study; age, educational level, marital status, current employment status, economical status, type of family and residency.

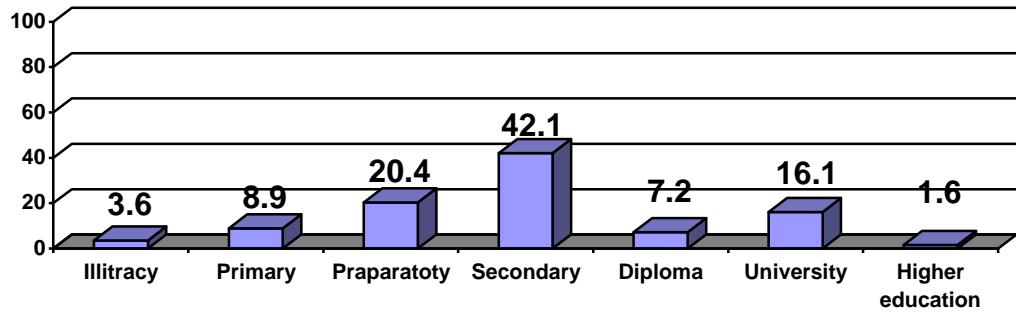
The mean age was 34 years and the standard deviation was 10.3 years. The highest age group was 21-30 years, which presented 38.2%, while the second highest age group was 31-40 years and presented 34.8% of the study population, while the third highest age group was more than 40 years, which presented 22.7% of the study population. The remaining percentage was that age group 20 years and below and presented 4.3% (Figure 4.1).



**Figure 4.1: Distribution of study population by age group**

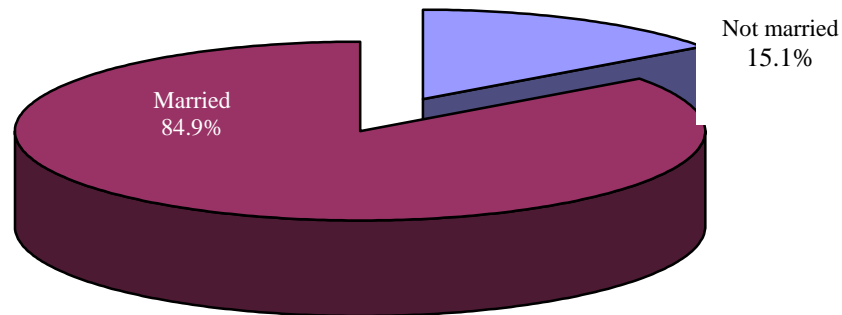
**Table 4.1: Demographic and socioeconomic characteristics of the study population**

	<b>Variables</b>	<b>Frequency</b>	<b>%</b>
<b>Age</b>	20Yrs and less	13	4.3
	21 to 30 Yrs	116	38.2
	31to 40 Yrs	106	34.8
	More than 40 Yrs	69	22.7
	<b>Total</b>	<b>304</b>	<b>100</b>
<b>Educational level</b>	Illiterate	11	3.6
	Primary	27	8.9
	Preparatory	62	20.4
	Secondary	128	42.1
	Diploma	22	7.2
	University	49	16.1
	Higher education	5	1.6
<b>Marital Status</b>	Married	258	84.9
	Unmarried	46	15.1
<b>Current employment status</b>	Employed	44	14.5
	Not employed	260	85.5
<b>Income</b>	1000NIS and less	177	60.8
	1001to 2000 NIS	64	22.0
	2001to 3500 NIS	29	10.0
	More than 3500	21	7.2
<b>Health Insurance</b>	Yes	280	92.1
	No	24	7.9
<b>House</b>	Own	276	90.8
	Rent	21	6.9
	Other	7	2.3
<b>Family Type</b>	Nuclear	210	69.1
	Extended	94	30.9



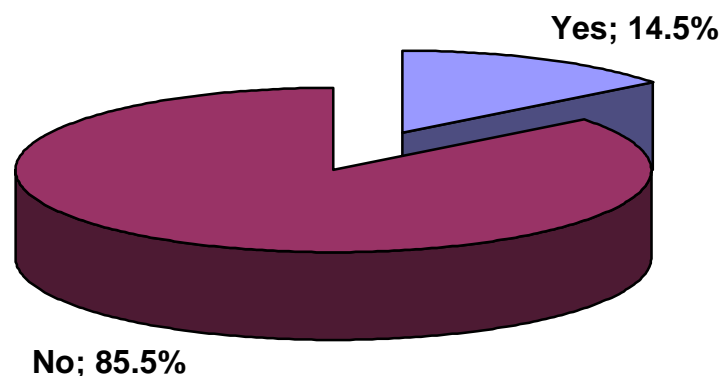
**Figure 4.2: Distribution of study population by educational level**

Figure 4.2 illustrates that, 42.1% of the study population attained secondary education, 23.3% have received Diploma or University education, followed by 20.4% have received preparatory education, followed by 8.9% have received primary education, 3.6% were illiterate, lastly, 1.6% of the study population have received higher education .



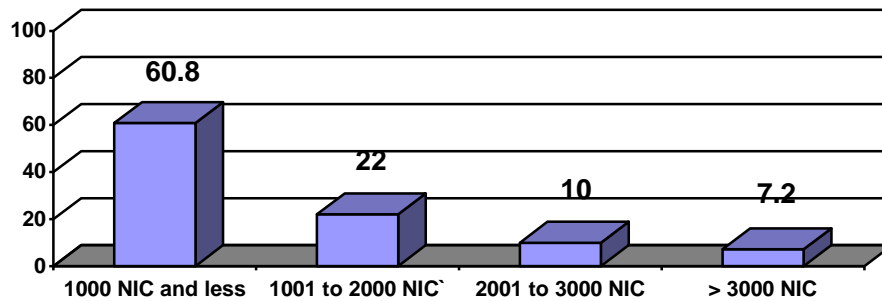
**Figure 4.3: Distribution of study population by marital status**

Regarding the marital status, the respondents who were married showed higher percentage, which represented 84.9% of the subjects, while the unmarried represented 15.1% of the study population (Figure 4.3).



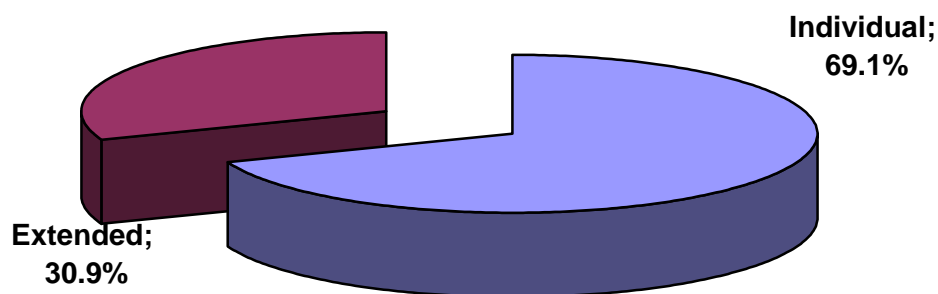
**Figure 4.4: Distribution of Study population by employment status**

Regarding the employment status, the majority of the study population was unemployed, which presented 85.5% and the remaining 14.5% were employed (Figure 4.4).



**Figure 4.5: Distribution of Study population by economical status**

As shown in Figure 4.5, 60.8% had income 1000 and less NIS from all resources, which is the highest percentage, they are followed by 22% for who had income from 1001 to 2000 NIS, the third group of study population which presented 10% had income 2001-3000NIS, and lastly the lowest percentage had more than 3000 NIS and presented 7.2%. The mean income was 1256NIS and standard deviation was 15.2.



**Figure 4.6: Distribution of Study population by type of family**

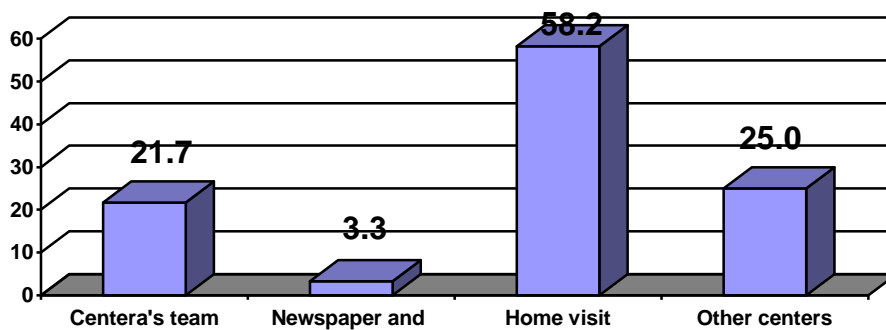
Gaza Strip has two types of families; the majority of the respondents of the study population lived in nuclear family, which presented 69.1%, while 30.9% lived in extended family as shown in (Figure 4.6)

**Table 4.2 General information about the centre visit**

<b>Cause of choosing the centre to get services</b>	<b>Frequency</b>	<b>Percent</b>
Easy reachable	202	66.4
Acceptable Cost	166	54.6
Better Services	187	61.5
Qualified Team	102	33.6
Personal relationship	37	12.2
good reputation	208	68.4
Diversity of services	73	24.0
<b>Known about center services(source)</b>	<b>Frequency</b>	<b>Percent</b>
Center's team	66	21.7
Newspaper and magazines	8	3.3
Friends and neighbors	177	58.2
Home visits	76	25.0
Other centers	7	2.3
<b>Do you know all services provided by the centre</b>	<b>Frequency</b>	<b>Percent</b>
Yes	251	82.6
No	53	17.4
<b>You had complete explanation about centre services from team</b>	<b>Frequency</b>	<b>Percent</b>
Yes	284	93.4
No	20	6.6
<b>Do you receive brochure about the centre</b>	<b>Frequency</b>	<b>Percent</b>
Yes	173	56.9
No	131	43.1
<b>How long it takes to reach the centre</b>	<b>Frequency</b>	<b>Percent</b>
15Min. and less	241	80.3
From 16 to 30 Min.	47	15.7
From 31 to 60 Min.	11	3.7
More than 60 Min.	1	0.3
<b>(Mean = 13.3 Median = 10.0 Std=7.6)</b>		
<b>How long it takes to return home</b>	<b>Frequency</b>	<b>Percent</b>
15Min. and less	240	80.0
From 16 to 30 Min.	48	16.0
From 31 to 60 Min.	11	3.7
More than 60 Min.	1	0.3
<b>Mean = 13.4 Median = 10.0 Std=7.5)</b>		
<b>What is the kind of transportation do you use to reach the centre</b>	<b>Frequency</b>	<b>Percent</b>
Walking	239	78.6
Car	61	20.1
Others	4	1.3

As shown in table 4.2, the general information about the centre, results revealed that, the highest percentage that lead women to come to the centre is good reputation, which represented 68.4% of study population, followed by easy reachable cause, that represented 66%, 61.5% of respondents said that better services is the cause, 54% rationalize coming because of acceptable cost of the services, while specialized team represented 33.6% of the study population , the lowest percentage was diversity of services which represented 24% and personal relationship which represented 12.2%.

Regarding source of knowing about centre services, the women mentioned that, 58.2% of them knew about the centre services from friends and neighbors which is the highest percentage, 25% of respondents knew from home visits, while 21.7% of women knew about the centre from centre's team. Newspapers and magazines were shown to have the lowest percentage and presented 3.3%, followed by 2.3% of women knew from other centers. (Figure 4.7)



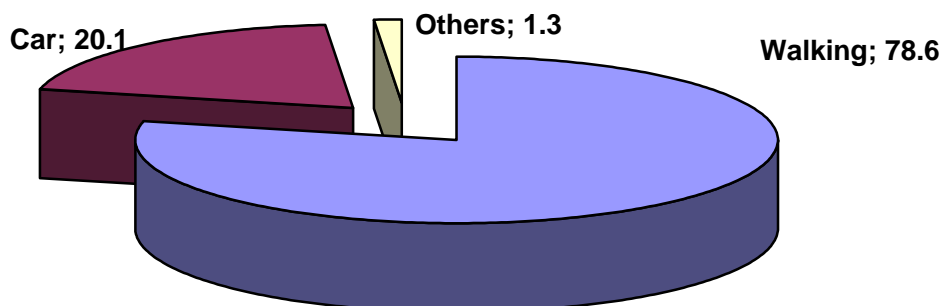
**Figure 4.7: Distribution of study population by source of knowing the centre services**

Table 4.2 shows that, 53.6% of women strongly agree that they had full explanation about all services of the centre from the centre team when coming to receive services, while 39.8% had partial explanation , 6.6% hadn't any information about the centre services. Also 56.9% received brochure about the centre, while 43.1 had not received.

Regarding reaching the centre, the highest percentage of study population reach the centre in 15 minute or less, which represented 80.3, followed by 15.7% who reach the centre from 16 to30 minutes. The remaining percentage reached the centre in more than 30 minutes.

The mean time taken to reach the centre is 13.4, the median is 10 and the standard deviation is 7.5 minutes. (Table 4.2)

Regarding means of transportation 78.6% walk to the centre, while using car represented 20.1%, only 1.3% used other means of transportation (Figure 4.8).

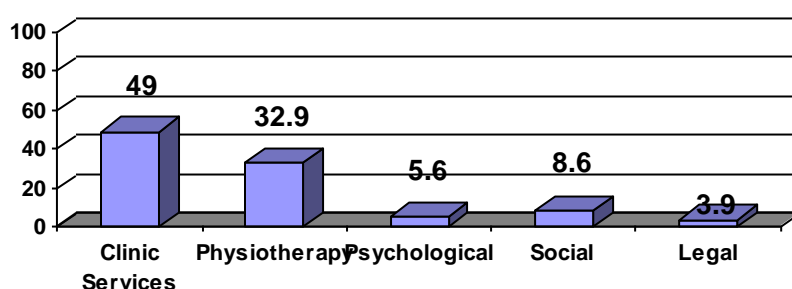


**Figure 4.8: Distribution of Study population regarding means of transportation**

**Table 4.3: Distribution of study population according to services received**

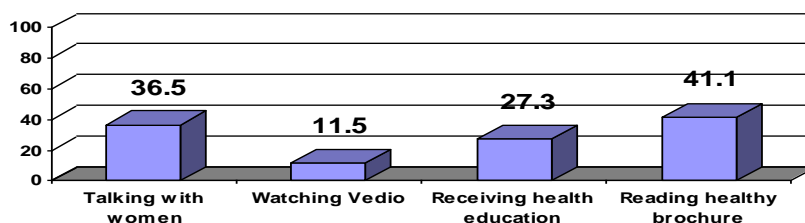
Type of services received	Frequency	%
Clinic Services	149	49.0
Physiotherapy Services	100	32.9
Social Counseling	26	8.6
Psychological Counseling	17	5.6
Legal Counseling	12	3.9
<b>Total</b>	<b>304</b>	<b>100.0</b>

As shown in table 4.3, the majority of women received Clinic services, which represented 49% of study population, the second highest services was received by study population is physiotherapy services, which represented 32.9%, 8.6% of respondents received social counseling services, followed by psychological services which represented 5.6%, and the lowest percentage is legal counseling that represented 3.9% of study population. (Figure 4.9)



**Figure 4.9: Distribution of study population according to services received**

The following figure showed that respondents who were reading health brochure during waiting time represented 41.1%, while 36.5% of women spent waiting time talking with other women, followed by 27.3% of women spent waiting time through receiving health education from staff, lastly 11.5% mentioned that they spent waiting time watching video (Figure 4.10)



**Figure 4.10: Distribution of study population by spent waiting time.**

Regarding client's experience with the centre, 56.6% of the respondents strongly agreed that their experiences were good with the centre, while 41.4% agreed, the rest of the subjects disagreed and their experiences with the centre were bad.

Results revealed that 56.9% of respondents preferred coming to the centre when necessary, while 41.4% preferred coming to the centre regularly, but 1.6% showed that it was not important to come. This finding is consistent with the results from the recommendation item in which 98.4% of respondents indicated that they would recommend the centre to family, friends and neighbors (Table 4.4).

**Table 4.4 Distribution of study population according to recommending centre, comparison with other centers, expectation, experience, preferences and evaluation**

Item	Frequency	%
<b>You recommend the centre for your relatives/friends</b>		
Yes	299	98.4
No	5	1.6
<b>With comparison with other health centers, the center is best</b>		
Yes	187	94.7
No	16	5.3
<b>The service you delivered congruent with your expectation</b>		
Completely	163	53.6
Partially	133	43.8
No	8	2.6

<b>Your experience with center is good</b>		
Excellent	172	56.6
Good	126	41.4
Bad	6	2.0
<b>You prefer to come to the centre</b>		
Regularly	126	41.4
When it is necessary	173	56.9
It's not important	5	1.6
<b>Generally you evaluate the center</b>		
Excellent	123	40.5
Very good	143	47.0
Good	34	11.2
Acceptable	4	1.3
Poor	0	0

#### **4.3 Assessment of quality dimensions from client's perspectives in reproductive health services**

Client's perspective is influenced by their expectation, needs and satisfaction with the services. In general, a finding from this study showed that client's perspective level with RH services is (84.6, 83, and 81.5%) in Clinic, physiotherapy and counseling services respectively. The findings revealed that the clients had positive perspective toward the centre services. The economical, social and political factors affect the client's perspective and let them consider the care they received as a value and accept the health services provided in any health facility even though they were not satisfied. Cultural factors lead to low level of client's expectation regarding health services that results in high level of satisfaction in most studies. The low client's perspective will encourage the centre management and staff to identify the factors or the causes which lead to this level and to find appropriate methods to change and improve quality RH service.

Findings were consistent with (Al Hindi, 2002) study which was conducted in GS to assess the degree of satisfaction among clients with radiology services, the researcher reported that the overall satisfaction level was 82.5%; the researcher attributed the high level of satisfaction to the political and socio-economic situation of the Palestinian people.

While the results were higher than the result revealed by ( Mousa, 2000; Abu Harbeed, 2004; Al Haj, 2008). The researchers reported that the overall perception or satisfaction level was 72%, 78%, 79.3%) as expressed by the patients who used services. Al Haj attributed that the patient's expectations were low due to the closure of Gaza Strip. Abu Harbeed attributed that client's satisfaction doesn't depend only on services but also on client's expectation, the researcher added that clients satisfy when services meet or exceed their expectation. Also Mousa referred the result to lack of knowledge and the work-load of the family planning staff.

