Deanship of Graduate Studies

Al- Quds University

Clients Centeredness of the Governmental Primary Health Care Services: Gaza Governorates

Huda Haidar Anan

MPH Thesis

Jerusalem – Palestine

1432/2011

Deanship of Graduate Studies

Al- Quds University

Clients Centeredness of the Governmental Primary Health Care Services: Gaza Governorates

Prepared By:

Huda Haidar Anan

BSc. of Pharmacy–Al Azhar University, Gaza

Supervisor:

Dr. Bassam Abu-Hamad

PhD Health Management

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Public Health- Al- Quds University.

1432/2011

Deanship of Graduate Studies

Al- Quds University

School of Public Health

Thesis Approval

Clients Centeredness of the Governmental Primary Health Care Services: Gaza Governorates

Prepared By: Huda Haidar Anan

Registration No.: 20812775

Supervisor: Dr. Bassam Abu-Hamad

Master thesis was submitted and accepted, Date: ……

The names and signatures of examining committee members were as follows:

1. Head of Committee:	**Dr. Bassam Abu-Hamad**	**Signature ……..**
2. Internal Examiner:	**Dr. Yehia Abed**	**Signature ……..**
3. External Examiner:	**Dr. Riyad El Zanoun**	**Signature ……..**

Jerusalem - Palestine

1432/2011

Dedication

To my precious father Professor Haidar Anan. You've been always my role model and my biggest source of support; you made my dreams come true; surrounded me with your care and taught me the passion of scientific research.

To my adorable mother Karima Anan. You always demonstrate greatest dedication and hard work in everything you do. Mother... I will never be able to thank you enough!

To my dear husband Samer Al-Shawa.....Thank you for giving me all the support I needed.

To my lovely sister Ola and my sweetest brother Ameer for their kind help and support.

To the beloved one who passed away leaving all of his good manners in our souls.... to my brother Salim.

Huda Haidar Anan

Declaration

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

Signed

Huda Haidar Anan

Date

.....

Acknowledgment

I was blessed with having all the kindest people ever who supported me during this study;

I was fortunate to be under the supervision and guidance of Dr. Bassam Abu Hamad my Academic Supervisor who supported me during the study period and through the whole Master of Public Health journey. Without his kind advises and unlimited help, this achievement would not have been achieved.

I would like to thank Dr. Yehia Abed for his continuous encouragement and support during the whole study period in the School of Public Health.

My sincere appreciation for Mr. Mohammad El Haj Yousef and Mr. Zaki Ayesh who helped me in the data collection. I would like to thank all the beneficiaries who responded to the questionnaire and all the PHC clinics managers and staff for their welcoming and cooperation.

Much gratitude for the health care professionals and the academic professionals who helped me in evaluating the study questionnaire (Dr. Yehia Abed, Dr. Sawsan Hammad, Dr. Abdelrahman El Dahodi, Dr. Mr. Sadi Abu Awwad, Dr. Asma El Imam, Mr. Abdelnaser Soboh, Ms. Lubna Al Sharief , Mr. Mahmoud Daher and Dr. Nihaya El Telbani).

A Special thank you message to all my supervisors and colleagues in the World Health Organization – Gaza Office for their help and support during the last year.

Finally, I would like to thank my friends Ms. Haya Al Rayess and Dr. Wesam Abu Amr who gave me all the support I needed and all my colleagues in the School of Public Health.

Abstract

Universally, Primary Health Care (PHC) services are considered the vertebral column of health care systems. Ideally, it is assumed that PHC services should be responsive to people's needs and expectations. Client-centered PHC services could meet the goal of being responsive through designing and providing health care services that suit clients and guarantee appropriate accessibility, involvement in the caring processes and the delivery of quality health care services.

A quantitative analytic cross-sectional study was conducted in order to assess the extent to which the governmental PHC services are client-centered. The instruments used in this study were exit interviews for 300 randomly selected clients who received health care services from the 10 randomly selected PHC clinics in the Gaza Governorates (GG), with a response rate of 91%. Another questionnaire was used to capture general information about the investigated PHC clinics. The researcher collected the data by herself with the help of two well-trained data collectors. Validity and reliability measures such as standardisation of data collection and data quality check and re-entry were assured. Reliability consistency test was very high (Cronbach's Alpha 0.9).

Clients' perceptions were good regarding physical, financial, technical and information accessibility. Accessibility to essential medications was good but there were gaps in the dispensing, labelling procedures and the constant availability of drugs. Most of the clients were satisfied with the delivery of health care services such as; waiting time, time spent with health care providers, communication, respect and quality of basic amenities. Clients have low chances to select the health care provider or to provide consent before undergoing medical procedures. Clients were not adequately involved where most of the clients did not participate in activities aiming to improve health care services. Three out of the ten (30%) investigated PHC clinics reported having community committees with regular meetings. Clients' participation in deciding their treatment plans were perceived as weak. Also, most of the clients did not participate in activities related to evaluating the health care services they receive from the PHC clinics. The most important factor that reflects good quality of health care services from clients perspectives was the availability of drugs (67.3%), being respected by the health care providers (46.5%) followed by being cured (34.6 %). Respondents from level two and level three clinics, southern governorates clinics and clinics that had community committees, elicited higher scores than their counterparts from other clinics with statistically significant differences ($P < 0.05$) between these groups. Similarly, respondents with higher education level reported higher scores than their counterparts with statistically significant differences between these groups ($P<0.05$).

The study recommends adopting new policies that enhance the client centeredness of the heath care services through increasing the awareness about basic clients' health rights, increasing clients' involvement in the planning, implementation and evaluation of health services. Also, improving communication and interaction between the clinics teams and the local communities is essential including establishing community committees.

Table of Contents

List of Tables

List of Figures

List of Annexes

List of Abbreviation

COPE	Client Oriented Provider Efficient
GG	Gaza Governorates
MOH	Ministry of Health
NIS	New Israeli Shekel
NGOs	Non Governmental Organizations
PCBS	Palestinian Central Bureau of Statistics
PNGO	Palestinian Non-Governmental Organizations
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
WHO	World Health Organization

Chapter (1)

Introduction

1.1 Background

Primary Health Care (PHC) services are considered as the vertebral column of health care services in most health systems including the Palestinian one. In 1994, the Palestinian Ministry of Health (MOH) adopted this approach like many other countries endorsing Alma-Ata Conference Declaration. Accordingly, it became a principal goal for MOH to "*make essential health services universally accessible, affordable, available, socially acceptable, attainable, and equitably distributed to the Palestinian citizens*" (Palestine, MOH, 2003, p. 88).

Health care services that understand/respond to its clients are called client-centered services. Universally, quality improvement initiatives raised the importance of being client-centered while designing and providing health care services. Massoud, *et al.* (2001) showed that focusing on the client is the first principle for quality improvement. This approach in health care ensures that each step in the caring process goes in line with meeting clients' needs that would finally lead to client satisfaction and improvement of health outcomes (Massoud, *et al.* 2001).

Client-centered services combines between both medical excellence and assurance of legislative people's rights in health care services. It is supposed to consider people needs and expectations, ensure proper physical and financial accessibility, and allows for participation in decisions and planning (Mead and Bower, 2000; Stewart, 2001; Davis *et al* 2005). This would finally lead to sharing the responsibility in improving health status between clients and health care providers and receiving appropriate health care services that guarantee clients' safety, dignity and privacy; by the end of the day, its citizens health its citizens money.

It is well-known that health care system is made out of a combination between health care providers who represent the internal clients as well as receivers of health care services who represent the external clients plus others such as regulators, funders and so on. Client-centered care assures proper health services delivery for external clients as well as assuring proper working conditions, supervision and continuous professional development for internal clients (COPE, 2005).

Because of its importance, this study focuses on the external clients-centeredness aspects. This study tries to ascertain the degree to which PHC services are oriented towards meeting clients' expectations and needs. The results of this study might give a preliminary image about the application of the wide concept of clients-centeredness in Gaza Governorates (GG) in the PHC sector.

The coming sentences illustrate the study problem, objectives and explain the importance of client-centeredness of health care services.

1.2 Research problem

Any health care service should always identify its customers, listen to their expectations and needs, and find ways to meet them in line with the known medical standards; otherwise, this service will have little impact on improving people health status and the wellbeing of the served beneficiaries (World Health Organization [WHO], 2004a). The old assumptions that had considered people as passive receivers of health care services are now replaced by concepts like partnership, stewardship, shared responsibility and involvement in health decisions. Now, people have the right to receive the care in a way that suits their needs, appreciates their values, ensures their privacy and respects their choices. Client-centered approach could be a building stone for designing and providing health services with those characteristics, thus, ensuring the provision of higher quality care that would lead to better compliance, client satisfaction and improved health status (Massoud, *et al.* 2001; Davis, *et al.* 2005; Moran, *et al.* 2008). In addition, it might enhance utilization of services (Rameshan and Singh, 2005).