Domains of quality that were extracted from the study after literature review reflected the meaningful dimensions of client's perspectives with reproductive health services in Gaza. **These dimensions are:**

**Table 4.5: Domain name, mean, percentage of services**

No.	Domains	Clinic		Physiotherapy		Counseling	
		Mean	%	Mean	%	Mean	%
1.	Provider competency	3.4	85.9	3.5	93.0	3.1	72.7
2.	Service provider consultation	3.6	93.3	3.8	97.0	3.5	76.4
3.	Interpersonal relations and communication	4.1	95.3	4.3	93.0	4.4	98.2
4.	Accessibility	3.4	89.3	3.4	89.0	3.3	89.1
5.	Drug and equipment availability	3.7	69.1	3.5	55.0	-	-
6.	Physical infrastructure	3.5	51.0	3.4	50.0	3.8	76.4
7.	General Satisfaction	1.6	89.9	1.7	98.0	1.5	78.2
<b>8.</b>	<b>Overall perspectives</b>	<b>3.5</b>	<b>84.6</b>	<b>3.4</b>	<b>83</b>	<b>3.3</b>	<b>81.5</b>

#### **4.3.1 Provider Competence**

Provider competence was the first domain. This dimension reflects the concern of clients about the qualifications and training of service providers, conducting proper examination,

identify the problem and prescribe treatment. In this study the findings showed that the provider competence domain in physiotherapy, clinical services and counseling services reported a percent of ( 93%,85.9%,72.7%) respectively, results mean that the clients have positive perspectives about provider competence in physiotherapy and clinic services, and moderate positive perspectives in counseling service but is higher in physiotherapy services (Table 4.5). Qualitative data reflect client's perspective with provider competence dimension, Some of clients registered positive comments: " every thing is good in the centre", " team understand our needs", " the providers are perfect", "health provider describe my problem" " health provider explained the drug usage", " they help me in solving my problem". Other women negative comments "as I come I go", "still I am complaining", " I don't used from counseling".

The result shown above supported with the results regarding choosing the center to receive RH care, 33.6% of the women replied the most important factor considered for choosing the center was qualified health provider and 61.5% of respondents considered the better services and good care as the best thing in RHS were received.

This is congruent with (Abu Harbeed, 2004; Al Haj, 2008; Al Hindi, 2002; Oskowitz, Schneider and Hlatshwayo, 1997) studies on satisfaction and perception in Gaza.

The study concludes upon client's perspective that, the health provider technical competence in the centre regarding RH services is good mainly in health services. It could be related to regular training courses, participation in meetings, study days, case conferences and workshops. Also, it could be related to knowledge and experience deficit regarding health issues and techniques used. In counseling services, the level of perspectives was moderate, the reason could be lack of supervision in counseling services, also takes time and follow up to achieve it's goals and help women to solve their problems.

#### **4.3.2 Service Provider Consultation**

Service provider consultation refers to clients concerns with the provider consultation through taking regular counseling from health provider, spend more time listening to their problem, explain the examination and procedures, explain the treatment, give clear instruction about medication, give clients the opportunity to ask questions and provide a referral if necessary.

The findings showed high percentage 97%, 93.3% and 76.4% for physiotherapy, clinical and counseling services respectively. The clients have positive perspective about service provider consultation in physiotherapy and Clinic services, and moderate positive perspective in counseling service but are higher in physiotherapy services.

The study results showed that there was statistically significant differences between consultation time and overall perspective (P value 0.047). Respondents more than 60 minutes consultation time had high scores of perspective. Respondents who spent (16-30), (31-60) had the same score of positive perspective and clients who is consultation time was 15 minutes and less reported the lowest scores .

The qualitative data reveals that most of women satisfied with consultation time for example one of them said:" the provider gave us chance to ask", the health providers tell me about the investigation result", other said " the doctor and the nurse explains the treatment and give clear instruction about medication", " the health provider explains the procedure to me".

The study findings are congruent with other related studies and differ with others. Some studies identified service provider consultation as IEC, and other described it as interaction and communication. Abu Harbeed (2004) found that the women reported the least level of satisfaction with service provider consultation domain 62%. Al Haj (2008) the level of information and communication dimension is 77.1%. Al Hindi (2002) reported that communication and interaction as expressed by women was 77.5% satisfied.

Providing more complete and accurate counseling that is tailored to the client's needs has been associated with higher levels of client satisfaction, as well as higher contraceptive prevalence and client retention (Townsend, 1991). The women reflected positive response regarding service provider consultation and consultation time. The researcher said from her experience with the centre that all the centre team shared in counseling courses in RH issues. The centre staff mainly counseling team should communicate well listen effectively, give chance to ask question and spent more time with the clients to enhance positive perspective regarding consultation domain. In addition, enhancing counseling skills through advance training audiovisual aids, role play and checklist.

#### **4.3.3 Interpersonal relations and communication**

Interpersonal relations are one of the most important issues for client's perception of quality. The interpersonal relations and communication refers to interaction between client and health provider which include trust, respect, confidentiality, courtesy, responsiveness, empathy, effective listening and communication between providers and clients (Brawley, 2000). The study findings revealed that interpersonal relations and communication reported (98.2%, 95.3%, and 93%) for counseling services, clinic services, and physiotherapy services respectively. It is considered the highest level of perspective in this study mainly in counseling and clinic services.

Qualitative data showed higher satisfaction with this domain. The respondents said: " they were nice especially physiotherapist", "I feel comfort through talking", "I'd like to come because of smile face", "and the providers welcome me and give me and they respect all".

The study results are congruent with other studies done in GS and other countries.

A study conducted to assess user expectations and degree of client satisfaction and quality of health care provided in Rural Bangladesh, the researchers found that the most powerful predictor for client satisfaction with the government services was provider behavior, especially respect and politeness. the second most powerful predictor was respect for privacy ,(Aldana, Piechulek, and Al-Sabir, 2001)

In one study in Zaire, most women who were asked about the two best qualities for a nurse first mentioned qualities related to communication style, such as respect and attentiveness, and second listed technical qualities (Haddad, and Fournier, 1995).

Mousa (2000) study shown that interaction received the lowest degree of satisfaction, 54% of the respondents satisfied with interaction domain. Mousa results are not congruent with this study. Also Al Hindi (2002) found that communication and interaction domain was 77.5% which is moderate satisfaction scores in relation to others while comfort and privacy level of satisfaction was reported 90%.

The researcher is convinced that the client like to be treated as a human, like to feel trust, respect, privacy and confidentiality which are very important to all persons not merely patients. The high scores of satisfaction with interpersonal relations and communications could be interpreted related to cultural and religion point of view, because Islam ask us to deal with the people and describe the Islamic religion as communicating and dealing well, also the prophet Mohammed invites humans to deal politely and Qur'an describes him as on great manner and we should follow him. In addition, to support of counseling courses in reproductive health issues.

#### 4.3.4 Accessibility

The degree to which client facilitated to receive services from the centre includes easiness to reach the centre, providers availability, service availability, proper waiting time and cost of service.

Clients would like to have increased access to health providers and service; the clients respect punctuality and shorter waiting times. It is no surprise that many clients believe that health services should be provided free or that fees charged should be reasonable.

The study findings showed that accessibility domain reported (89.3%, 89.1%, and 89%) of perspective level in clinic, counseling services and physiotherapy services respectively which mean that patients have also positive perspective about accessibility. The result could be related to easiness to reach the centre because of its middle location in the camp. The highest percentage of study population reaches the centre in 15 minute and less, which represented 80.3%. The mean of time taken to reach the centre is 13.4 minute. About 78.6% of clients walking to the centre, which distance is not a problem to reach the centre and it's easy to access the centre. Also when asking women about cause of coming to the centre, 66% considered easy reachable cause was important one.

The result was congruent with Bender and Santander (1999 when assessed quality of health care In Bolivia, One hundred women was interviewed. Findings showed that women provided objective responses about ease of access to the health clinic. While 90% reported that it was easy to walk to the health clinic, making scheduled visits.

Regarding waiting time that the client waits from registration until receiving the service, the results showed that the mean of waiting time in clinic was 11.9 minutes, while in physiotherapy services the mean of waiting time was 7 and in the counseling services the mean was 15.3. Regarding waiting time and study domains, results shown that there was statistical significant difference between waiting time and overall perspective (P value 0.048). Clients wait from 16-30 had high scores of perspective and clients who wait more than 60 minutes had lowest scores and dissatisfied. Findings also shown that only 13% suggested reducing waiting time to improve quality of services.

Qualitative data support the results, one respondent said that;" waiting time is logic", "there is no problem with waiting time", "I don't wait mainly in physiotherapy services". Clients

who were dissatisfied with waiting time said; "the worst thing is long waiting time". The respondents satisfied with waiting time because they spent it in reading health brochure during waiting time which represented 41.1%, while 36.5% of women spent waiting time talking with other women, followed by 27.3% of women spent waiting time through receiving health education from staff, lastly 11.5% mentioned that they spent waiting time watching video. The centre has an appointment system which facilitates the services and reduces waiting times.

Studies identify distance and cost as being among the major factors that constrain women's ability to access services (Bongaarts, and Bruce, 1995). Costs, including fees for transportation, services, and supplies, can be another barrier to care. 54% rationalize coming to WHCJ because of acceptable cost of the services, also 35% of women suggested to reduce service cost because of unemployment and poverty in GS. In the 2000 Cambodia Demographic and Health Survey (DHS), women said that lack of money was the main obstruction to obtaining health care (National Institute of Statistics, 2000). In Kenya, clients said that low costs and proximity of services were the two most important factors that attracted them to services (Ndhlovu 1995).

The findings are consistent with other studies. Abu Harbeed (2004) found that the level of satisfaction with accessibility was 89.5% of study population which is congruent with this study. Abu Harbeed added that the women were satisfied with waiting time less than 30 minutes nearly 75.8% of total satisfied women, and the level of satisfaction with waiting time was 86%. Belachew (2001) cited the level of satisfaction with waiting time was 75% of respondents in Ethiopia.

The researcher concludes that, distance to reach the service, increased access to health providers and service, respect of punctuality and shorter waiting times and acceptable cost are important factors to be taken into consideration because it affects client's acceptance of services, increase their satisfaction and met the client's expectation and needs.

#### **4.3.5 Drug and proper equipment availability**

Clients believe drugs are necessary for treatment. Users often think that receiving drugs means receiving treatment. Many users will choose a health facility where they expect to

find drugs all the time. Results shown that this domain reported a percent of (69.1%, 55%) at clinic and physiotherapy services respectively. It means that the clients of the study have a low positive perspective regarding drug and proper equipment availability. 75% suggested providing the centre with new equipment to improve the quality of care. Many women said "the drug is not available most of times", other said "we are coming because of cheap drugs", third response is " what I am used if drug is not available". Because of closure (siege) many supplies, drugs and equipment don't enter Gaza which affect the client's perspective of the quality of services. Also the project is not self sustained and worked within the budget lines of donors and may this budget don't cover clients needs.

Abu Harbeed (2004) results revealed that 79.5% were satisfied with drug availability, but his concern was iron an folic, so the results was differ from this study, because the domain evaluated the drug and supplies availability.

The women were not satisfied with drug and equipment availability for treatment, because of socio-cultural and economical factors related to poverty, unemployment, and increase price of drugs in pharmacist.

#### **4.3.6 Physical Infrastructure**

Clients typically noted the following concerns for quality of the facility building in good repair running water & electricity available cleanliness and sanitation, examination rooms, space to maintain client confidentiality and beds. The findings showed that the physical infrastructure domain reported (76.4%, 51%, 50%) for counseling services, clinic and physiotherapy services respectively. It means that the respondents have low perspective about physical infrastructure mainly in clinic and physiotherapy which expressed the lowest level of perspective in this study. Counseling services clients have moderate positive perspective about physical infrastructure. Qualitative data assured this results; clients said that the "centre area is too narrow", "it is better to buy new building", " waiting halls are bad", " physiotherapy hall has bad ventilation". Positive perspective women said " it' is suitable for the service provides", "cleanliness is very good", "there is room for check up but small", "water and electricity is available every time"

This is congruent with the women suggestions to improve quality of care, the results shown that 79% suggested widening the centre.

Al Haj (2008) results shown that hotel services domain reported 74.5% in EGH, while Abu Harbeed (2004) reported level of satisfaction with infrastructure 82% in his study in UNRWA and MOH clinics.

Generally, the clients were not satisfied with infrastructure because the centre area, waiting rooms, halls and check up rooms are narrow and not enough to clients. Also has poor ventilation. To improve infrastructures, a new building is needed which was in the plan of the centre since one year. Current political situation and siege considered a big obstacle. The researcher will provide the management with the results and suggestions.

#### **4.3.7 General satisfaction**

Client satisfaction is one of the most important results of good-quality care. Because client's satisfaction influences their behavior. Client satisfaction may influence whether clients seek care, follow the provider's instructions on correct use, return to the provider and recommend services. In this study the findings showed that the general satisfaction domain reported (98%, 89.9%, 78.2%) for physiotherapy, clinical services and counseling services respectively. It means that the clients have positive perspective about general satisfaction in physiotherapy and clinic services, and moderate positive perspective in counseling service. About 56.6% of the respondents had strongly agreed that their experience was good with the centre, while 41.4 agree, the rest of the subjects disagreed and their experience with the centre is bad. In addition to 56.9% of respondents preferred coming to the centre on necessary, while 41.4% preferred coming to the centre regularly, but 1.6% showed that it's not important to come.

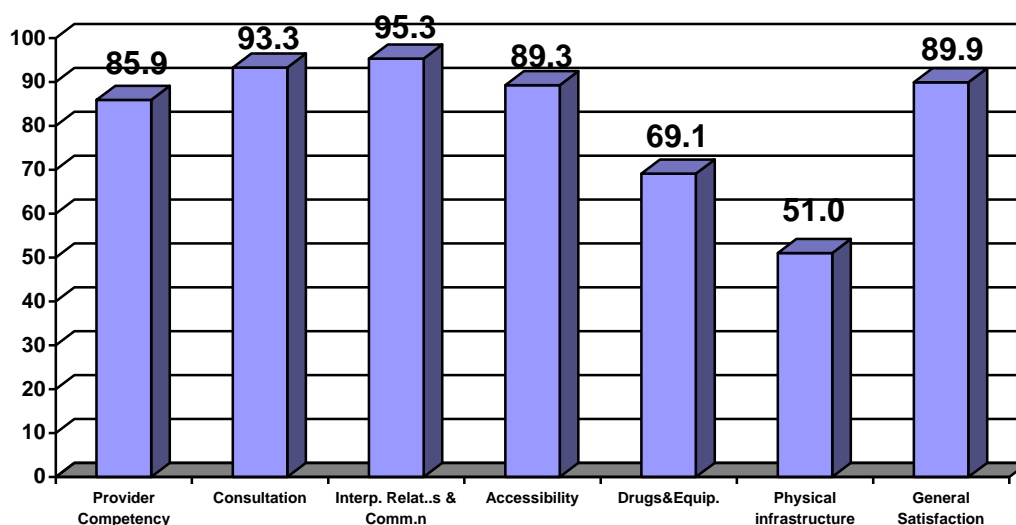
The results above showed that the study population was highly satisfied with the quality of services provided at the centre.

#### **4.4 Overall perspectives**

The total perspectives score (overall perspective) reflects all the subscales scores. Dimensions of quality from client's perspectives with reproductive health services were provider competency, service provider consultation, interpersonal relations& communication, accessibility, drug and supplies availability, physical infrastructure, and general Satisfaction.

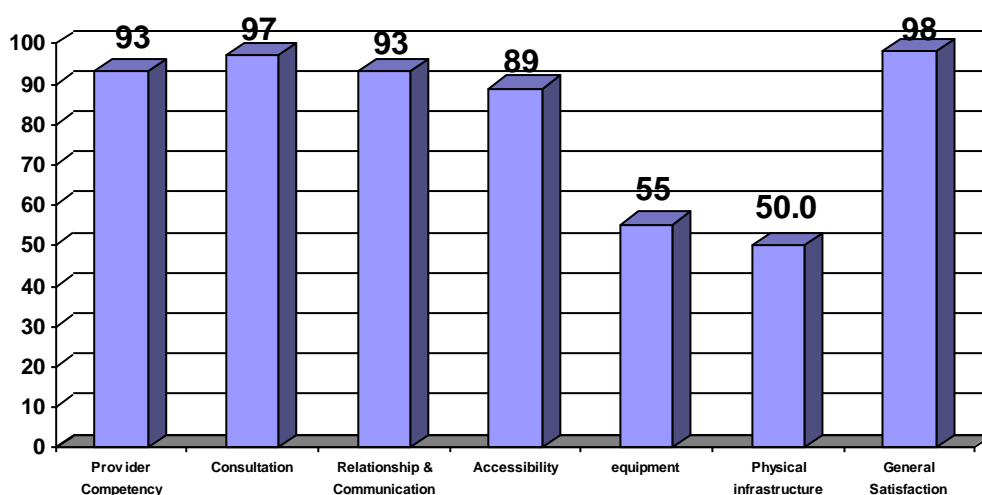
The overall mean of client's perspectives score in **clinic services** was 3.5 (84.6 %). The mean perspectives scores for the subscale dimensions ranged from (51% - 95.3%), the high mean scores indicated positive perspectives toward quality of reproductive health and vice

versa. The highest level of perspectives was expressed by the clients toward interpersonal relations and communications (95.3%). The lowest level of perspectives was expressed by the clients toward physical infrastructure (Figure 4.11).



**Figure 4.11: Percent of client's perspectives dimensions in clinic services**

The overall mean of client's perspectives score in **physiotherapy services** was 3.4 (83 %). The perspectives scores for the subscale dimensions ranged from (50% - 98%), the high mean scores indicated positive perspectives toward quality of reproductive health and vice versa (table 4.5 and Figure 4.12). The highest level of perspectives was expressed by the clients toward general satisfaction (98%). The lowest level of perspectives was expressed by the clients toward physical infrastructure(50 %).



**Figure 4.12: percent of client's perspectives dimensions in physiotherapy services**

The overall mean of client's perspectives score in **counseling services** was 3.3 (81.5 %). The perspectives scores for the subscale dimensions ranged from) (72.7% - 98.2%), the high mean scores indicated positive perspectives toward quality of reproductive health and

vice versa (Table 4.5 and Figure 4.13). The highest level of perspectives was expressed by the clients toward interpersonal relations and communications (98.2%). The lowest level of perspectives was expressed by the clients toward provider competency (72.7%).

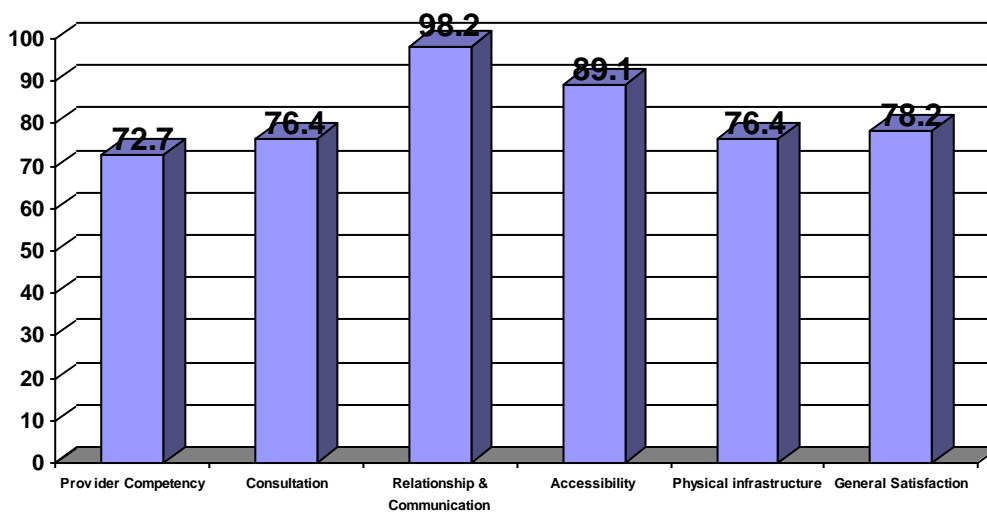


Figure 4.13: percent of client's perspectives dimensions in counseling services

#### 4.5 Client's perspective with regard to selected demographic variables (age, educational level, economical state and employment status).

The researcher conducted One Way ANOVA to investigate if there is significant difference between demographic variables (age, educational level and income) and client's perspective. An independent t-test was used to compare the means of perspectives in regard to employment status toward Clinic services.

##### Part one

##### Clinic

##### Age

One-Way ANOVA statistical test was used to estimate the difference in client's perspective with regard to age. Table 4.6, illustrates the differences between client's perspective and the age groups of study population. The result revealed that there are no significant statistical differences between the age groups of clients and overall perspectives. This result is consistent with some studies conducted in GS and inconsistent with others. Abu Salleek (2004) who found statistical significance between age groups and satisfaction, older age reported higher level of satisfaction. Al Haj (2008) found that there were significant difference between age and perception of clients. Al Haj study results that older age had higher scores of perception than younger age groups.

Al Hindi (2002) found that there no real differences between age and satisfaction with radiology services. Mousa (2000) found that the level of overall satisfaction was decreased as the age was increased, and he concluded that older people in the Palestinian context tended to be less satisfied than younger. The inconsistent relationship between satisfaction or perception and age means that client's perspective is influenced by other variables rather than age of the clients (Table 4.6).

**Table 4.6: Differences in client's perspective by age in clinic services**

Dep. Var.	Indep. Var.	Mean	Indep. Var.	df	Mean Square	F	Sig.
"Client's perspectives"	"Age"						
	=<20 Yrs	29.6	Between Groups	3	2.6	0.23	0.877
	21 to 30 Yrs	30.9	Within Groups	145	11.4		
	31 to 40 Yes	30.8	<b>Total</b>	148			
Provider competency	>40 Yrs	30.7					
	=<20 Yrs	30.8	Between Groups	3	23.7	2.32	0.078
	21 to 30 Yrs	28.1	Within Groups	145	10.2		
	31 to 40 Yes	28.9	<b>Total</b>	148			
Service provider consultation	>40 Yrs	29.7					
	=<20 Yrs	58.6	Between Groups	3	66.5	2.05	0.110
	21 to 30 Yrs	56.8	Within Groups	145	32.5		
	31 to 40 Yes	58.4	<b>Total</b>	148			
Interpersonal relations and communication	>40 Yrs	60.0					
	=<20 Yrs	40.6	Between Groups	3	89.5	3.96	0.009*
	21 to 30 Yrs	38.8	Within Groups	145	22.6		
	31 to 40 Yes	41.4	<b>Total</b>	148			
Accessibility	>40 Yrs	41.8					
	=<20 Yrs	26.2	Between Groups	3	26.7	1.59	0.194
	21 to 30 Yrs	26.6	Within Groups	145	16.7		
	31 to 40 Yes	26.8	<b>Total</b>	148			
Drug and equipment availability	>40 Yrs	24.6					
	=<20 Yrs	26.6	Between Groups	3	8.0	0.30	0.829
	21 to 30 Yrs	28.2	Within Groups	145	27.1		
	31 to 40 Yes	27.9	<b>Total</b>	148			
Physical infrastructure	>40 Yrs	28.8					
	=<20 Yrs	17.6	Between Groups	3	5.7	1.12	0.344
	21 to 30 Yrs	16.1	Within Groups	145	5.1		
	31 to 40 Yes	16.0	<b>Total</b>	148			
General Satisfaction	>40 Yrs	16.6					
	=<20 Yrs	230.0	Between Groups	3	382.6	0.96	0.415
	21 to 30 Yrs	225.4	Within Groups	145	400.2		
	31 to 40 Yes	230.3	<b>Total</b>	148			
Overall perspectives	>40 Yrs	232.3					

\* Statistically significant

### **Educational level**

One-Way ANOVA statistical test was used to estimate the difference in client's perspective with regard to educational level. The results according to Table 4.7 revealed that there is significant differences between clients education level overall perspectives (P-value 0.007). The table indicates that the illiteracy clients reported higher scores of perspectives, while the university level of education reported the lowest scores of perception. The researcher attributes the result, in the clinic that higher educated people expectation is higher than the service they received, or receive the same services in a better quality than in the centre. The results are inconsistent in this study related to type of services received.

The clinic results regarding level of education and perspective is consistent with Al Haj (2008) results, that illiterate and preparatory patients reported higher scores of perception, while the university level of education reported the lowest scores of perception. Al Hindi (2002) study population of higher level of education reported higher satisfaction level and concluded that because those with higher educational level might be more informed about the services. Abu Harbeed (2004) findings revealed that there was no a significant statistical difference between educational level and satisfaction's dimensions regarding overall satisfaction.

There is inconsistency between the studies results regarding level of education and perception, perspective and satisfaction level. It means that the client's expectations and needs have an important role in determine the client's responses. Also experience and other factors could affect the results.

**Table 4.7: Differences in client's perspective by level of education in clinic services**

Dep. Var. "Client's perspectives "	Ind. Var. "level of education "	Mean	Ind. Var. "level of education"	df	Mean Square	F	Sig.
Provider competency	Illiteracy	28.5	Between Groups	5	11.7	1.04	0.396
	Primary	31.0	Within Groups	143	11.2		
	Preparatory	30.1	Total	148			
	secondary	31.2					
	Diploma university	29.7 30.9					
Service provider consultation	Illiteracy	31.3	Between Groups	5	19.1	1.88	0.102
	Primary	28.9	Within Groups	143	10.2		
	Preparatory	29.4	Total	148			
	secondary	28.9					
	Diploma university	27.5 27.5					
Interpersonal relations and communication	Illiteracy	60.0	Between Groups	5	136.1	4.60	0.001*
	Primary	57.0	Within Groups	143	29.6		
	Preparatory	59.1	Total	148			
	secondary	58.6					
	Diploma university	63.2 54.2					
Accessibility	Illiteracy	45.5	Between Groups	5	95.2	4.43	0.001*
	Primary	38.6	Within Groups	143	21.5		
	Preparatory	42.1	Total	148			
	secondary	39.7					
	Diploma university	44.7 38.4					
Drug and equipment availability	Illiteracy	30.5	Between Groups	5	61.8	4.02	0.002*
	Primary	24.0	Within Groups	143	15.4		
	Preparatory	28.0	Total	148			
	secondary	26.1					
	Diploma university	29.2 24.9					
Physical infrastructure	Illiteracy	34.5	Between Groups	5	45.1	1.73	0.131
	Primary	28.4	Within Groups	143	26.0		
	Preparatory	28.9	Total	148			
	secondary	27.7					
	Diploma university	28.7 27.1					
General Satisfaction	Illiteracy	18.0	Between Groups	5	5.2	1.01	0.414
	Primary	16.4	Within Groups	143	5.1		
	Preparatory	16.6	Total	148			
	secondary	16.0					
	Diploma university	16.7 15.9					
Overall perspectives	Illiteracy	248.3	Between Groups	5	1230.3	3.32	0.007*
	Primary	224.3	Within Groups	143	370.8		
	Preparatory	234.1	Total	148			
	secondary	228.3					
	Diploma university	239.5 218.8					

\* Statistically significant

### Employment Status

An independent t-test to compare the means of the perspectives scores in regard to employment status, table 4.8 revealed that there are no significant statistical differences between the employment status of clients and overall perspectives. Abu Harbeed (2004) findings showed that higher level of satisfaction has a significant statistical difference with

employment status. However, women were employed have a high educational level and their expectation higher than low educational level.

Result is inconsistent with Al Haj (2008); the results revealed that the unemployed (75%) patients elicited higher level of overall perception scores, while the employed (25%) patients reported lower level. Al Hindi (2002) found that unemployed clients were more perspective with health services than the employed clients.

**Table 4.8: Differences in client's perspective by current employment status in clinic services**

Dep. Var. "Client's perspectives "	Ind. Var. "Employment status "	Mean	Std	df	t	.Sig
Provider competency	Yes	31.3	2.6	146	0.54	0.554
	No	30.7	3.4	19.850		
Service provider consultation	Yes	26.1	4.2	146	-2.90	0.001*
	No	29.0	3.0	15.699		
Interpersonal relations and commutations	Yes	55.7	8.0	146	-2.42	0.125
	No	58.2	5.5	15.492		
Accessibility	Yes	40.6	4.9	146	0.49	0.717
	No	40.1	4.9	17.351		
Drug and equipment availability	Yes	25.2	2.9	146	-1.30	0.251
	No	26.5	4.2	21.512		
Physical infrastructure	Yes	26.5	4.6	146	-1.86	0.186
	No	28.3	5.2	18.276		
General Satisfaction	Yes	15.8	1.7	146	-0.43	0.494
	No	16.2	2.3	20.865		
Overall perspectives	Yes	221.2	21.8	146	-1.446	0.150
	No	229.1	19.8	16.694		

\* Statistical significant

### Income

One-Way ANOVA statistical test was used to estimate the difference in client's perspective with regard to income.

Table 4.9 demonstrates the comparison between client's perspectives and income. The findings showed that, there was no statistical significance between income variable and overall perspectives. The result is congruent with (Mousa, 2000 and Al Hindi, 2002) satisfaction studies. It could be interpreted as the center is non profit organization and suitable to all economical status. In addition, further studies in more stable political and socio-economical condition need to be conducted to discover the relations between different variables and perspective.

**Table 4.9: Differences in client's perspective by income in clinic services**

<b>Dep. Var. "Client's Perspectives"</b>	<b>Indep. Var. "Income"</b>	<b>Mean</b>	<b>Indep. Var. "Income"</b>	<b>df</b>	<b>Mean Square</b>	<b>F</b>	<b>Sig.</b>
Provider competency	=<1000 NIS	30.9	Between Groups	3	0.5	0.04	0.989
	1001 to 2000 NIS	30.7	Within Groups	144	11.5		
	2001 to 3000 NIS	30.5	Total	147			
	>3001 Yrs	31.0					
Service provider consultation	=<1000 NIS	29.3	Between Groups	3	43.5	4.41	0.005*
	1001 to 2000 NIS	27.2	Within Groups	144	9.9		
	2001 to 3000 NIS	29.2	Total	147			
	>3001 Yrs	26.5					
Interpersonal relations and communication	=<1000 NIS	58.3	Between Groups	3	43.8	1.34	0.263
	1001 to 2000 NIS	56.8	Within Groups	144	32.6		
	2001 to 3000 NIS	60.2	Total	147			
	>3001 Yrs	55.5					
Accessibility	=<1000 NIS	40.5	Between Groups	3	20.3	0.84	0.475
	1001 to 2000 NIS	39.3	Within Groups	144	24.2		
	2001 to 3000 NIS	41.1	Total	147			
	>3001 Yrs	38.0					
Drug and equipment availability	=<1000 NIS	26.6	Between Groups	3	38.1	2.32	0.078
	1001 to 2000 NIS	25.9	Within Groups	144	16.4		
	2001 to 3000 NIS	28.0	Total	147			
	>3001 Yrs	22.0					
Physical infrastructure	=<1000 NIS	28.4	Between Groups	3	54.1	2.06	0.108
	1001 to 2000 NIS	27.4	Within Groups	144	26.3		
	2001 to 3000 NIS	29.9	Total	147			
	>3001 Yrs	23.0					
General Satisfaction	=<1000 NIS	16.3	Between Groups	3	3.2	0.61	0.607
	1001 to 2000 NIS	16.0	Within Groups	144	5.1		
	2001 to 3000 NIS	16.0	Total	147			
	>3001 Yrs	15.0					
Overall perspectives	=<1000 NIS	230.2	Between Groups	3	938.8	2.42	0.069
	1001 to 2000 NIS	223.4	Within Groups	144	387.9		
	2001 to 3000 NIS	234.9	Total	147			
	>3001 Yrs	211.0					

**Part two**

**Physiotherapy services**

**Age**

One-Way ANOVA statistical test was used to estimate the difference in client's perspective with regard to age.

Table 4.10, illustrates the differences between client's perspective and the age groups of study population. The result revealed a significant statistical differences between the age groups of clients overall perspectives (P-value0.004). The table shows that those who were 20 years and less of age have higher scores of perspectives, while the age group 31-40 years reported the lowest scores of perspectives.

**Table 4.10: Differences in client's perspective by age in physiotherapy services**

Dep. Var. "Client's perspectives"	Ind. Var. "Age"	Mean	Ind. Var. "Age"	df	Mean Square	F	Sig.
Provider competency	=<20 Yrs	26.7	Between Groups	3	29.0	2.77	0.046*
	21 to 30 Yrs	23.6	Within Groups	96	10.5		
	31 to 40 Yes	24.0	<b>Total</b>	99			
	>40 Yrs	25.3					
Service provider consultation	=<20 Yrs	34.6	Between Groups	3	74.9	9.77	0.000*
	21 to 30 Yrs	29.3	Within Groups	96	7.7		
	31 to 40 Yes	29.4	<b>Total</b>	99			
	>40 Yrs	31.5					
Interpersonal relations and communication	=<20 Yrs	61.0	Between Groups	3	73.1	1.87	0.139
	21 to 30 Yrs	55.5	Within Groups	96	39.0		
	31 to 40 Yes	55.6	<b>Total</b>	99			
	>40 Yrs	57.3					
Accessibility	=<20 Yrs	44.4	Between Groups	3	39.5	1.46	0.229
	21 to 30 Yrs	40.3	Within Groups	96	27.0		
	31 to 40 Yes	41.0	<b>Total</b>	99			
	>40 Yrs	42.0					
Equipment availability	=<20 Yrs	13.9	Between Groups	3	32.5	2.72	0.049*
	21 to 30 Yrs	17.7	Within Groups	96	12.0		
	31 to 40 Yes	17.1	<b>Total</b>	99			
	>40 Yrs	17.8					
Physical infrastructure	=<20 Yrs	41.7	Between Groups	3	39.1	1.46	0.231
	21 to 30 Yrs	42.3	Within Groups	96	26.8		
	31 to 40 Yes	39.6	<b>Total</b>	99			
	>40 Yrs	41.1					
General Satisfaction	=<20 Yrs	20.0	Between Groups	3	30.1	10.97	0.000*
	21 to 30 Yrs	17.5	Within Groups	96	2.7		
	31 to 40 Yes	16.1	<b>Total</b>	99			
	>40 Yrs	17.2					
Overall perspectives	=<20 Yrs	242.3	Between Groups	3	950.2	4.69	0.004*
	21 to 30 Yrs	226.3	Within Groups	96	202.5		
	31 to 40 Yes	222.7	<b>Total</b>	99			
	>40 Yrs	232.2					

## Education level

One-Way ANOVA statistical test was used to estimate the difference in client's perspective with regard to educational level. The results according to Table 4.11 revealed that there is a real difference between client's education level and overall perspectives (P-value 0.000). The table indicates that higher education clients reported higher scores of overall perspectives followed by preparatory clients, while secondary clients reported lowest scores of perspectives. They were satisfied with physiotherapy services because of a unique service provided in the area.

**Table 4.11: Differences in client's perspective by level of education in Physiotherapy services**

Dep. Var. "Client's perspectives"	Ind. Var. "Level of education"	Mean		df	Mean Square	F	Sig.
Provider competency	Illiteracy	25.0	Between Groups	6	40.9	4.49	0.000*
	Primary	22.4	Within Groups	93	9.1		
	Preparatory	25.1	Total	99			
	secondary	23.1					
	Diploma	24.6					
	university	26.4					
Service provider consultation	Higher Edu.	29.0					
	Illiteracy	33.0	Between Groups	6	28.9	3.42	0.004*
	Primary	29.6	Within Groups	93	8.5		
	Preparatory	31.9	Total	99			
	secondary	29.5					
	Diploma	28.6					
university	31.9						
Interpersonal relations and communication	Higher Edu.	30.0					
	Illiteracy	56.0	Between Groups	6	116.9	3.33	0.005*
	Primary	50.4	Within Groups	93	35.1		
	Preparatory	59.2	Total	99			
	secondary	54.2					
	Diploma	57.9					
university	57.3						
Accessibility	Higher Edu.	62.0					
	Illiteracy	37.0	Between Groups	6	38.2	1.43	0.211
	Primary	40.8	Within Groups	93	26.7		
	Preparatory	42.1	Total	99			
	secondary	40.3					
	Diploma	42.1					
university	41.3						
Equipment availability	Higher Edu.	47.0					
	Illiteracy	21.0	Between Groups	6	35.7	3.22	0.006*
	Primary	21.2	Within Groups	93	11.1		
	Preparatory	18.0	Total	99			
	secondary	15.8					
	Diploma	18.2					
university	17.4						
Physical infrastructure	Higher Edu.	17.0					
	Illiteracy	36	Between Groups	6	73.4	3.03	0.009*
	Primary	40.4	Within Groups	93	24.2		
	Preparatory	44.0	Total	99			
	secondary	39.7					
	Diploma	43.3					
university	39.1						
General Satisfaction	Higher Edu.	42.0					
	Illiteracy	19.0	Between Groups	6	4.0	1.12	0.359
Primary	16.0	Within Groups	93	3.5			

	Preparatory	17.4	Total	99			
	secondary	17.1					
	Diploma	17.4					
	university	17.6					
	Higher Edu.	16.0					
	Illiteracy	227.0	Between Groups	6	1039.0	6.02	0.000*
	Primary	220.8	Within Groups	93	172.6		
	Preparatory	237.7	Total	99			
<b>Overall perspectives</b>	secondary	219.7					
	Diploma	232.1					
	university	231.0					
	Higher Edu.	243.0					

### Employment status

An independent t-test was used to compare the means of client's perspective with regard to employment status.

Using an independent t-test to compare the means of the perspectives scores in regard to employment status, table 4.12 revealed that the employed clients had higher level of overall perspectives, while the unemployed clients reported lower level. There were statistical significance difference between the employment status and overall perspectives (P-value 0.006); this result indicates that the employed women have positive perspectives with reproductive health services than unemployed clients.