The literature search indicates that this study is the first that handles the topic of client-centered health care services in GG in a focused way. The long episodes of deteriorated conditions and lack of stability created a situation where people are not usually asked about their opinions and most of the time they should adopt themselves to the existing services. Community partnership with the surrounding health care facilities is almost absent (Health Sector Review, 2005) and people are neither participate in their treatment plans (Abu Dayya, 2000) nor evaluate health care services.

Accordingly, this study tries to explore the extent to which extent PHC services are client-centered and probes to detect areas of strengths and weaknesses in PHC services regarding the factors that would create client-centered health care services. In other words, it bridges important information gaps related to the degree of clients-centeredness of PHC services as that degree is not precisely known yet.

1.3 Justification

Although client-centeredness has no unified definition, its core value is considering the receivers of health care services as partners in care (WHO, 2008). Many studies pointed to the importance of understanding people needs and designing health care services that would meet their expectations (Wolosin, 2005; Rao, *et al.* 2006). Client-centered health care services would enhance understanding people and designing health care services that meet their needs and expectations (Davis, *et al*. 2005) and this is very important to ensure continuous connection between health care facilities and the communities they are serving (WHO, 2008).

In GG, most of the studies that assessed clients' satisfaction with health care services reflected adequate satisfaction (Hamad, 2009). However, the revealed level of satisfaction might be resulted from people's low expectations as they might assume that the quality of free or public services will not be as good as the private or more expensive health care services (Hamad, 2009). In addition, satisfaction with PHC services is higher among refugees than non-refugees who mostly receive their services from governmental PHC centers (Graduate Institute of Development Studies, 2005). In addition, Abed (2007) pointed that people satisfaction levels with private and Non-Governmental Organizations (NGOs) health care services were higher than governmental sector (Abed, 2007). This would highlight that people might be used to get the available services without asking for what they were supposed to receive, especially from the governmental health sector. Furthermore, the phenomenon of shopping among providers is well known in the Palestinian context; which might reflect that people do not trust one single provider and they try to receive what they are looking for by searching for it among the providers and/or lack of comprehensive integrated services within the facilities serving them. In addition, people were not fully aware about their rights in

receiving health care services (El Haj, 2008). A study pointed that there were low levels of clients participation in decisions related to treatment plans and choosing health provider and health facility (Abu Dayya, 2000; Hamad, 2011).

Choosing health care facilities or re-utilizing health care services from the same place does not necessarily indicate people satisfaction or higher perceived quality. In Palestine, people reasons for choosing health care facilities vary according to their economic level. People with lower incomes select the facility which provides free or low cost services while people with higher income select the facility according to their trust in the quality of services (Graduate Institute of development studies, 2005).

Client-centered practice improves health outcomes (Little *et al.* 2001b; Davis *et al*. 2005; Saha *et al.* 2008). According to the literature, client-centered approach could enhance the nature of interactions between health facilities and local communities; it would create responsive health facilities that improve community health and wellbeing. In addition, it enhances continuous utilization of health services (COPE, 2005; WHO, 2008). It could be argued that the presence of responsive services increases the trust of people with the local health care system and reduces the need for referrals. Client-centered approach in care creates more satisfied clients (Little *et al.* 2001b). Meeting people's expectations contributes to the process of democratization of health care services where the people have the right in evaluating the quality of the services provided to them (Calnan, 1988 as mentioned in Haddad *et al*.1998). Considering people's voice and responding to their expectations contributes to creating a healthy atmosphere within the community as it influences the mental outlook of the individuals and groups and thus reduces tensions among the community members. It could be regarded as moral and ethical responsibility towards the mental health of the population (Hamad, 2001).

It is well known that the percentage of Gaza population who live in deep poverty has been steadily increasing within the last years (Giacaman. *et al.* 2009) and the role of any health care system is to assure protection of people dignity and continuum of acceptable levels of health care services quality. And it is known that client-centered services would create responsive health providers and might minimize social exclusion and decrease the discrepancies against

vulnerable groups and medically underserved people by assuring their representation and hearing their voices (Berry, *et al.* 2003; WHO, 2008).