**Table 4.12: Differences in client's perspective by current employment status in Physiotherapy services**

Dep. Var. "Client's perspectives"	Ind. Var. "Employment status "	Mean	Std	df	t	.Sig
Provider competency	Yes	26.3	2.0	98	2.944	0.004*
	No	24.0	3.5	59.500		
Service provider consultation	Yes	30.5	3.2	98	0.196	0.845
	No	30.4	3.1	32.574		
Interpersonal relations and communications	Yes	59.7	5.8	98	2.800	0.006*
	No	55.6	6.2	35.788		
Accessibility	Yes	44.4	5.1	98	3.211	0.002*
	No	40.5	5.0	33.039		
Equipment availability	Yes	17.4	2.2	98	0.110	0.913
	No	17.3	3.9	62.520		
Physical infrastructure	Yes	39.7	3.7	98	-1.426	0.157
	No	41.5	5.5	51.120		
General Satisfaction	Yes	18.1	1.6	98	2.514	0.014*
	No	17.0	1.9	39.308		
Overall satisfaction	Yes	236.1	11.8	98	2.816	0.006*
	No	226.2	15.2	42.680		

## Income

One-Way ANOVA statistical test was used to estimate the difference in client's perspective with regard to income.

Table 4.13 demonstrates the comparison between client's perspectives and income. The findings showed that, there was statistical significance between income variable and overall perspectives (P value 0.005). Findings revealed that the clients income more than 3000NIS elicited highest level of overall perspectives, while clients income 2001-3000NIS elicited lowest level of overall perspectives. The physiotherapy services covered the majority needs, the department is well equipped and the physiotherapist has good experience and updated with new knowledge and practices in her field.

**Table 4.13: Differences in client's perspective by income in physiotherapy services**

Dep. Var. "Client's perspectives"	Ind. Var. "Income "	Mean		df	Mean Square	F	Sig.
Provider competency	=<1000 NIS	24.5	Between Groups	3	8.2	1.04	0.378
	1001 to 2000 NIS	23.9	Within Groups	85	7.9		
	2001 to 3000 NIS	24.9	<b>Total</b>	88			
	>3001 Yrs	25.4					
Service provider consultation	=<1000 NIS	30.5	Between Groups	3	43.1	5.35	0.002*
	1001 to 2000 NIS	28.8	Within Groups	85	8.1		
	2001 to 3000 NIS	30.4	<b>Total</b>	88			
	>3001 Yrs	32.4					
Interpersonal relations and communication	=<1000 NIS	55.5	Between Groups	3	137.2	4.00	0.010*
	1001 to 2000 NIS	58.8	Within Groups	85	34.3		
	2001 to 3000 NIS	54.0	<b>Total</b>	88			
	>3001 Yrs	59.8					
Accessibility	=<1000 NIS	40.9	Between Groups	3	181.7	8.66	0.000*
	1001 to 2000 NIS	42.4	Within Groups	85	21.0		
	2001 to 3000 NIS	38.5	<b>Total</b>	88			
	>3001 Yrs	46.3					
Equipment availability	=<1000 NIS	18.0	Between Groups	3	13.2	1.05	0.376
	1001 to 2000 NIS	17.4	Within Groups	85	12.6		
	2001 to 3000 NIS	18.3	<b>Total</b>	88			
	>3001 Yrs	16.4					
Physical infrastructure	=<1000 NIS	41.8	Between Groups	3	90.6	4.00	0.010*
	1001 to 2000 NIS	41.1	Within Groups	85	22.7		
	2001 to 3000 NIS	36.8	<b>Total</b>	88			
	>3001 Yrs	39.7					
General Satisfaction	=<1000 NIS	16.6	Between Groups	3	8.6	2.49	0.066
	1001 to 2000 NIS	17.1	Within Groups	85	3.5		
	2001 to 3000 NIS	17.4	<b>Total</b>	88			

	>3001 Yrs	18.1					
	=<1000 NIS	227.8	Between Groups	3	864.4	4.66	0.005*
Overall perspectives	1001 to 2000 NIS	229.3	Within Groups	85	185.7		
	2001 to 3000 NIS	220.3	<b>Total</b>	88			
	>3001 Yrs	238.1					

### **Part three**

#### **Counseling services**

##### **Age**

One-Way ANOVA statistical test was used to estimate the difference in client's perspective with regard to age. Table 4.14, illustrates the differences between client's perspective and the age groups of study population. There were no statistical significant differences between the age and overall perspectives.

**Table 4.14: Differences in client's perspective by age in counseling services**

Dep. Var. "Client's perspectives"	Ind. Var. "Age "	Mean	Ind. Var. "Age "	df	Mean Square	F	Sig.
Provider competency	=<20 Yrs	19.0	Between Groups	3	12.3	0.63	0.601
	21 to 30 Yrs	20.8	Within Groups	51	19.7		
	31 to 40 Yes	22.6	<b>Total</b>	54			
	>40 Yrs	22.4					
Service provider consultation	=<20 Yrs	19.0	Between Groups	3	91.0	1.59	0.203
	21 to 30 Yrs	26.9	Within Groups	51	57.2		
	31 to 40 Yes	27.6	<b>Total</b>	54			
	>40 Yrs	31.6					
Interpersonal relations and communication	=<20 Yrs	66.0	Between Groups	3	27.4	0.74	0.535
	21 to 30 Yrs	61.5	Within Groups	51	37.3		
	31 to 40 Yes	59.8	<b>Total</b>	54			
	>40 Yrs	62.1					
Accessibility	=<20 Yrs	46.0	Between Groups	3	17.4	0.77	0.516
	21 to 30 Yrs	39.2	Within Groups	51	22.5		
	31 to 40 Yes	39.9	<b>Total</b>	54			
	>40 Yrs	38.9					
Physical infrastructure	=<20 Yrs	38.0	Between Groups	3	27.6	2.09	0.113
	21 to 30 Yrs	30.1	Within Groups	51	13.2		
	31 to 40 Yes	31.3	<b>Total</b>	54			
	>40 Yrs	29.7					
General Satisfaction	=<20 Yrs	15.0	Between Groups	3	3.0	0.26	0.857
	21 to 30 Yrs	15.0	Within Groups	51	11.9		
	31 to 40 Yes	15.6	<b>Total</b>	54			
	>40 Yrs	16.1					
Overall perspectives	=<20 Yrs	203.0	Between Groups	3	166.5	0.33	0.801
	21 to 30 Yrs	193.5	Within Groups	51	500.0		
	31 to 40 Yes	197.3	<b>Total</b>	54			
	>40 Yrs	201.9					

##### **Educational level**

One-Way ANOVA statistical test was used to estimate the difference in client's perspective with regard to educational level. The results according to Table 4.15 revealed that there is

no statistical significance difference between client's educational level and overall perspectives.

**Table 4.15: Differences in client's perspective by level of education in counseling services**

Dep. Var. "Client's perspectives"	Ind. Var. "level of education "	Mean	Ind. Var. "level of education "	df	Mean Square	F	Sig.
Provider competency	Illiteracy	20.8	Between Groups	6	7.6	0.37	0.897
	Primary	21.5	Within Groups	48	20.7		
	Preparatory	22.0	Total	54			
	secondary	22.9					
	Diploma	20.0					
	university	23.7					
Service provider consultation	Higher Edu.	22.0	Between Groups	6	24.4	0.38	0.885
	Illiteracy	25.6	Within Groups	48	63.4		
	Primary	30.9	Total	54			
	Preparatory	27.0					
	secondary	28.0					
	Diploma	27.7					
Interpersonal relations and communication	university	28.7	Between Groups	6	17.3	0.44	0.846
	Higher Edu.	28.0	Within Groups	48	39.1		
	Illiteracy	60.4	Total	54			
	Primary	60.2					
	Preparatory	61.3					
	secondary	61.6					
Accessibility	Diploma	57.7	Between Groups	6	26.0	1.19	0.326
	university	64.0	Within Groups	48	21.8		
	Higher Edu.	56.0	Total	54			
	Illiteracy	37.8					
	Primary	38.2					
	Preparatory	39.5					
Physical infrastructure	secondary	40.7	Between Groups	6	23.1	1.80	0.118
	Diploma	43.3	Within Groups	48	12.8		
	university	36.3	Total	54			
	Higher Edu.	44.0					
	Illiteracy	31.8					
	Primary	30.7					
General Satisfaction	Preparatory	27.9	Between Groups	6	4.8	0.39	0.879
	secondary	32.1	Within Groups	48	12.3		
	Diploma	31.3	Total	54			
	university	30.3					
	Higher Edu.	27.0					
	Illiteracy	15.2					
Overall perspectives	Primary	14.8	Between Groups	6	135.3	0.26	0.954
	Preparatory	16.2	Within Groups	48	524.8		
	secondary	15.8	Total	54			
	Diploma	17.3					
	university	14.0					
	Higher Edu.	16.0					

**Employment status**

Using an independent t-test to compare the means of the perspectives scores with regard to employment status, there were no statistical significance difference between the employment status and overall perspectives (Table, 4.16)

**Table 4.16: Differences in client's perspective by current employment status in counseling services**

Dep. Var. "Client's perspectives"	Ind. Var. "Current employment status "	Mean	Ind. Var. "Current employment status "	df	Mean Square	F	Sig.
Provider competency	Yes	26.8	Between Groups	1	153.8	9.19	0.004*
	No	21.5	Within Groups	53	16.7		
Service provider consultation	Yes	32.0	Between Groups	1	91.7	1.57	0.216
	No	27.9	Within Groups	53	58.5		
Interpersonal relations and communication	Yes	65.3	Between Groups	1	131.8	3.78	0.047*
	No	60.4	Within Groups	53	34.9		
Accessibility	Yes	39.2	Between Groups	1	1.2	0.05	0.822
	No	39.6	Within Groups	53	22.6		
Physical infrastructure	Yes	29.3	Between Groups	1	13.4	0.96	0.332
	No	30.9	Within Groups	53	14.0		
General Satisfaction	Yes	18.7	Between Groups	1	64.8	6.22	0.016*
	No	15.2	Within Groups	53	10.4		
Overall perspectives	Yes	211.3	Between Groups	1	1256.8	2.69	0.107
	No	196.0	Within Groups	53	466.9		

### Income

One-Way ANOVA statistical test was used to estimate the difference in client's perspective with regard to income.

Table 4.17, demonstrates the comparison between client's perspectives and income. The findings showed that, there was no statistical significance between income variable and overall perspectives.

**Table 4.17: Differences in client's perspective by income in counseling services**

Dep. Var. "Client's perspectives"	Ind. Var. "Current employment status "	Mean		df	Mean Square	F	Sig.
Provider competency	=<1000 NIS	21.5	Between Groups	3	18.7	0.99	0.407
	1001 to 2000 NIS	24.0	Within Groups	50	19.0		
	2001 to 3000 NIS	20.7	<b>Total</b>	53			
	>3001 Yrs	23.0					
Service provider consultation	=<1000 NIS	27.7	Between Groups	3	18.5	0.30	0.826
	1001 to 2000 NIS	30.2	Within Groups	50	61.8		
	2001 to 3000 NIS	28.0	<b>Total</b>	53			
	>3001 Yrs	30.0					
Interpersonal relations and communication	=<1000 NIS	60.5	Between Groups	3	40.6	1.13	0.345
	1001 to 2000 NIS	63.0	Within Groups	50	35.9		
	2001 to 3000 NIS	56.0	<b>Total</b>	53			
	>3001 Yrs	62.0					
Accessibility	=<1000 NIS	39.7	Between Groups	3	24.8	1.11	0.356
	1001 to 2000 NIS	39.6	Within Groups	50	22.4		
	2001 to 3000 NIS	39.7	<b>Total</b>	53			
	>3001 Yrs	31.0					
Physical infrastructure	=<1000 NIS	31.2	Between Groups	3	19.8	1.44	0.242
	1001 to 2000 NIS	30.1	Within Groups	50	13.7		
	2001 to 3000 NIS	27.0	<b>Total</b>	53			
	>3001 Yrs	33.0					
General Satisfaction	=<1000 NIS	15.5	Between Groups	3	4.3	0.36	0.784
	1001 to 2000 NIS	16.0	Within Groups	50	12.0		
	2001 to 3000 NIS	13.7	<b>Total</b>	53			
	>3001 Yrs	16.0					
Overall perspectives	=<1000 NIS	196.1	Between Groups	3	241.7	0.49	0.692
	1001 to 2000 NIS	204.3	Within Groups	50	495.3		
	2001 to 3000 NIS	189.7	<b>Total</b>	53			
	>3001 Yrs	195.0					

#### 4.6 Client's perspective with regard to selected organizational variables (waiting time and consultation time).

With regard to research question 7, One-Way ANOVA was used to test the difference in client's perspective with reproductive health services regard to organizational factors (consultation time and waiting time).

**Table 4.18 Distribution of study population by service time, consultation time and waiting time**

	15Min. and less %	16 to 30 Min. %	31 to 60 Min. %	More than 60 Min. %
<b>1. Service time</b>				
Clinic Services	<b>59.5</b>	35.8	4.7	0.0
Physiotherapy	<b>12.9</b>	<b>8.6</b>	<b>53.8</b>	<b>24.7</b>
Psychological Counseling	17.6	<b>52.9</b>	29.4	0.0
Social Counseling	57.7	<b>42.3</b>	0.0	0.0
Legal Counseling	<b>58.3</b>	41.7	0.0	0.0
<b>2. Consultation time</b>				
Clinic Services	<b>83.4</b>	<b>16.6</b>	0.0	0.0
Physiotherapy	67.0	33.0	0.0	0.0
Psychological Counseling	<b>47.1</b>	<b>41.2</b>	11.8	0.0
Social Counseling	65.4	34.6	0.0	0.0
Legal Counseling	66.7	33.3	0.0	0.0
<b>.3Waiting time</b>				
Clinic Services	86.2	<b>11.6</b>	2.2	0.0
Physiotherapy	<b>97.5</b>	2.5	0.0	0.0
Psychological Counseling	88.2	5.9	5.9	0.0
Social Counseling	76.9	11.5	<b>7.7</b>	3.8
Legal Counseling	<b>100.0</b>	0.0	0.0	0.0

Regarding service time that the health provider spent with the health provider, the results showed that the mean of spent time in clinic was 19.2 and Std 9.7, while in physiotherapy services the mean of spent time was 56.2 and Std was 27 and in the counseling services the mean was 23.1 and Std was 13.2.

Regarding consultation time, the results showed that the mean of consultation time in clinic was 13.5 and Std 7.1, while in physiotherapy services the mean of consultation time was 16.6 and Std was 9.1 and in the counseling services the mean was 16.9 and Std was 11.1.

Regarding waiting time that the client waits from registration until receiving the service, the results showed that the mean of waiting time in clinic was 11.9 and Std 10.1, while in physiotherapy services the mean of waiting time was 7 and Std was 4.3 and in the

counseling services the mean was 15.3 and Std was 10.5. To get more details, the researcher calculated the percentage of each time in each service as clear in.

**Table 4.19: Differences in dimensions of client's perspective and waiting time**

Dep. Var. "Client's perspectives"	Ind. Var. "Waiting time Mean	Ind. Var. "Waiting time Mean	Sum of Squares	df	Mean Square	F	.Sig
Provider competency	15 Min and less	27.0	Between Groups	129.148	3	43.049	1.588 0.193
	From 16 to 30	29.2	Within Groups	7318.345	270	27.105	
	From 31 to 60	26.3	<b>Total</b>	7447.493	273		
	More than 60	22.0					
Service provider consultation	15 Min and less	29.0	Between Groups	15.556	3	5.185	0.255 0.858
	From 16 to 30	29.1	Within Groups	5492.444	270	20.342	
	From 31 to 60	28.0	<b>Total</b>	5508.000	273		
	More than 60	26.0					
Interpersonal relations and communication	15 Min and less	57.9	Between Groups	133.737	3	44.579	1.107 0.347
	From 16 to 30	57.7	Within Groups	10876.497	270	40.283	
	From 31 to 60	61.3	<b>Total</b>	11010.234	273		
	More than 60	50.0					
Accessibility	15 Min and less	40.3	Between Groups	167.166	3	55.722	2.397 0.68
	From 16 to 30	39.1	Within Groups	6276.765	270	23.247	
	From 31 to 60	37.7	<b>Total</b>	6443.931	273		
	More than 60	30.0					
Drug and equipment availability	15 Min and less	22.8	Between Groups	309.471	2	154.735	4.544 0.012*
	From 16 to 30	26.9	Within Groups	7355.899	216	34.055	
	From 31 to 60	19.7	<b>Total</b>	7665.370	218		
	More than 60	0.0					
Physical infrastructure	15 Min and less	32.9	Between Groups	393.147	3	131.049	2.189 0.090
	From 16 to 30	29.3	Within Groups	16165.221	270	59.871	
	From 31 to 60	30.2	<b>Total</b>	16558.369	273		
	More than 60	23.0					
General Satisfaction	15 Min and less	16.4	Between Groups	6.642	3	2.214	0.355 0.786
	From 16 to 30	16.2	Within Groups	1686.136	270	6.245	
	From 31 to 60	15.3	<b>Total</b>	1692.777	273		
	More than 60	16.0					
Overall perspectives	15 Min and less	221.9	Between Groups	4026.004	3	1342.001	2.670 0.048*
	From 16 to 30	222.7	Within Groups	135724.131	270	502.682	
	From 31 to 60	208.7	<b>Total</b>	139750.135	273		
	More than 60	167.0					

As shown in Table 4.19, regarding waiting time and study domains, results shown that there was statistical significant difference between waiting time and overall perspectives (P value 0.048 ). Clients wait from 16-30 had high scores of perspectives and clients who wait more than 60 minutes had lowest scores.