Despite the importance of being client-centered, heath providers are not used to adopt this approach as they are not used to the concept of partnership or informed choices that would empower people to improve their health by being involved in their treatment process. The traditional conceptualization of health services is "provider-centeredness" where the provider has the knowledge and the skills and people should respond to the instructions for their good. This study explores the client-centeredness of health services within the current Palestinian situation by looking through people's eyes and identifying their perceptions regarding all the factors that shape client-cantered health care services.

1.4 Study objectives

1.4.1 General objective

To ascertain the degree of client-centeredness of the governmental PHC services in GG and its attributing factors; providing suggestions that could enhance the responsiveness of the Palestinian health system to its clients expectations and needs.

1.4.2 Specific objectives

1. To assess the degree of client-centeredness of PHC services.
2. To appraise people perspectives about the services they receive and its responsiveness to their needs.
3. To explore the degree of clients' involvement in planning, implementing and evaluating PHC services.
4. To verify differences in perceptions about client-centeredness in reference to PHC settings and clients characteristics .
5. To identify areas of strengths and weaknesses in PHC services in relation to client-centeredness.

6. To develop recommendations that might help in enhancing client-centeredness of governmental PHC services.

1.5 Research questions

1. How is the current access status for PHC services from clients' perspectives?
2. How do clients perceive PHC services delivery?
3. How do clients perceive provider-client communication and information sharing?
4. Is there any interaction between the clinic and local community in the catchment area?
5. Are clients involved in determining health services provided by PHC in their catchment area?
6. What is the extent of clients' participation in the evaluation of PHC services?
7. Is the health care system responsive for clients' needs and expectations from their perspectives?
8. What are the factors that indicate good quality of services from clients' perspectives?
9. Are there any variations between Gaza areas PHC services in its clients-centeredness?
10. Are there differences in perceptions about health services centeredness in relation to clients' characteristics related variables such as demographic variables?
11. Which recommendations could be inferred from this study to increase the responsiveness of PHC services?

1.6 Context of the study

1.6.1 Gaza Governorates demographic characteristics

GG are located in the southern area of Palestine (Annex 1) with 1,535,120 inhabitants according to the Palestinian Central Bureau of Statistics (PCBS) and are divided into five governorates: North Gaza, Gaza City, Mid Zone, Khnunis and Rafah (PCBS, 2010). GG are characterized with high population density with more than 4,500 individuals per square kilometer. This high population density and narrow place of land creates high demands for health care services and possible work overload health care facilities. On the other hand, it

could be positive in terms of accessibility in contrast with the West Bank which is characterized by wider spaces and the presence of remote areas.

The percentage of Gazans who live in deep poverty has been steadily increasing within the last years as it raised from nearly 22% in 1998 to nearly 35% in 2006 (Giacaman, *et al.* 2009). With the continued economic decline and the implementation of even stricter closures on Gaza, the poverty rate in 2008 is expected to be higher than it was in 2006 (Giacaman, *et al.* 2009). This deterioration in economic situation might have its impacts on financial access to health care facilities. Furthermore, it might increase the burden of poverty related diseases such as malnutrition, iron deficiency anemia and sanitary related diseases (PNGO, 2009) which is directly related with PHC services. In addition, people might decrease utilizing health care services and they would be more prone for sudden financial disasters when they require more sophisticated health care services.

1.6.2 Palestinian health care system

Palestinian health care system is complex as there are four main providers for healthcare services; MOH, United Nations Relief and Works Agency (UNRWA), NGOs and the private for-profit service providers. MOH is the main health care provider in the governorates; it provides 40% of the PHC services and 80% of the secondary and tertiary services for the whole population (WHO, 2011). It purchase advanced medical services through referring patients to the neighboring countries and other private and NGO health care facilities.
UNRWA provides mainly PHC services to the refugee population, and purchases secondary and tertiary care services when needed. The NGO sector ranges from missionary hospitals, to facilities supported by international organizations, to community health centers. The private for-profit health sector also provides the three levels of care through a wide range of practices (WHO, 2009). In the Palestinian context, MOH is not only responsible for providing those three objectives but also it is responsible for regulating the provision of health services provided by the other providers to assure proper distribution of scarce resources and enhance health care services delivery (WHO, 2009).