**Table 4.20: Differences in dimensions of client's perspective and consultation time**

Dep. Var. "Client's perspectives"	Ind. Var. "consultation time"	Mean	Ind. Var. "consultation time"	Sum of Squares	df	Mean Square	F	.Sig
Provider competency	15 Min and less	27.8	Between Groups	185.301	2	92.651	3.914	0.021*
	From 16 to 30	26.4	Within Groups	6818.273	288	23.675		
	From 31 to 60	21.5	<b>Total</b>	7003.574	290			
	More than 60	27.4						
Service provider consultation	15 Min and less	29.3	Between Groups	10.001	2	5.001	0.252	0.777
	From 16 to 30	31.5	Within Groups	5709.552	288	19.825		
	From 31 to 60	29.3	<b>Total</b>	5719.553	290			
	More than 60	58.5						
Interpersonal relations and communication	15 Min and less	60.5	Between Groups	87.608	2	43.804	1.206	0.301
	From 16 to 30	58.2	Within Groups	10457.615	288	36.311		
	From 31 to 60	40.9	<b>Total</b>	10545.223	290			
	More than 60	39.4						
Accessibility	15 Min and less	40.5	Between Groups	122.415	2	61.207	2.452	0.08
	From 16 to 30	23.5	Within Groups	7188.327	288	24.959		
	From 31 to 60	20.6	<b>Total</b>	7310.742	290			
	More than 60	.						
Drug and supplies availability	15 Min and less	31.6	Between Groups	349.706	1	349.706	10.273	0.002*
	From 16 to 30	35.0	Within Groups	7965.955	234	34.043		
	From 31 to 60	30.5	<b>Total</b>	8315.661	235			
	More than 60	32.5						
Physical infrastructure	15 Min and less	16.1	Between Groups	647.378	2	323.689	6.121	0.002*
	From 16 to 30	15.0	Within Groups	15229.350	288	52.880		
	From 31 to 60	16.4	<b>Total</b>	15876.729	290			
	More than 60	224.5						
General Satisfaction	15 Min and less	201.5	Between Groups	12.236	2	6.118	0.991	0.373
	From 16 to 30	222.8	Within Groups	1778.884	288	6.177		
	From 31 to 60	27.8	<b>Total</b>	1791.120	290			
	More than 60	26.4						
Overall perspectives	15 Min and less	27.4	Between Groups	2837.174	2	1418.587	2.895	0.047*
	From 16 to 30	29.3	Within Groups	141126.234	288	490.022		
	From 31 to 60	29.3	<b>Total</b>	143963.409	290			
	More than 60	31.5						

As shown in Table 4.20 regarding consultation time and study domains, results shown that there was statistical significant difference between consultation time and overall perspectives. (P value 0.047). Respondents spent more than 60 minutes consultation time had high scores of perspectives while, respondents who spent (16-30), (31-60) had the same score of positive perspectives and clients who is consultation time was 15 minutes and less reported the lowest scores.

#### 4.7 The client's general views regarding the services provided at the centre

**Table 4.21: Differences in dimensions of client's perspective and client's evaluation of the center services**

Dep. Var. "Client's perspectives"	Ind. Var. "Evaluation "	Mean	Ind. Var. "Evaluation "	Sum of Squares	df	Mean Square	F	.Sig
Provider competency	Excellent	28.1	Between Groups	468.448	3	156.149	6.338	0.000*
	Very good	27.0	Within Groups	7391.434	300	24.638		
	Good	26.1	<b>Total</b>	7859.882	303			
	Acceptable	18.3						
Service provider consultation	Excellent	31.3	Between Groups	1255.099	3	418.366	26.849	0.000*
	Very good	28.5	Within Groups	4674.572	300	15.582		
	Good	26.0	<b>Total</b>	5929.671	303			
	Acceptable	20.3						
Interpersonal relations and communication	Excellent	60.1	Between Groups	1278.443	3	426.148	12.444	0.000*
	Very good	57.3	Within Groups	10273.504	300	34.245		
	Good	53.9	<b>Total</b>	11551.947	303			
	Acceptable	52.8						
Accessibility	Excellent	41.9	Between Groups	559.474	3	186.491	7.961	0.000*
	Very good	39.9	Within Groups	7027.882	300	23.426		
	Good	38.4	<b>Total</b>	7587.355	303			
	Acceptable	35.0						
Physical infrastructure	Excellent	35.3	Between Groups	1295.481	3	431.827	7.834	0.000*
	Very good	31.2	Within Groups	16535.989	300	55.120		
	Good	31.6	<b>Total</b>	17831.470	303			
	Acceptable	26.8						
General Satisfaction	Excellent	17.5	Between Groups	541.143	3	180.381	41.548	0.000*
	Very good	16.2	Within Groups	1302.459	300	4.342		
	Good	14.3	<b>Total</b>	1843.602	303			
	Acceptable	8.8						
Overall perspectives	Excellent	231.9	Between Groups	32835.428	3	10945.143	28.079	0.000*
	Very good	220.4	Within Groups	116939.911	300	389.800		
	Good	206.4	<b>Total</b>	149775.339	303			
	Acceptable	166.5						

\* Statistical significant

As shown in Table 4.21, client's evaluation of WHCJ services was categorized into five groups; excellent, very good, good, acceptable and poor. The results indicate that there were significant differences between client's evaluation and all domains (P-value 0.000) . The table indicates that, clients who evaluated the centre services as excellent reported positive scores of perspectives, while the clients who evaluated services as acceptable reported less positive perspectives. In regard to the evaluation of the centre health services provided to the study population, the study revealed that 40.5% of population perceived the centre services as excellent, 47% very good and 11.2% evaluated the services as good, 1.3% of the study population perceived the services as acceptable. This indicates that the level of satisfaction was high reported by clients at their centre visit.

**Table 4.22: Differences in dimensions of client's perspective and recommending the center services to others**

Dep. Var. "Client's perspectives"	Ind. Var. "recommending the centre to others "	Mean	Std	df	t	.Sig
Provider competency	Yes	27.2642	5.04414	302	0.898	0.370
	No	25.2000	8.01249	4.053		
Service provider consultation	Yes	29.2742	4.40161	302	1.748	0.082
	No	25.8000	4.91935	4.108		
Interpersonal relations and communication	Yes	58.0803	6.16443	302	2.051	0.041*
	No	52.4000	4.15933	4.299		
Accessibility	Yes	40.4983	4.99421	302	1.197	0.232
	No	37.8000	5.44977	4.113		
Drug and supplies availability	Yes	22.6707	5.93238	247	-1.164	0.246
	No	26.6667	2.30940	2.335		
Physical infrastructure	Yes	32.9398	7.69531	302	1.314	0.190
	No	28.4000	4.56070	4.390		
General Satisfaction	Yes	16.4716	2.41257	302	3.356	0.001*
	No	12.8000	3.27109	4.073		
Overall perspectives	Yes	223.1806	21.78728	302	2.493	0.013*
	No	198.4000	36.39780	4.048		

As shown in Table 4.22, regarding recommendation the centre to others, results shown that there was statistical significant difference between recommendation the centre to others and overall perspectives (P 0.013). Clients recommending the JWCH to other family members, friends and neighbors reported higher scores of perspectives, while the clients who will not recommend the center to others reported lower scores.

Regarding recommended the centre to others, 98.4% of the respondents will recommend the centre to family, friends and neighbors. Also, 1.6% of the respondents would not recommend the centre to others. In addition, with comparison with other health centers, 49.5% of respondents were strongly agree the centre is better than others, while 45.2% of the study population agree, and 5.3% of the respondents are disagree that the centre is better than others .

The result is congruent with a study conducted by Al Haj (2008) who assesses perception of hospitalized patients about services provided at EGH. Perspective are strongly associated with recommending the health facility to other family, friends and neighbors.

The researcher viewed that the clients were satisfied with the services; more efforts needed to enhance quality of services and increase client's satisfaction

**Table 4.23: Differences in dimensions of client's perspective and meeting client's expectation**

Dep. Var. "Client's perspectives"	Ind. Var. "met expectation "	Mean	Ind. Var. "met expectation "	Sum of Squares	df	Mean Square	F	.Sig
Provider competency	Strongly agree	28.2	Between Groups	387.122	2	193.561	7.797	0.001*
	Agree	26.2	Within Groups	7472.759	301	24.826		
	Disagree	23.8	<b>Total</b>	7859.882	303			
Service provider consultation	Strongly agree	27.5	Between Groups	1570.045	2	785.022	54.200	0.001*
	Agree	20.4	Within Groups	4359.626	301	14.484		
	Disagree	29.2	<b>Total</b>	5929.671	303			
Interpersonal relations and communication	Strongly agree	46.6	Between Groups	2201.740	2	1100.870	35.439	0.001*
	Agree	58.0	Within Groups	9350.208	301	31.064		
	Disagree	41.6	<b>Total</b>	11551.947	303			
Accessibility	Strongly agree	40.5	Between Groups	876.235	2	438.118	19.650	0.001*
	Agree	22.8	Within Groups	6711.120	301	22.296		
	Disagree	22.7	<b>Total</b>	7587.355	303			
Physical infrastructure	Strongly agree	15.3	Between Groups	954.125	2	477.062	8.508	0.001*
	Agree	10.5	Within Groups	16877.345	301	56.071		
	Disagree	16.4	<b>Total</b>	17831.470	303			
General Satisfaction	Strongly agree	172.3	Between Groups	676.761	2	338.380	87.289	0.001*
	Agree	222.8	Within Groups	1166.841	301	3.877		
	Disagree	28.2	<b>Total</b>	1843.602	303			
Overall perspectives	Strongly agree	27.5	Between Groups	44204.641	2	22102.320	63.017	0.001*
	Agree	31.1	Within Groups	105570.698	301	350.733		
	Disagree	27.0	<b>Total</b>	149775.339	303			

\* Statistical significant

As shown in Table 4.23, regarding meeting expectation of the clients, results shown that there were real difference between meeting the client's expectation and overall perspectives (P value 0.001). Clients who was agree that the centre met his expectation reported higher scores of overall perspectives, while who disagree with the centre service that it's met his expectation reported lower scores of perception.

Quantitative results shown that 53.6% of the respondents strongly agree that the service they delivered represented their expectation, while 43.8% of the study population agreed regarding expectation, and the respondents who disagree with the service delivery that it met their expectation represented 2.6%.

#### **4.8 Suggestions to improve reproductive health services quality in Jabalia Woman's Health Center**

The researcher collected descriptive data from different questions and the results shown the following.

The main focus of this study was to explore the client's perspectives toward quality of reproductive health services that provided at WHC-J. The clients were asked if their experience with the services was good. Most of respondents had strongly agreed and agreed that their experience was good, they represented (98%). This findings is consistent with the results from the advice and recommendation of the centre to family, friends and neighbors, they represented (98.4%) of study population. Also the result is consistent with the result of clients who is the centre services met their expectation in which they represented (97.4%).

On responding to the question " what did you enjoy mostly in the centre? Most of clients enjoyed good relation and communication, acceptable cost and quality service. Others were pleased because of the women team, diversity of services, awareness sessions and easy to reach the centre. Many clients were pleased with the centre services and felt that the centre is better than others; they said the centre is clean, the centre has different services for different ages, they felt comfortable when coming to the centre, they found what they needed, the team listens well, it is enough to see a smiling face, staff dealt with us as humans and other sayings.

On responding to the question " what are the obstacles that prevent the centre to provide quality services?" the women said; absence of health provider sometimes, drug unavailability is a major obstacle, unavailable of pediatrician for our children, some were displeased with working hours and need afternoon shift, many respondents were displeased with the centre area and waiting rooms area, they said it is better to widen the centre, reception is too narrow, physiotherapy hall has bad ventilation and is narrow also and a few dislike communication of some staff.

On responding to the question " what do you think the centre could do to improve the quality of services provided?

As shown in table 4.24 the women suggested major options to improve reproductive health services, they reported that, 79% of them suggested to widen the centre area, 75% suggested to provide centre with other department mainly pediatrician and orthopedist , 41% suggested to increase staff number, 35% suggested to reduce service price, 24% of the respondents suggested to trained the centre team, 13% of them suggested to reduce waiting time, 11% of them suggested to change working hours and 5% suggested other suggestions.

Table 4.24: The major women suggestions to improve reproductive health services

<b>Suggestions</b>	<b>Frequency</b>	<b>Percent %</b>
Widen the center area	243	%79
providing center with new equipment	228	%75
providing center with other departments	220	%72
Increase staff numbers	125	%41
Reduce service prices	107	%35
Train the center team members	74	%24
Reduce waiting time	41	%13
Change working hours	34	%11
Other	16	%5

## *Chapter Five*

### *Conclusions and Recommendations*

## **Chapter 5**

### **Conclusions and Recommendations**

#### **5.1 Conclusions**

Recent research considers client's perspective on the services they receive an essential part of understanding and assessing quality of care (Williams, et al., 2000). Clients' perceptions are shaped by their cultural values, previous experiences, perceptions of the role of the health system, and interactions with providers. Their perceptions affect how clients view the risks and benefits of care (Kelley, and Boucar, 2000). To provide high-quality reproductive health care, providers must understand and respect their clients' needs, attitudes, and concerns. These client perceptions are in turn affected by personal, social, and cultural factors. Research highlights the benefits of addressing client perspectives on quality of care, since it leads to improved client satisfaction, continued and sustained use of services, and improved health outcomes (Bertrand, et al. 1995; Kols, and Sherman, 1998; Vera, 1993).

The results of the literature review suggest that the most important dimensions of quality for the client are technical competence, interpersonal relations, accessibility and amenities.

This study was conducted to evaluate the quality of reproductive health services of WHCJ from client's perspectives. The study results might help in improving the quality of reproductive health services at the centre and furthermore, in GS . The study explored the main dimension of quality from client's perspectives; in addition to identifying the differences within the demographics, socio-economic and other factors with the client's perspectives. The response rate was high 88.8%. The reliability coefficient of the study was high; (0.79, 0.69, 0.77) Cronbach's Alpha and (0.79, 0.69, 0.82) using Split Half Reliability in clinic, physiotherapy and counseling services.

Over all, the results revealed that the mean age of respondents was 10.3, the highest age group was 21-30 years, which presented 38.2%. The majority had secondary school education which represented 42.1% of the study population. Meanwhile 85.5% of them were unemployed and 84.9% were married .

The overall perspectives level was reported (84.6, 83. 81.5%) in clinic, physiotherapy and counseling services respectively. Quality dimensions with RH services from client's perspectives which provided in GS were conceptualized; provider competence, service provider consultation, interpersonal relations and communication, accessibility, drug and equipment availability, physical infrastructure and general satisfaction.

The level of perspectives were different as following:

- *In clinic*: the highest level of perspectives was expressed by the clients toward interpersonal relations and communications (95.3%). The lowest level of perspectives was expressed by the clients toward physical infrastructure (51 %).
- *In physiotherapy*: the highest level of perspectives was expressed by the clients toward general satisfaction (98.3%). The lowest level of perspectives was expressed by the clients toward physical infrastructure (50 %).
- *In counseling services*: the highest level of perspectives was expressed by the clients toward interpersonal relations and communications (98.2%). The lowest level of perspectives was expressed by the clients toward provider competency (72.7 %).

Regarding service time that the health provider spent with the health provider, the results showed that the mean of spent time in clinic was 19.2, while in physiotherapy services the mean of spent time was 56.2 and in the counseling services the mean was 23.1.

Regarding consultation time, the results showed that the mean of consultation time in clinic was 13.5, while in physiotherapy services the mean of consultation time was 16.6 and in the counseling services the mean was 16.9. Respondents spent more than 60 minutes consultation time had high scores of perspectives. Respondents who spent (16-30), (31-60) had the same score of positive perspectives and clients who is consultation time was 15 minutes and less reported the lowest scores.

Regarding waiting time that the client waits from registration until receiving the service, the results showed that the mean of waiting time in clinic was 11.9, while in physiotherapy services the mean of waiting time was 7 and in the counseling services the mean was 15.3. Clients wait from 16-30 had positive perspectives and clients who wait more than 60 minutes had lowest scores of perspectives regarding services provided.

In regard to the evaluation of the centre health services provided to the study population , the study revealed that 40.5% of population perceived the centre services as excellent, 47% very good and 11.2% evaluated the services as good, 1.3% of the study population perceived the services as acceptable. This indicates that the level of satisfaction was high reported by clients at their centre visit. Also 79.4% of clients reported that the centre met their expectation. 98.4% of the respondents will recommend the centre to family, friends and neighbors. The results discussed shown that the clients were satisfied with the centre services and with the quality of the services provided.

Lastly, the study explores the important domains of quality in RH from client's perspective, these domains could be considered as a framework to establish highest level of satisfaction and quality services through application in different health facilities regularly.

## **5.2 Recommendations**

The findings of this study gave the researcher the chance to make recommendations that base on the study results, understanding and interpreting these findings. The suggestions might help the health provide, program managers and decision makers to set priorities for improving reproductive health services.

### **General Recommendations according to findings:**

- The respondents reported relatively, the least level of perspectives and satisfaction with drug and supplies availability and physical infrastructure, these could be improved by renovation of the centre, provides essential drugs that needed by beneficiaries. In addition, supporting the centre with equipment needed.
- Regarding counseling services, provider competency and service provider consultation scores low perspectives, effort needed to improve the services through:
  - On-job training.
  - Counseling courses training .
  - Regular meetings and supervision of psychosocial team.

### **Recommendations for management**

- Encourage capacity building and training for providers.
- Providing the providers with protocols and guidelines needed and trained them how to use it.
- Providing comfortable physical and psychological environment.
- Providing financial support for reproductive health services.
- Regular monitoring and evaluation.
- Facilitative supervision.
- Involving and motivating staff to create ownership and commitment to quality improvement.
- Measuring client's satisfaction should be ongoing process.

### **Recommendations for providers**

- Information on technical issues, training on technical and communication skills should be updated regularly.
- Follow guidance from service guidelines and protocols.
- Respect and recognition from co-workers, managers, clients, and community
- Meeting client's reproductive needs and keep client's rights.

### **Recommendations for clients**

- Access to all service delivery systems and health care providers.
- Express their opinions about the quality of services received
- Respect the health facility system.
- Increase their awareness about clients' rights and reproductive health.

### **Further Research Attention**

- Women's perspectives about reproductive health services in private, UNRWA and MOH clinics.
- Evaluation of quality of reproductive health services from providers' perspectives.
- Study concerned with the relationship between socio-economical status and the client's perspective toward health services in more stable political situation.
- In – depth interview and focus groups are needed in other studies to fully understand client's perspective.