The availability of various health providers does not necessarily guarantee covering all of the needed health services. The early mentioned demographic characters of the Gaza population imply that there is an increasing load on the health sector which should respond not only to the current challenges of occupation, siege and political divisions but also to the increasing demands for health services resulted from the ongoing increase in population size (PNGO, 2009). It's well known that health systems have three fundamental objectives which are; improving population health, responding to people expectations and providing protection against sudden unplanned payment for health services specially for the poor (WHO, 2000).

Every year the MOH refer thousands of patients outside the GG to receive advanced diagnosis and health care services which are not available within the GG (WHO, 2010). In the year 2010, almost 11,700 patients were referred to the WB, Jordan, East Jerusalem and Israeli hospitals (WHO, 2010). Those referrals produce financial burden on the total annual running costs of the MOH (Palestine, MOH, 2006). The delivery of higher quality health care services would return population overall trust in the health care system and it would necessarily decrease numbers of referrals outside GG (El-Haj, 2008).

A previous study (Abu Dayya, 2000) showed that there is good levels of satisfaction with health care services, yet, people are not fully aware about their rights in receiving health care services as well as there are low levels of clients participation in decisions related to treatment plans, choosing health provider and health facility regardless of their education levels. That study showed that the major areas of dissatisfaction were in long waiting times and the difficulties in dispensing medications (Abu Dayya, 2000). That complains still valid as mentioned in the results and discussion chapters.

1.6.3 Primary health care services

Regarding governmental PHC services, MOH runs well-established and well-equipped PHC centers (PNGO, 2009). There are 56 governmental PHC centers in the GG (Hamad, 2011). Governmental PHC centers are classified from level two to level four, offering different health services according to the clinic level, these services include maternal and child health, care of

chronic diseases, daily care, family planning, dental, mental services and others (Palestine, MOH, 2006).

Access to health services survey conducted by the PCBS mentioned that 97.7% of people said that they have a health center at their same locality and 83.5 % from the people who needed health service managed to receive it (PCBS, 2004). However, the debate is on the quality of the health care services. A report mentioned that 81% of people are satisfied with the provided PHC services, yet refugees were more satisfied than non-refuges who receive PHC services mainly from governmental sector (Graduate Institute of Development Studies, 2005).

These findings might not reflect the current situation as lots of changes happened during the last few years starting from the latest war on Gaza where some of the PHC facilities were destroyed and the current siege and political situation which created shortages in the essential medications where 38% of the essential drugs were out of stock in early 2011 (WHO, 2011). This would have its impacts on clients' accessibility for essential drugs at the PHC facilities.

Some of the problems that exist in PHC services are related to unequal patient's flow where many of the patients arrive in the first hours of the day and in the first days of the month which is linked with drug availability within the first days of the month (Palestine, MOH, 2005). Nearly 40% of all prescriptions were written in the first 4 days of the month while the last 4 days accounted for just 4% (Palestine, MOH, 2005). This would create overload and short examination times for patients, long waiting lines and absolutely this would not improve peoples' views about the quality of services (Palestine, MOH, 2005).

Another factor that might contribute to those problems is the lack of confidence with PHC services due to diagnostic limitations, inadequate specialized staff and finally, unavailability of afternoon shifts in most of PHC facilities (Abed, 2007). Abu Mourad *et al.* (2008) recommended that more investments in health promotion activities and public health services will be necessary to improve the confidence in PHC services and enhance its effects on the health status in the Palestinian territories.

To sum up, evaluating health system functioning considers many issues including counting the number of health care facilities, number of beds, beneficiaries and health personnel distribution which might underestimate or even mask low quality of care (Giacaman, *et al.* 2009). Though, studies which appraise quality of health care services would give clearer image and develop initiatives for improving health care services delivery. It is well known that clients' perceptions and general image about the health care in general are predictive for their future reactions such as their compliance with treatment plans (Hamad, 2009). In addition, the perceived quality of health care services shapes the way of utilization for these services (Haddad *et al.* 1998). Thus, it is important to understand clients' perceptions about the services. This study measured some of the domains that reflect client-centered care that guarantees the adequacy and appropriateness of health care services at the PHC level in order to contribute hopefully in the improvement of PHC services.