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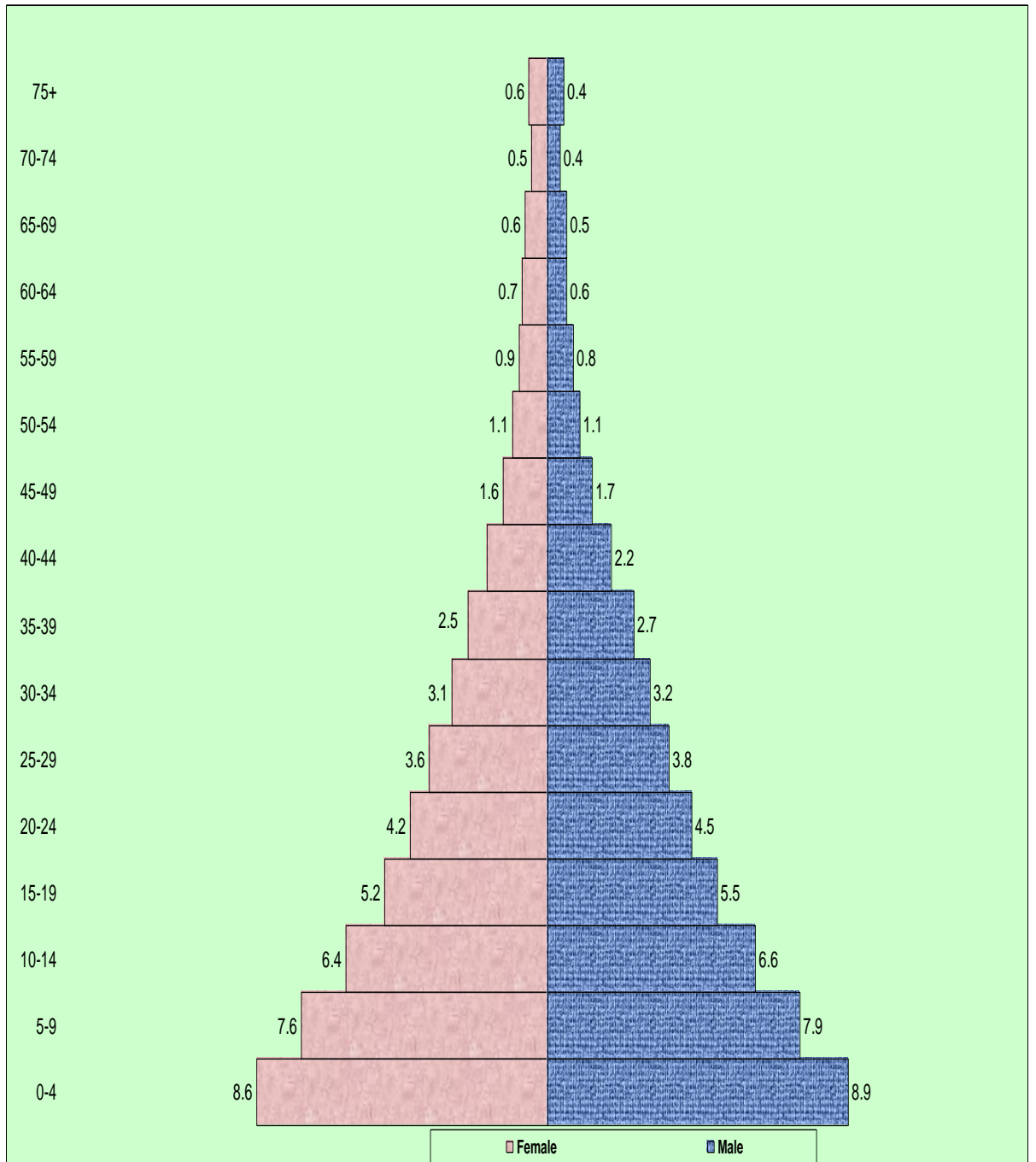
# *Annexes*

## Annex (1) Map of Palestine



Source: MOH, 1999a







## Annex ( 4 ) summary of dimensions of quality of health care from client's perspectives

### Dimensions of quality of health care from client perception

No. of study	Aim of study	Dimensions	Reference
1	Definition of quality/technical quality of care, non technical aspects	Waiting time, staff attitude, infrastructure, access, management, privacy	Population Report (1998)
2	Factors affecting quality of health care- patient perception of cumulative satisfaction in Egypt and Jordan	Atmosphere interaction, quality of object, process and infrastructure	Zineldin (2003)
3	Measuring family planning services quality through client satisfaction exit interviews	Waiting time, distance of reaching, price of services	William, et. al. ( (2000)
4	Multiple perspectives on quality in women health care	Interpersonal aspect of care, how well were treated, responsiveness of provider	Jaynelle, and Marianne, (2001 )
5	Delivery of improved services-client perspectives: what is quality health care services	1- technical competence: performance of service, provider competence and consultation 2- interpersonal relations: welcome, confidential, pay attention, effective listening, communication skills 3- accessibility: waiting time, cost, availability of provider 4- amenities: infrastructure, equipment supplies, drug available	Brawley,(2000)
6	Toward patient - centered health services in India- a scale to measure patient perceptions of quality	Medicine availability, medical information, staff behavior, provider behavior. hospital Infrastructure	Rao , Peters, and Roche, (2006)
7	Client satisfaction and quality of health care in Rural Bangladesh	Provider behavior, reduction in waiting time, consultation time, efficacy of medical treatment	Aldana,Piechulek, and Al-Sabir, (2001)
8	The Client's view of high-quality care in	Cleanliness, service availability, time,	Vera, (1993)

9	Santiago, Chile Assessing quality of health care in Bolivia	learning opportunity, cordial treatment Access, technical management, interpersonal relations and continuity	Bender, and Santander, (1999)
10	a assessment the quality of reproductive health services in Egypt	Waiting time, furnishings, cleanliness, consultation time, working hours and social environment.	Zakey, et. al.,2007
11	Quality of STDs care in south Africa	Interpersonal relations, confidentiality and technical competence	Oskowitz, Schneidero, Hiatshwango, 1997
12	Influence of quality of care on contraceptive behavior in Bangladesh	Trust relationship, welcoming, accepted standard of care and views of services	Koenig, Hossain, and Hossain, 1997
13	Analysis of literature review, dimensions of quality	Technical performance, access, effective of care, efficiency of service choice, interpersonal relationships, continuity of service, infrastructure and safety	Quality Assurance Project, 2007

## Annex (5) The sample size by using Epi-info program

### Population Survey or Descriptive Study Using Random (Not Cluster) Sampling

Population size	:	5000
Expected Frequency	:	60.00%
Worst Acceptance	:	55.00%
<u>Confidence Level</u>		<u>Sample Size</u>
80%		154
90%		249
<b>95%</b>		<b>342</b>
99%		576
99.9%		886
99.99%		1.170

Change value of Population, Frequency, or Worst Acceptance to recalculate

## Annex (6) WHC-J Annual 2007

تقرير

من شهر يناير - ديسمبر/2007م

القانونية		النفسية		الاجتماعية		العلاج الطبيعي		العيادة		الخدمة
متكرر	جديد	متكرر	جديد	متكرر	جديد	متكرر	جديد	متكرر	جديد	
2	1	13	5	37	11	81	30	150	29	يناير
5	1	8	4	22	19	100	36	212	45	فبراير
1	4	14	9	22	8	115	41	170	33	مارس
6	1	10	4	17	8	100	46	126	27	أبريل
4	1	1	1	18	3	125	35	150	22	مايو
2	6	5	5	11	6	131	43	140	27	يونيو
2	3	12	4	16	3	170	55	213	31	يوليو
3	5	13	11	33	14	100	40	194	37	أغسطس
5	2	17	18	55	32	111	30	167	42	سبتمبر
3	7	25	10	29	12	77	35	189	32	أكتوبر
10	4	22	10	15	9	99	33	180	44	نوفمبر
12	5	27	13	35	5	95	22	166	28	ديسمبر
<b>55</b>	<b>40</b>	<b>167</b>	<b>94</b>	<b>310</b>	<b>130</b>	<b>1304</b>	<b>446</b>	<b>2057</b>	<b>397</b>	<b>الاجمالي</b>
<b>95</b>		<b>261</b>		<b>440</b>		<b>1750</b>		<b>2454</b>		<b>الاجمالي</b>

## Annex (7) Distribution of proportional sample

### Distribution of proportional sample

Sample proportion for each service

<b>Service</b>	<b>Pop.</b>	<b>% of total</b>	<b>sample</b>
Clinical services	2454	48	167
Physiotherapy services	1750	34	118
Social counseling	440	9	30
Psychological counseling	261	5	18
Legal counseling	95	4	9
<b>Total</b>	<b>5000</b>	<b>100</b>	<b>342</b>

## Annex (8) Interview Questionnaire

رقم الاستبانة: .....  
نتيجة المقابلة 1 اكتملت 2 أجلت 3 رفض 4 اكتملت بشكل جزئي سبب الرفض.....

### 1- معلومات عامة عن الزيارة

الرجاء وضع دائرة للجواب الذي تختاره:

\*\*هل تم مقابلتك بخصوص تقييم جودة الخدمات المقدمة من قبل أحد العاملين؟ 1 نعم 2 لا

1. هل هذه أول زيارة لك للمركز؟

نعم (جديدة) 2- لا (متكررة)

2. ما السبب وراء اختيارك المركز؟ (يمكن اختيار أكثر من جواب)

1 سهولة الوصول إليه 2 التكلفة مقبولة 3 خدمة أفضل  
4 فريق العمل مختص في المجال 5 يوجد علاقات شخصية مع الطاقم 6 سمعة جيدة  
7 تنوع الخدمات 8 أخرى حديدي.....

3. كيف عرفت عن الخدمات التي يقدمها المركز؟ (يمكن اختيار أكثر من جواب)

1 طاقم المركز 2 الصحف والمجلات 3 الأصدقاء والجيران 4 زيارات منزلية

5 مراكز أخرى 6- أخرى/حديدي \_\_\_\_\_

4. ما الخدمة التي تلقيتها اليوم؟

1 خدمات العيادة 2 خدمات قسم العلاج الطبيعي 3 إرشاد نفسي 4 إرشاد اجتماعي 5 إرشاد قانوني  
5 هل تعرفي جميع الخدمات التي يقدمها المركز؟

1 نعم 2 لا

6 هل يوجد لوحة/قائمة توضح الخدمات التي يقدمها المركز

1 نعم 2 لا 3 غير متأكد

7 تم شرح معلومات وافية لك عن جميع الخدمات المتوفرة في المركز

1. أوافق بشكل كبير 2. أوافق بشكل متوسط 3. لا أوافق

8 هل تم تزويدك بنشرة تعريفية عن المركز (بروشور)؟ 1. نعم 2. لا

9 كم من الوقت بالدقيقة تحتاجين للوصول إلى المركز؟.....

10 كم من الوقت بالدقيقة تحتاجين للرجوع إلى البيت؟.....

11 ما هي وسيلة المواصلات الرئيسية التي تستخدمها للوصول إلى المركز؟

1. مشياً على الأقدام 2. سيارة 3. باص 4. أخرى/حديدي \_\_\_\_\_

## خدمات العيادة:

م	البند	غير موافق بشدة	غير موافق	غير متأكد	موافق	موافق بشدة
	<b>كفاءة مقدم الخدمة</b>					
12.	قام مقدم الخدمة بتقديم تعريف نفسه لك					
13.	تم توضيح حالتك الصحية من قبل مقدم الخدمة					
14.	تم تقديم الفحوصات اللازمة بشكل صحيح					
15.	تم شرح الإرشادات اللازمة فيما يتعلق بالعلاج					
16.	تم إعطاءك الإرشادات الملائمة للتعامل مع المشكلة الصحية التي تعاني منها					
17.	تمت مشاركتك في خطة العلاج					
18.	تفهم مقدم الخدمة احتياجاتك الصحية					
19.	تم تحويلك لقسم آخر لاستكمال الخدمة					
20.	كم من الوقت قضيت مع مقدم الخدمة لتلقي الخدمة بالديقة؟ .....					
	<b>المشورة</b>					
21.	كم كانت مدة المشورة المقدمة لك؟ .....					
22.	وقت المشورة الذي قدم لك من قبل مقدم الخدمة كاف					
23.	المشورة التي قدمت لك كانت جيدة					
24.	تم إعطاؤك فرصة للاستفسار عن مشكلتك					
25.	طريقة طرح الأسئلة خلال وقت المشورة كانت مريحة					
26.	اهتم مقدم الخدمة بالأسئلة التي توجهيها فيما يخص حالتك					
27.	شجعك مقدم الخدمة على العودة لتلقي الخدمة مرة أخرى					
28.	موعد المراجعة كان مناسباً					
	<b>العلاقات والاتصال</b>					
29.	قام مقدم الخدمة بالترحيب بك					
30.	كان استقبال مقدم الخدمة لك أثناء الزيارة مهذب					
31.	يصغي مقدم الخدمة لك أثناء تقديم الخدمة					
32.	يتوفر ستائر/غرف خاصة للمحافظة على الخصوصية					
33.	تم إغلاق باب الغرفة للحفاظ على الخصوصية					
34.	شعرت بمراعاة خصوصيتك من قبل مقدم الخدمة					
35.	شعرت أن المعلومات التي تزودي بها مقدم الخدمة سيتم التعامل معها بسرية					
36.	أثناء تلقي الخدمة شعرت بالاحترام من قبل مقدم الخدمة					
37.	أثناء تلقي الخدمة شعرت بالاهتمام من قبل مقدم الخدمة					
38.	اللغة التي يتم مخاطبتك بها واضحة					
39.	كان مقدم الخدمة مشغول بما حوله من أشياء					
40.	توفر جو من الثقة عند تلقي الخدمة					

41. تواجهي صعوبة في التواصل مع مقدمي الخدمة  
42. يميز مقدمي الخدمات في المعاملة بين منتفع وآخر

#### سهولة الوصول

43. من السهل الوصول للمركز  
44. أتيت إلى المركز و لم تجدي مقدم الخدمة  
45. تم تأجيل موعدك رغم وجود مقدم الخدمة  
46. تكلفة الخدمات المقدمة لك مناسبة  
47. يوجد التزام لدى مقدمي الخدمات بالمواعيد المحددة  
48. بشكل عام نظام الحصول على الخدمة داخل المركز سهل  
49. كم انتظرت منذ وصولك إلى المركز إلى أن حصلت على الخدمة؟..... دقيقة  
50. برأيك وقت الانتظار معقول  
51. عانيت من مشكلة طول وقت الانتظار  
52. ماذا تفعلين عادة خلال فترة انتظارك لتلقي الخدمة؟  
1 التحادث مع النساء اللواتي ينتظرن الخدمة 2 مشاهدة الفيديو 3 تلقي إرشاد من مقدمي الخدمة 4 قراءة نشرة صحية  
5 أخرى / حدي \_\_\_\_\_  
53. ساعات دوام المركز مناسبة بالنسبة إليك  
54. موقع المركز مناسب بالنسبة إليك

#### توفر العلاج والمستلزمات

55. المستلزمات و الأجهزة اللازمة لتقديم الخدمة متوفرة  
56. صادف وان تعطل الجهاز أثناء تقديم الخدمة  
57. العلاج في صيدلة المركز متوفر  
58. تجرى لك الفحوصات اللازمة في موعدها  
59. تتوفر جميع الفحوصات التي تحتاجها  
60. حصلت على النتائج في الموعد المحدد  
61. واجهتك مشكلة عدم توفر جهاز الفحص

#### تجهيزات المركز

62. مساحة المركز بالنسبة لعدد المنتفعات مناسبة  
63. المساحة المخصصة لنوعية الخدمات مناسبة  
64. المساحة المخصصة للانتظار في المركز مناسبة  
65. يتوفر كراسي للجلوس أثناء الانتظار  
66. مستوى النظافة في المركز ممتازة  
67. يتوفر الماء داخل المركز  
68. تتوفر الكهرباء بشكل دائم  
69. تتوفر في المركز وسائل التثقيف الصحي للقراءة

#### الرضا العام

70. الخدمة التي حصلت عليها كانت متكاملة  
71. الخدمة المقدمة لك ساهمت في حل مشكلتك  
72. الخدمة التي حصلت عليها مرضية

73. أداء مقدم الخدمة بشكل عام جيد

74 . تتصحين من تعينك (قريبائك، صديقاتك ..) بالحصول على خدمات المركز

1 نعم 2 لا

75 بالمقارنة مع مؤسسات صحية أخرى في المنطقة تقيمي جودة الخدمة في المركز بأنها أفضل

1 أوافق بدرجة كبيرة 2 أوافق بدرجة متوسطة 3 لا أوافق

76 الخدمة التي تلقيتها فعلا تمثل توقعاتك

1 أوافق بدرجة كبيرة 2 أوافق بدرجة متوسطة 3 لا أوافق

77 تجربتي جيدة بالنسبة للخدمة المقدمة لي

1 أوافق بدرجة كبيرة 2 أوافق بدرجة متوسطة 3 لا أوافق

78 ترغيبين بالحضور إلى المركز للمتابعة

1 بشكل منتظم 2 عند الضرورة 3 لا اشعر بضرورة المتابعة

79 بشكل عام تقيمين الخدمة التي تلقيتها في المركز مرضية

( ) ممتازة ( ) جيدة جدا ( ) جيدة ( ) مقبولة ( ) سيئة

80 ما هي المعوقات التي تقلل من جودة الخدمة المقدمة في هذا المركز؟

1.....  
2.....  
3.....

81 ما هي أكثر الأشياء التي أعجبتك في المركز؟

1.....  
2.....  
3.....

82 ما هي اقتراحاتك لديك لتحسين جودة الخدمة المقدمة في هذا المركز

( ) تخفيض تكلفة الخدمة

( ) توسيع المكان

( ) زيادة عدد الطاقم

( ) تدريب الطاقم

( ) تغيير ساعات الدوام

( ) تقليل وقت الانتظار

( ) تزويد المركز بأقسام أخرى

( ) تزويد المركز بالأجهزة الحديثة

( ) أخرى حدددي.....

معلومات شخصية:

الرجاء وضع إشارة (√) في المكان الذي يناسبك:

1. كم عمرك : \_\_\_\_\_ سنة

2. مستوى التعليم؟

( ) أمي ( ) الابتدائية ( ) الإعدادية ( ) الثانوية  
دبلوم متوسط ( ) جامعه ( ) دراسات عليا ( )

3. الحالة الاجتماعية: ( ) عزباء ( ) متزوجة ( ) غير ذلك

4. هل تعملين؟ ( ) أعمل ( ) لا أعمل

إذا كنت تعملين، ماذا تعملين؟.....

5. ما هو معدل الدخل الشهري للعائلة من جميع المصادر؟.....

6. هل لديك أي تأمين صحي؟ ( ) نعم ( ) لا

7. المسكن الذي تعيشين فيه هو:

( ) ملك ( ) بالإيجار ( ) أخرى (حددي) \_\_\_\_\_

8. نوع الأسرة التي تعيشين فيها : ( ) نووية ( ) ممتدة

9. البيت الذي تسكنين فيه ( ) قريب من المركز ( ) بعيد عن المركز

شكرا لتعاونك معنا

نتيجة المقابلة 1 اكتملت 2 أجلت 3 رفضت 4 اكتملت بشكل جزئي سبب الرفض.....

### 1- معلومات عامة عن الزيارة

الرجاء وضع دائرة للجواب الذي تختاره:

\*\*هل تم مقابلتك بخصوص تقييم جودة الخدمات المقدمة من قبل أحد العاملين؟ 1 نعم 2 لا

1. هل هذه أول زيارة لك للمركز؟

نعم (جديدة) 2- لا (متردة)

2. ما السبب وراء اختيارك المركز؟ (يمكن اختيار أكثر من جواب)

- 1 سهولة الوصول إليه 2 التكلفة مقبولة 3 خدمة أفضل  
4 فريق العمل مختص في المجال 5 يوجد علاقات شخصية مع الطاقم 6 سمعة جيدة  
7 تنوع الخدمات 8 أخرى حددى.....

3. كيف عرفت عن الخدمات التي يقدمها المركز؟ (يمكن اختيار أكثر من جواب)

1 طاقم المركز 2 الصحف والمجلات 3 الأصدقاء والجيران 4 زيارات منزلية

5 مراكز أخرى 6- أخرى/حددى \_\_\_\_\_

4. ما الخدمة التي تلقيتها اليوم؟

1 خدمات العيادة 2 خدمات قسم العلاج الطبيعي 3 إرشاد نفسي 4 إرشاد اجتماعي 5 إرشاد قانوني

5 هل تعرفي جميع الخدمات التي يقدمها المركز؟

1 نعم 2 لا

6 هل يوجد لوحة/قائمة توضح الخدمات التي يقدمها المركز

1 نعم 2 لا 3 غير متأكد

7 تم شرح معلومات وافية لك عن جميع الخدمات المتوفرة في المركز

1. أوافق بشكل كبير 2. أوافق بشكل متوسط 3. لا أوافق

8 هل تم تزويدك بنشرة تعريفية عن المركز (بروشور)؟ 1. نعم 2. لا

9 كم من الوقت بالدقيقة تحتاجين للوصول إلى المركز؟.....

10 كم من الوقت بالدقيقة تحتاجين للرجوع إلى البيت؟.....

11 ما هي وسيلة المواصلات الرئيسية التي تستخدمها للوصول إلى المركز؟

1. مشياً على الأقدام 2. سيارة 3. باص 4. أخرى/حددى \_\_\_\_\_

## خدمات العلاج الطبيعي:

م	البند	غير موافق بشدة	غير موافق	غير متأكد	موافق	موافق بشدة
	<b>كفاءة مقدم الخدمة</b>					
74.	قام مقدم الخدمة بتقديم تعريف نفسه لك					
75.	تم توضيح حالتك الصحية من قبل مقدم الخدمة					
76.	تم إعطائك الإرشادات الملائمة للتعامل مع المشكلة الصحية التي تعاني منها					
77.	تمت مشاركتك في خطة العلاج					
78.	تم تحويلك لقسم آخر لاستكمال الخدمة					
79.	تفهم مقدم الخدمة احتياجاتك					
80.	كم من الوقت قضيت مع مقدم الخدمة لتلقي الخدمة بالديققة؟ .....					
	<b>المشورة</b>					
81.	كم كانت مدة المشورة المقدمة لك؟ .....					
82.	وقت المشورة الذي قدم لك من قبل مقدم الخدمة كاف					
83.	المشورة التي قدمت لك كانت جيدة					
84.	تم إعطاؤك فرصة للاستفسار عن مشكلتك					
85.	طريقة طرح الأسئلة خلال وقت المشورة كانت مريحة					
86.	اهتم مقدم الخدمة بالأسئلة التي توجهيها فيما يخص حالتك					
87.	شجعك مقدم الخدمة على العودة لتلقي الخدمة مرة أخرى					
88.	موعد المراجعة كان مناسباً					
	<b>العلاقات والاتصال</b>					
89.	قام مقدم الخدمة بالترحيب بك					
90.	كان استقبال مقدم الخدمة لك أثناء الزيارة مهذب					
91.	يصغي مقدم الخدمة لك أثناء تقديم الخدمة					
92.	يتوفر ستائر/غرف خاصة للمحافظة على الخصوصية					
93.	تم إغلاق باب الغرفة للحفاظ على الخصوصية					
94.	شعرت بمراعاة لخصوصيتك من قبل مقدم الخدمة					
95.	شعرت أن المعلومات التي تزودي بها مقدم الخدمة سيتم التعامل معها بسرية					
96.	أثناء تلقي الخدمة شعرت بالاحترام من قبل مقدم الخدمة					
97.	أثناء تلقي الخدمة شعرت بالاهتمام من قبل مقدم الخدمة					
98.	اللغة التي يتم مخاطبتك بها واضحة					
99.	كان مقدم الخدمة مشغول بما حوله من أشياء					
100.	توفر جو من الثقة عند تلقي الخدمة					
101.	تواجهي صعوبة في التواصل مع مقدمي الخدمة					
	<b>سهولة الوصول</b>					
102.	من السهل الوصول للمركز					

103. أتيت إلى المركز و لم تجدي مقدم الخدمة  
 104. تم تأجيل موعدك رغم وجود مقدم الخدمة  
 105. تكلفة الخدمات المقدمة لك مناسبة  
 106. يوجد التزام لدى مقدمي الخدمات بالمواعيد المحددة  
 107. بشكل عام نظام الحصول على الخدمة داخل المركز سهل  
 108. كم انتظرت منذ وصولك إلى المركز إلى أن حصلت على الخدمة؟..... دقيقة  
 109. برأيك وقت الانتظار معقول  
 110. عانيت من مشكلة طول وقت الانتظار  
 111. ماذا تفعلين عادة خلال فترة انتظارك لتلقي الخدمة؟

1 التحدث مع النساء اللواتي ينتظرن الخدمة 2 مشاهدة الفيديو 3 تلقي إرشاد من مقدمي الخدمة 4 قراءة نشرة صحية  
 5 أخرى / حدي \_\_\_\_\_

112. ساعات دوام المركز مناسبة بالنسبة إليك  
 113. موقع المركز مناسب بالنسبة إليك

#### توفر العلاج والمستلزمات

- 52 برأيك الأجهزة كافية لتقديم الخدمة  
 53 الأجهزة قديمة مما يقلل من كفاءتها  
 114. المستلزمات و الأجهزة اللازمة لتقديم الخدمة متوفرة  
 115. صادف وان تعطل الجهاز أثناء تقديم الخدمة  
 116. واجهتك مشكلة عدم توفر جهاز ما لتقديم الخدمة

#### تجهيزات المركز

- 54 التهوية داخل الصالة جيدة  
 56 يوجد نشرات تثقيفية داخل الصالة  
 57 مساحة القسم غير كافية  
 58 عدد المترددين على القسم لا يتناسب مع عدد الأخصائيين  
 59 عدد المترددين على القسم لا يتناسب مع مساحة صالة الرياضة  
 117. مساحة المركز بالنسبة لعدد المنتفعات مناسبة  
 118. المساحة المخصصة لنوعية الخدمات مناسبة  
 119. المساحة المخصصة للانتظار في المركز مناسبة  
 120. يتوفر كراسي للجلوس أثناء الانتظار  
 121. مستوى النظافة في المركز ممتازة  
 122. يتوفر الماء داخل المركز  
 123. تتوفر الكهرباء بشكل دائم

#### الرضا العام

124. الخدمة التي حصلت عليها كانت متكاملة  
 125. الخدمة المقدمة لك ساهمت في حل مشكلتك  
 126. الخدمة التي حصلت عليها مرضية  
 127. أداء مقدم الخدمة بشكل عام جيد

66 . تنصحين من تعيينك (قريبائك، صديقاتك ..) بالحصول على خدمات المركز

1 نعم 2 لا

67 بالمقارنة مع مؤسسات صحية أخرى في المنطقة تقيمي جودة الخدمة في المركز بأنها أفضل

1 أوافق بدرجة كبيرة 2 أوافق بدرجة متوسطة 3 لا أوافق

68 الخدمة التي تلقيتها فعلا تمثل توقعاتك

1 أوافق بدرجة كبيرة 2 أوافق بدرجة متوسطة 3 لا أوافق

69 تجربتي جيدة بالنسبة للخدمة المقدمة لي

1 أوافق بدرجة كبيرة 2 أوافق بدرجة متوسطة 3 لا أوافق

70 ترغيبين بالحضور إلى المركز للمتابعة

1 بشكل منتظم 2 عند الضرورة 3 لا اشعر بضرورة المتابعة

71 بشكل عام تقيمين الخدمة التي تلقيتها في المركز مرضية

( ) ممتازة ( ) جيدة جدا ( ) جيدة ( ) مقبولة ( ) سيئة

72 ما هي المعوقات التي تقلل من جودة الخدمة المقدمة في هذا المركز؟

1.....

2.....

3.....

73 ما هي أكثر الأشياء التي أعجبتك في المركز؟

1.....

2.....

3.....

74 ما هي اقتراحاتك لديك لتحسين جودة الخدمة المقدمة في هذا المركز

( ) تخفيض تكلفة الخدمة

( ) توسيع المكان

( ) زيادة عدد الطاقم

( ) تدريب الطاقم

( ) تغيير ساعات الدوام

( ) تقليل وقت الانتظار

( ) تزويد المركز بأقسام أخرى

( ) تزويد المركز بالأجهزة الحديثة

( ) أخرى حددى.....

معلومات شخصية:

الرجاء وضع إشارة (√) في المكان الذي يناسبك:

1. كم عمرك : \_\_\_\_\_ سنة

2. مستوى التعليم؟

( ) أمي ( ) الابتدائية ( ) الإعدادية ( ) الثانوية

( ) دبلوم متوسط ( ) جامعه فأعلى

3. الحالة الاجتماعية: ( ) عزباء ( ) متزوجة ( ) غير ذلك

4. هل تعملين؟ ( ) أعمل ( ) لا أعمل

إذا كنت تعملين، ماذا تعملين؟.....

5. ما هو معدل الدخل الشهري للعائلة من جميع المصادر؟.....

6. هل لديك أي تأمين صحي؟ ( ) نعم ( ) لا

7. المسكن الذي تعيشين فيه هو:

( ) ملك ( ) بالإيجار ( ) أخرى (حددي) \_\_\_\_\_

8. نوع الأسرة التي تعيشين فيها : ( ) نووية ( ) ممتدة

9. البيت الذي تسكنين فيه ( ) قريب من المركز ( ) بعيد عن المركز

شكرا لتعاونك معنا

رقم الاستبانة: .....

نتيجة المقابلة 1 اكتملت 2 أجل 3 رفضت 4 اكتملت بشكل جزئي سبب الرفض.....

### 1- معلومات عامة عن الزيارة

الرجاء وضع دائرة للجواب الذي تختاره:

\*\*هل تم مقابلتك بخصوص تقييم جودة الخدمات المقدمة من قبل أحد العاملين؟ 1 نعم 2 لا

1. هل هذه أول زيارة لك للمركز؟

نعم (جديدة) 2- لا (متكررة)

2. ما السبب وراء اختيارك المركز؟ (يمكن اختيار أكثر من جواب)

1 سهولة الوصول إليه 2 التكلفة مقبولة 3 خدمة أفضل

4 فريق العمل مختص في المجال 5 يوجد علاقات شخصية مع الطاقم 6 سمعة جيدة

7 تنوع الخدمات 8 أخرى حددى.....

3. كيف عرفت عن الخدمات التي يقدمها المركز؟ (يمكن اختيار أكثر من جواب)

1 طاقم المركز 2 الصحف والمجلات 3 الأصدقاء والجيران 4 زيارات منزلية

5 مراكز أخرى 6- أخرى/حددى \_\_\_\_\_

4. ما الخدمة التي تلقيتها اليوم؟

1 خدمات العيادة 2 خدمات قسم العلاج الطبيعي 3 إرشاد نفسي 4 إرشاد اجتماعي 5 إرشاد قانوني

5 هل تعرفي جميع الخدمات التي يقدمها المركز؟

1 نعم 2 لا

6 هل يوجد لوحة/قائمة توضح الخدمات التي يقدمها المركز

1 نعم 2 لا 3 غير متأكد

7 تم شرح معلومات وافية لك عن جميع الخدمات المتوفرة في المركز

1. أوافق بشكل كبير 2. أوافق بشكل متوسط 3. لا أوافق

8 هل تم تزويدك بنشرة تعريفية عن المركز (بروشور)؟ 1. نعم 2. لا

9 كم من الوقت بالدقيقة تحتاجين للوصول إلى المركز؟.....

10 كم من الوقت بالدقيقة تحتاجين للرجوع إلى البيت؟.....

11 ما هي وسيلة المواصلات الرئيسية التي تستخدمها للوصول إلى المركز؟

1. مشياً على الأقدام 2. سيارة 3. باص 4. أخرى/حددى \_\_\_\_\_

## خدمات الإرشاد:

م	البند	غير موافق بشدة	غير موافق	غير متأكد	موافق	موافق بشدة
	<b>كفاءة مقدم الخدمة</b>					
128.	قام مقدم الخدمة بتقديم تعريف نفسه لك					
129.	تم توضيح مشكلتك من قبل مقدم الخدمة					
130.	تم إعطائك الإرشادات الملائمة للتعامل مع المشكلة الصحية التي تعاني منها					
131.	تمت مشاركتك في خطة العلاج					
132.	تفهم مقدم الخدمة احتياجاتك الصحية					
133.	تم تحويلك لقسم آخر لاستكمال الخدمة					
134.	كم من الوقت قضيت مع مقدم الخدمة لتلقي الخدمة بالديققة؟ .....					
	<b>المشورة</b>					
135.	كم كانت مدة المشورة المقدمة لك؟ .....					
136.	وقت المشورة الذي قدم لك من قبل مقدم الخدمة كاف					
137.	المشورة التي قدمت لك كانت جيدة					
138.	تم إعطاؤك فرصة للاستفسار عن مشكلتك					
139.	طريقة طرح الأسئلة خلال وقت المشورة كانت مريحة					
140.	اهتم مقدم الخدمة بالأسئلة التي توجهيها فيما يخص حالتك					
141.	شجعك مقدم الخدمة على العودة لتلقي الخدمة مرة أخرى					
142.	موعد المراجعة كان مناسباً					
	<b>العلاقات والاتصال</b>					
143.	قام مقدم الخدمة بالترحيب بك					
144.	كان استقبال مقدم الخدمة لك أثناء الزيارة مهذب					
145.	يصغي مقدم الخدمة لك أثناء تقديم الخدمة					
146.	يتوفر سناثر/غرف خاصة للمحافظة على الخصوصية					
147.	تم إغلاق باب الغرفة للحفاظ على الخصوصية					
148.	شعرت بمراعاة لخصوصيتك من قبل مقدم الخدمة					
149.	شعرت أن المعلومات التي تزودي بها مقدم الخدمة سيتم التعامل معها بسرية					
150.	أثناء تلقي الخدمة شعرت بالاحترام من قبل مقدم الخدمة					
151.	أثناء تلقي الخدمة شعرت بالاهتمام من قبل مقدم الخدمة					
152.	اللغة التي يتم مخاطبتك بها واضحة					
153.	كان مقدم الخدمة مشغول بما حوله من أشياء					
154.	توفر جو من الثقة عند تلقي الخدمة					
155.	تواجهي صعوبة في التواصل مع مقدمي الخدمة					
156.	يتميز مقدمي الخدمات في المعاملة بين منتفع وآخر					

## سهولة الوصول

157. من السهل الوصول للمركز
158. أتيت إلى المركز و لم تجدي مقدم الخدمة
159. تم تأجيل موعدك رغم وجود مقدم الخدمة
160. تكلفة الخدمات المقدمة لك مناسبة
161. يوجد التزام لدى مقدمي الخدمات بالمواعيد المحددة
162. بشكل عام نظام الحصول على الخدمة داخل المركز سهل
163. كم انتظرت منذ وصولك إلى المركز إلى أن حصلت على الخدمة؟..... دقيقة
164. برأيك وقت الانتظار معقول
165. عانيت من مشكلة طول وقت الانتظار
166. ماذا تفعلين عادة خلال فترة انتظارك لتلقي الخدمة؟

1 التحدث مع النساء اللواتي ينتظرن الخدمة 2 مشاهدة الفيديو 3 تلقي إرشاد من مقدمي الخدمة 4 قراءة نشرة صحية

5 أخرى / حدي \_\_\_\_\_

167. ساعات دوام المركز مناسبة بالنسبة إليك

168. موقع المركز مناسب بالنسبة إليك

## تجهيزات المركز

169. مساحة المركز بالنسبة لعدد المنتفعات مناسبة
170. المساحة المخصصة لنوعية الخدمات مناسبة
171. المساحة المخصصة للانتظار في المركز مناسبة
172. يتوفر كراسي للجلوس أثناء الانتظار
173. مستوى النظافة في المركز ممتازة
174. يتوفر الماء داخل المركز
175. تتوفر الكهرباء بشكل دائم
176. تتوفر في المركز وسائل التعقيم الصحي للقراءة

## الرضا العام

177. الخدمة التي حصلت عليها كانت متكاملة
178. الخدمة المقدمة لك ساهمت في حل مشكلتك
179. الخدمة التي حصلت عليها مرضية
180. أداء مقدم الخدمة بشكل عام جيد

65 . تنصحين من تعينك (قريبائك، صديقاتك ..) بالحصول على خدمات المركز

1 نعم 2 لا

66 بالمقارنة مع مؤسسات صحية أخرى في المنطقة تقيمي جودة الخدمة في المركز بأنها أفضل

1 أوافق بدرجة كبيرة 2 أوافق بدرجة متوسطة 3 لا أوافق

67 الخدمة التي تلقيتها فعلا تمثل توقعاتك

1 أوافق بدرجة كبيرة 2 أوافق بدرجة متوسطة 3 لا أوافق

69 تجربتي جيدة بالنسبة للخدمة المقدمة لي

1 أوافق بدرجة كبيرة 2 أوافق بدرجة متوسطة 3 لا أوافق

70 ترغبن بالحضور إلى المركز للمتابعة

1 بشكل منتظم 2 عند الضرورة 3 لا اشعر بضرورة المتابعة

71 بشكل عام تقيمين الخدمة التي تلقيتها في المركز مرضية

( ) ممتازة ( ) جيدة جدا ( ) جيدة ( ) مقبولة ( ) سيئة

72 ما هي المعوقات التي تقلل من جودة الخدمة المقدمة في هذا المركز؟

1.....  
2.....  
3.....

73 ما هي أكثر الأشياء التي أعجبتك في المركز؟

1.....  
2.....  
3.....

74 ما هي اقتراحاتك لديك لتحسين جودة الخدمة المقدمة في هذا المركز

( ) تخفيض تكلفة الخدمة

( ) توسيع المكان

( ) زيادة عدد الطاقم

( ) تدريب الطاقم

( ) تغيير ساعات الدوام

( ) تقليل وقت الانتظار

( ) تزويد المركز بأقسام أخرى

( ) تزويد المركز بالأجهزة الحديثة

( ) أخرى حددى.....

معلومات شخصية:

الرجاء وضع إشارة (√) في المكان الذي يناسبك:

1. كم عمرك : \_\_\_\_\_ سنة

2. مستوى التعليم؟

( ) أمي ( ) الابتدائية ( ) الإعدادية ( ) الثانوية  
دبلوم متوسط ( ) جامعه ( ) دراسات عليا ( )

3. الحالة الاجتماعية: ( ) عزباء ( ) متزوجة ( ) غير ذلك

4. هل تعملين؟ ( ) أعمل ( ) لا أعمل

إذا كنت تعملين، ماذا تعملين؟.....

5. ما هو معدل الدخل الشهري للعائلة من جميع المصادر؟.....