1.7 Operational definitions

1.7.1 Quality of health care services

Proper performance, in accordance with standards, of interventions that are known to be safe, that are affordable to the society in question, and that have the ability to produce an impact on mortality, morbidity, disability, and malnutrition (WHO, 2006a). This WHO definition for quality health care services includes six dimensions that should be guaranteed for all the people. Those are; effective services, efficient delivery of services, accessible services, patient-centered services, equitable delivering of health care and, finally it should be safe.

1.7.2 Primary health care

PHC is an essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (Declaration of Alma Ata, 1978).

1.7.3 Client-centered health care services

Health care services designed to meet clients needs and expectations with full consideration of medical standards to assure safety and continuity of care (Massoud, *et al*. 2001) and assures access of individuals to the kind of care that suits them (Davis, *et al.* 2005).

1.7.4 Accessibility to health care services

Reaching services that are affordable and available at convenient times and places, are fully accessible with no physical barriers, and have no inappropriate eligibility requirements or social barriers (COPE, 2005)

1.7.5 Responsiveness of health care system

It is one of the intrinsic goals of health systems which assure the responsiveness of the health system to the legitimate expectations of the population for the non-health improving dimensions of their interaction with the health system. There are seven elements of responsiveness they are dignity, autonomy and confidentiality of information, communication, prompt attention, quality of basic amenities, access to social support networks during care and finally choice of care provider (WHO, 2007a).

1.7.6 Client Satisfaction

The extent to which individuals or the community agree with the nature, volume and quality of services offered in response to their expressed health needs (WHO, 2007a).

1.7.7 Needs

Health needs are health problems that have been recognized and expressed by individuals, the community and/or the health care professionals (WHO, 2007a).

1.7.8 Quality of basic amenities

One of the aspects of the responsiveness of health systems that pay attention to non-health enhancing physical attributes of health care units, such as cleanliness of the facility, adequacy of furniture and quality of food (WHO, 2007a).

The following chapter will illustrate what the literature have said and discussed about the concepts of the client-centered care.

Chapter (2)

Literature review

2.1 Conceptual framework

According to the literature, PHC services should be shaped according to people needs and perspectives in line with assurance of clinical excellence and protection of public safety.
The following are the domains that reflect and affect on the centeredness of the PHC services towards clients as identified by the researcher. The perceptions about these domains are a complex process of interactions between direct health related and non-direct health related dimensions pertaining to health care services delivery. The domains could be categorized into two main groups;

1. Domains reflecting the clients' centeredness of the PHC services

a. **Responsive primary health care services**

The researcher identified responsiveness of health care system to non-health dimensions of interaction between individuals and the health care as the umbrella that guarantees the existence of client-centered PHC. According to WHO definition for responsiveness (2001a), it includes "respect for persons" and "client orientation". The researcher included the definitions of the responsiveness related factors within the following three domains of this frame work and linked them under the most relevant domain.

b. **Accessibility to health care services**

The first domain is the accessibility to health care services is the possibility of reaching health care facility and obtaining the required service and information. It includes several factors; they are physical access, financial accessibility and affordability of services, access to information, availability of the skilled health provider and finally access to essential medications (availability of drugs, proper drug dispensing and accurate labeling).

c. Appropriate health care services delivery

The appropriateness of health service delivery includes the following sub-domains; duration of waiting time to receive the required health care service, adequacy of time spent with health care provider from client perspective, characteristics of communication with health care

providers, client freedom of choice of favorable provider and finally respect and confidentiality of clients. The researcher also assessed clients' perceptions about the basic amenities within the PHC facilities. And this represents the second domain reflecting centeredness of services.

d. Clients' involvement in health care

The degree of involvement of people in planning, evaluating and implementing health care interventions is the third domain. The researcher tried to identify clients' preferences in being involved in the implementation of health interventions and planning for health care services. In addition, one of the most important aspects that indicate clients' centeredness is their involvement in evaluating PHC services.

2. Factors affecting on/shaping clients' perspectives regarding the previously mentioned domains;

a. Clients characteristics variables

There are various characteristics that might affect people needs and perspectives and their overall image about the PHC services. The researcher considered the client's sex, age and attained education level in this study.

b. PHC clinics characteristics variables

PHC facilities have different characteristics that might affect perceptions about the health care services provided through it. Those characteristics are PHC facility location in the GG, the clinics level and finally clinics relations with communities through the absence or presence of representative committees for the clients.

c. Clients' preferences

It is known that meeting client's needs and preferences is an important indicator for the extent of responsiveness of health care services. The researcher identified the most important factors

that indicate good quality of services from clients' perspective and the extent at which PHC services meet those factors.