6. هل لديك أي تأمين صحي؟ ( ) نعم ( ) لا

7. المسكن الذي تعيشين فيه هو:

( ) ملك ( ) بالإيجار ( ) أخرى (حددي) \_\_\_\_\_

8. نوع الأسرة التي تعيشين فيها : ( ) نووية ( ) ممتدة

9. البيت الذي تسكنين فيه ( ) قريب من المركز ( ) بعيد عن المركز

شكرا لتعاونك معنا

## Annex (9) Helsinki Committee Approval Letter

Palestinian National Authority  
Ministry of Health  
Helsinki Committee



السلطة الوطنية الفلسطينية  
وزارة الصحة  
لجنة هلسنكي

Date: 5 / 9 / 2006

التاريخ: 2006/ 9/ 5

Mr./ Mariam Shaqura

السيد: مريم شقورة

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

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم

حول:-

Evaluation of the quality of Reproductive  
Health Services in Jabalia Woman's Health  
Center : Client's Perspective.

In its meeting on September 2006  
and decided the Following:-

و ذلك في جلستها المنعقدة لشهر سبتمبر 2006  
و قد قررت ما يلي:-

To approve the above mention research study.

الموافقة على البحث المذكور عاليه.

Signature

توقيع



Member  
عضو

Member  
عضو

Chairperson  
رئيس

Conditions:-

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

Gaza Etwam – Telefax 972-7-2878166

Annex (10) RCS permission letter

Al-Quds University  
Jerusalem  
School of Public Health



جامعة القدس  
القدس  
كلية الصحة العامة

5/8/2008

محترم  
حضرة السيد / عبد العزيز أبو القرايا  
مدير عام جمعية الهلال الأحمر  
تحية طيبة وبعد،،،

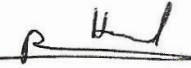
الموضوع: مساعدة الطالبة مريم شقورة

تقوم الطالبة المذكورة أعلاه بإجراء بحث بعنوان:

**“Evaluation of the Quality of Reproductive Health Services in Jabalia  
Woman’s Health Center Client’s Perspective”**

كمتطلب للحصول على درجة الماجستير في الصحة العامة-مسار إدارة صحية و عليه نرجو التكرم للإيعاز لمن ترونه مناسب لتسهيل مهمة الطالبة في جمع البيانات اللازمة. علما بأن المعلومات ستكون متوفرة لدى الباحثة و الجامعة فقط.

و اقبلوا فائق التحية و الاحترام،،،

  
د. بسام أبو جاد  
منسق عام برامج الصحة العامة  
College of Public Health  
AL-QUDS UNIVERSITY  
جامعة القدس

نسخة:

- الملف

## Annex (11) Consent Form

### جامعة القدس كلية الصحة العامة

#### نموذج موافقة

عزيزتي المشاركة

أنا الطالبة/ **مريم محمد شقورة** ملتحنة ببرنامج ماجستير الصحة العامة/ إدارة صحية - جامعة القدس  
لقد تم اختيارك للمشاركة في هذه الدراسة والتي تهدف إلى تقييم جودة خدمات الصحة الإنجابية المقدمة في مركز  
صحة المرأة - جباليا من وجهة نظر المنتفعة مما يساهم في تعزيز جودة الخدمة المقدمة لتحسين صحة المرأة.  
ستجرى هذه الدراسة كجزء من متطلبات برنامج الماجستير - كلية الصحة العامة.

أختي المشاركة إذا أبدت الموافقة للمشاركة في هذه الدراسة، عليك إجابة الأسئلة ضمن المقابلة التي ستجرى معك  
والتي ستتم تعبئتها في فترة زمنية مدتها 15 دقيقة. سيتم جمع المعلومات بصورة فردية وسنضمن لك الخصوصية أثناء  
المقابلة.

نود إعلامك بان جميع المعلومات التي سيتم جمعها سيتم التعامل معها بسرية تامة وهي بغرض البحث العلمي فقط.  
نزيدك علماً بان لديك كامل الحرية في الرفض أو الموافقة على المشاركة في هذه الدراسة، ويمكنك الانسحاب في أي  
لحظة أو عدم الإجابة على أي سؤال لا ينسجم وآرائك.

للاستفسار عن مزيد من المعلومات عن هذه الدراسة يمكنك الاتصال على كلية الصحة العامة تلفون **2884422**

شكرا لتعاونك معنا

الباحثة

مريم شقورة

## **Annex (12) List of Expert Names**

### **List of Expert names who reviewed study questionnaire**

Dr.	Yehia Abed	Associate Professor , School of Public Health –Al Quds University
Dr.	Bassam Abu Hamad	MPH Program Coordinator , School of Public Health –Al Quds University
Miss	Lubna Al Shareef	Evaluation & Monitoring Specialist, Hanan Project
Dr.	Nehaya Al Telbani	Associate Professor, Al Azhar University
Dr.	Sanna Abou Dagga	Associate Professor, Islamic University
Dr.	Amna Abed	Medical Consultant, Red Crescent Society for Gaza Strip
Mr.	Jihad Okasha	Statistician , Palestinian Information Centre



**Annex ( 13) Correlation coefficient between domain items and total scores of domains**

**1. Clinic Services**

**Correlation coefficient between provider competence items and total score of domains**

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	Service provider introduces himself	0.53	0.001
2.	Service provider explains your health condition	0.50	0.001
3.	Service provider writes you the suitable investigations	0.61	0.001
4.	Service provider instructs about your treatment	0.54	0.001
5.	Service provider provide you instructions about your health problems	0.45	0.001
6.	Service provider integrates you in treatment plan	0.55	0.001
7.	Service provider understands your health problem	0.42	0.001
8.	Service provider transfers you to other centre department	0.45	0.001

**Correlation coefficient between service provider consultation items and total score of domains**

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	the counseling time is enough for you	0.77	0.001
2.	the counseling your received is good	0.64	0.001
3.	you receive a chance for questioning	0.80	0.001
4.	the way of questioning is comfortable to you	0.71	0.001
5.	the service provider concerns with your questions	0.86	0.001
6.	the service provider encourages you to follow up	0.80	0.001
7.	the time of follow up is suitable to you	0.64	0.001

**Correlation coefficient between interpersonal relations and communications items and total score of domains**

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	service provider welcome you	0.51	0.001
2.	Reception of service provider is polite	0.67	0.001
3.	service provider listens to you	0.55	0.001
4.	there is a curtain to keep your privacy	0.56	0.001
5.	service provider closed the door while getting service	0.53	0.001
6.	you felt privacy keeping from service	0.64	0.001

7.	provider you felt that your information is confidential	0.65	0.001
8.	service provider respect you	0.66	0.001
9.	service provider cared for you	0.72	0.001
10.	service provider used clear language	0.58	0.001
11.	the service provider is busy with surrounding things while you getting the service	0.43	0.001
12.	there is a trust between you and the service provider	0.55	0.001
13.	you have barriers when dealing with the service provider	0.44	0.001
14.	there is a bias in giving the services between clients	0.56	0.001

**Correlation coefficient between accessibility relations and communications items and total score of domains**

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	it is easy to come to the centre	0.63	0.001
2.	You have ever come to the centre and you don't find the service provider	0.53	0.001
3.	your appointment canceled even though the service provider is available in the centre	0.66	0.001
4.	the cost of the service is suitable for you	0.39	0.001
5.	there is appointment commitment	0.52	0.001
6.	generally, system of getting the services is easy at the center	0.41	0.001
7.	In your opinions is waiting time reasonable	0.52	0.001
8.	you suffered from the problem of long waiting	0.64	0.001
9.	working hours is suitable for you	0.65	0.001
10.	the centre locations is suitable for you	0.55	0.001

**Correlation coefficient between drugs and supplies availability and communications items and total score of domains**

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	supplies and sets are available	0.63	0.001
2.	has ever asset damaged during the work	0.64	0.001
3.	the medication is available at the centre pharmacy	0.48	0.001

4.	the tests are done at the determined time	0.64	0.001
5.	all the tests you need are available in the centre	0.65	0.001
6.	you get results at it's appointment	0.65	0.001
7.	you faced problem with unavailable any lab machine	0.71	0.001

**Correlation coefficient between physical infrastructure and communications items and total score of domains**

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	center width suitable for no. of clients	0.74	0.001
2.	center width suitable for services type	0.85	0.001
3.	suitable waiting place	0.84	0.001
4.	Available of enough chair for waiting	0.58	0.001
5.	hygiene level in center	0.47	0.001
6.	Availability of water	0.52	0.001
7.	Availability of electricity	0.50	0.001
8.	availability of health education material	0.52	0.001

**Correlation coefficient between general satisfaction and communications items and total score of domains**

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	the service you received is completes	0.79	0.001
2.	the provided service contributed in solving your problem	0.85	0.001
3.	you are satisfied with the service	0.87	0.001
4.	the service provider performance is good	0.81	0.001

## 2. Physiotherapy

### Correlation coefficient between provider competence items and total score of domains

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	service provider introduces himself	0.85	0.001
2.	Service provider explains your health condition	0.77	0.001
3.	Service provider provide you instructions about your health problems	0.83	0.001
4.	Service provider integrates you in treatment plan	0.66	0.001
5.	Service provider transfers you to other centre department	0.44	0.001
6.	Service provider understands your health problem	0.57	0.001

### Correlation coefficient between service provider consultation items and total score of domains

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	the counseling time is enough for you	0.62	0.001
2.	the counseling your received is good	0.54	0.001
3.	you receive a chance for questioning	0.77	0.001
4.	the way of questioning is comfortable to you	0.69	0.001
5.	the service provider concerns with your questions	0.67	0.001
6.	the service provider encourages you to follow up	0.61	0.001
7.	the time of follow up is suitable to you	0.60	0.001

### Correlation coefficient between interpersonal relations and communications items and total score of domains

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	service provider welcome you	0.72	0.001
2.	Reception of service provider is polite	0.72	0.001
3.	service provider listens to you	0.74	0.001
4.	there is a curtain to keep your privacy	0.25	0.001
5.	service provider closed the door while getting service	0.51	0.001
6.	you felt privacy keeping from service	0.74	0.001

7.	provider you felt that your information is confidential	0.61	0.001
8.	service provider respect you	0.80	0.001
9.	service provider cared for you	0.76	0.001
10.	service provider used clear language	0.71	0.001
11.	the service provider is busy with surrounding things while you getting the service?	0.52	0.001
12.	there is a trust between you and the service provider	0.54	0.001
13.	you have barriers when dealing with the service provider	0.53	0.001

**Correlation coefficient between accessibility relations and communications items and total score of domains**

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	it is easy to come to the centre	0.49	0.001
2.	You have ever come to the centre and you don't find the service provider	0.50	0.001
3.	your appointment canceled even though the service provider is available in the centre	0.74	0.001
4.	the cost of the service is suitable for you	0.55	0.001
5.	there is appointment commitment	0.65	0.001
6.	generally, system of getting the services is easy at the center	0.64	0.001
7.	In your opinions is waiting time reasonable	0.47	0.001
8.	you suffered from the problem of long waiting	0.67	0.001
9.	working hours is suitable for you	0.44	0.001
10.	the centre locations is suitable for you	0.57	0.001

**Correlation coefficient between drugs and supplies availability and communications items and total score of domains**

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	equipment are enough for providing services	0.40	0.001
2.	equipment are old that decrease it's efficiency	0.61	0.001
3.	and supplies are available for providing services	0.32	0.001
4.	you faced problem with equipment	0.82	0.001

5.	through getting services you faced problem with unavailable equipment for providing services centre infrastructure	0.81	0.001
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**Correlation coefficient between physical infrastructure and  
communications items and total score of domains**

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	the physiotherapy hall has good ventilation	0.39	0.001
2.	there is educational material inside the hall	0.21	0.041
3.	ward area is suitable	0.67	0.001
4.	no. of clients is unsuitable with no of service providers	0.63	0.001
5.	no of clients is unsuitable with the ward area	0.59	0.001
6.	center area suitable for services type	0.51	0.001
7.	suitable waiting place	0.69	0.001
8.	Available of enough chair for waiting	0.62	0.001
9.	hygiene level in center	0.36	0.031
10	Availability of water	0.24	0.014
11.	Availability of electricity	0.26	0.021
12	Availability of health education material	0.35	0.011

**Correlation coefficient between general satisfaction and communications  
items and total score of domains**

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	the service you received is completes	0.74	0.001
2.	the provided service contributed in solving your problem	0.68	0.001
3.	you are satisfied with the service	0.83	0.001
4.	the service provider performance is good	0.70	0.001
3.			

## 4. Counseling services

### Correlation coefficient between provider competence items and total score of domains

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	service provider introduces himself	0.41	0.002
2.	Service provider explains your problem	0.61	0.001
3.	Service provider provided you instructions about your problems	0.62	0.001
4.	Service provider integrates you in treatment plan	0.63	0.001
5.	Service provider understands your health problem	0.69	0.001
6.	Service provider transfers you to other centre department	0.64	0.001

### Correlation coefficient between service provider consultation items and total score of domains

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	counseling time is enough for you	0.53	0.001
2.	counseling you received is good	0.83	0.001
3.	you receive a chance for questioning	0.52	0.001
4.	the way of questioning is comfortable to you	0.47	0.001
5.	the service provider concerns with your questions	0.46	0.001
6.	the service provider encourages you to follow up	0.50	0.001
7.	the time of follow up is suitable to you	0.47	0.001

**Correlation coefficient between interpersonal relations and communications items and total score of domains**

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	service provider welcome you	0.69	0.001
2.	Reception of service provider is polite	0.73	0.001
3.	service provider listens to you	0.75	0.001
4.	there is a curtain to keep your privacy	0.72	0.001
5.	service provider closed the door while getting service	0.61	0.001
6.	you felt privacy keeping from service provider	0.65	0.001
7.	felt that your information is confidential	0.68	0.001
8.	service provider respect you	0.62	0.001
9.	service provider cared for you	0.69	0.001
10.	service provider used clear language	0.65	0.001
11.	the service provider is busy with surrounding things while you getting the service?	0.31	0.023
12.	there is a trust between you and the service provider	0.56	0.001
13.	you have barriers when dealing with the service provider	0.44	0.001
	there is a bias in giving the services between clients	0.50	0.001

**Correlation coefficient between accessibility relations and communications items and total score of domains**

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	it is easy to come to the centre	0.34	0.011
2.	You have ever come to the centre and you don't find the service provider	0.35	0.009
3.	your appointment canceled even though the service provider is available in the centre	0.54	0.000
4.	the cost of the service is suitable for you	0.66	0.000
5.	there is appointment commitment	0.35	0.009
6.	generally, system of getting the services is easy at the center?	0.29	0.035
7.	In your opinions is waiting time reasonable	0.56	0.000
8.	you suffered from the problem of long waiting	0.38	0.005
9.	working hours is suitable for you	0.45	0.001

10.	the centre locations is suitable for you	0.39	0.003
-----	--	------	-------

**Correlation coefficient between physical infrastructure and communications items and total score of domains**

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	center width suitable for no. of clients	0.73	0.000
2.	center width suitable for services type	0.64	0.000
3.	suitable waiting place	0.86	0.000
4.	Available of enough chair for waiting	0.57	0.000
5.	hygiene level in center	0.24	0.032
6.	Availability of water	0.56	0.001
7.	Availability of electricity	0.35	0.002
8.	availability of health education material	0.42	0.003

**Correlation coefficient between general satisfaction and communications items and total score of domains**

<b>Sn</b>	<b>Items</b>	<b>r</b>	<b>Sig.</b>
1.	the service you received is completes	0.82	0.001
2.	the provided service contributed in solving your problem	0.89	0.001
3.	you are satisfied with the service	0.94	0.001
4.	the service provider performance is good	0.74	0.001

## **Annex ( 14) Construct Validity**

### **Correlation coefficient between instrument domains and total scores of domains**

#### **Correlation coefficient between instrument domains and total scores of instrument in clinic services**

<b>No.</b>	<b>Domains</b>	<b>Pearson correlation</b>	<b>Significant level</b>
1.	Provider competency	0.36	0.001**
2.	Service provider consultation	0.77	0.001**
3.	Interpersonal relations and communication	0.83	0.001**
4.	Accessibility	0.74	0.001**
5.	Drug and supplies availability	0.68	0.001**
6.	Physical infrastructure	0.65	0.001**
7.	General Satisfaction	0.74	0.001**

**\*\* Correlation is significant at 0.01 level**

#### **Correlation coefficient between instrument domains and total scores of instrument in physiotherapy services**

<b>No.</b>	<b>Domains</b>	<b>Pearson correlation</b>	<b>Significant level</b>
1.	Provider competency	0.68	0.001**
2.	Service provider consultation	0.66	0.001**
3.	Interpersonal relations and communication	0.85	0.001**
4.	Accessibility	0.76	0.001**
5.	Drug and supplies availability	0.64	0.001**
6.	Physical infrastructure	0.72	0.001**
7.	General Satisfaction	0.49	0.001**

**\*\* Correlation is significant at 0.01 level**

#### **Correlation coefficient between instrument domains and total scores of instrument in counseling services**

<b>No.</b>	<b>Domains</b>	<b>Pearson correlation</b>	<b>Significant level</b>
1.	Provider competency	0.72	0.001**
2.	Service provider consultation	0.78	0.001**
3.	Interpersonal relations and communication	0.86	0.001**
4.	Accessibility	0.66	0.001**
6.	Physical infrastructure	0.41	0.001**
7.	General Satisfaction	0.75	0.001**

**\*\* Correlation is significant at 0.01 level**

**Annex (15) Cronbach's Alpha & Split Half values for instrument domains**  
**Cronbach's Alpha & Split Half values for instrument domains for clinic**

<b>No.</b>	<b>Domains</b>	<b>Cronbach's Alpha</b>	<b>Split Half</b>
1.	Provider competency	0.696	0.673
2.	Service provider consultation	0.782	0.759
3.	Interpersonal relations and communication	0.734	0.552
4.	Accessibility	0.728	0.599
5.	Drug and supplies availability	0.749	0.653
6.	Physical infrastructure	0.757	0.896
7.	General Satisfaction	0.821	0.869
8.	Total	0.766	0.795

**Cronbach's Alpha & Split Half values for instrument domains for physiotherapy services**

<b>No.</b>	<b>Domains</b>	<b>Cronbach's Alpha</b>	<b>Split Half</b>
1.	Provider competency	0.690	0.785
2.	Service provider consultation	0.755	0.678
3.	Interpersonal relations and communication	0.604	0.771
4.	Accessibility	0.736	0.622
5.	Drug and supplies availability	0.744	0.454
6.	Physical infrastructure	0.688	0.697
7.	General Satisfaction	0.789	0.929
8.	Total	0.690	0.825

**Cronbach's Alpha & Split Half values for instrument domains for counseling services**

<b>No.</b>	<b>Domains</b>	<b>Cronbach's Alpha</b>	<b>Split Half</b>
1.	Provider competency	0.711	0.589
2.	Service provider consultation	0.593	0.872
3.	Interpersonal relations and communication	0.749	0.769
4.	Accessibility	0.667	0.742
5.	Physical infrastructure	0.691	0.872
6.	General Satisfaction	0.829	0.960
7.	Total	0.774	0.940