The following (figure 2.1) shows the factors that were assessed in this study

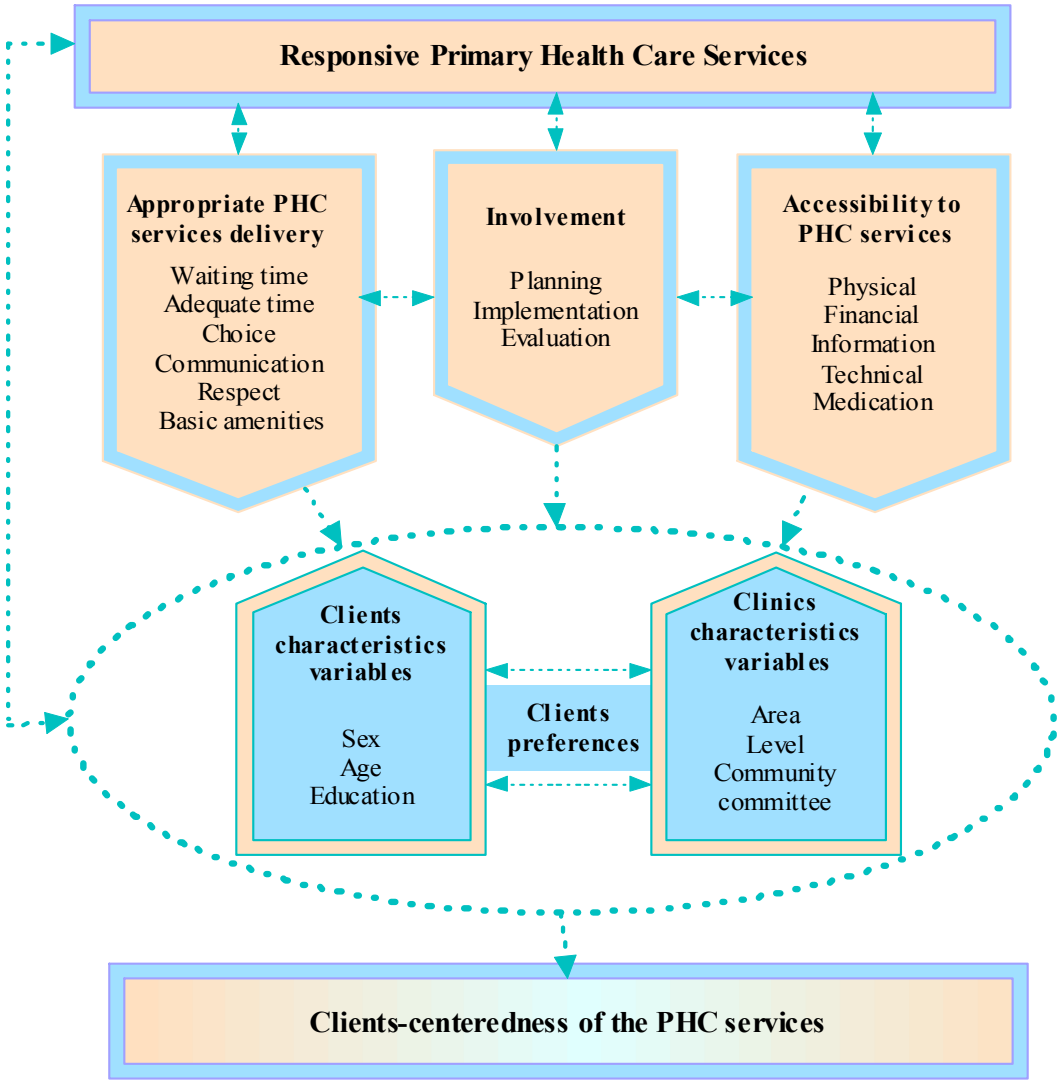

Figure (2.1) Conceptual framework for the study -Self developed

The following paragraphs will start to explain what the client-centered care is and what the determinants that shape this approach in the caring process are.

2.2 Definitions of client-centered care

During the last three decades, a revolution in the way of evaluating health care services delivery and its way of interacting with people had evolved. Starting with Donabedian (1988), quality improvement initiatives have identified the interactions between health care providers and clients as an aspect that indicates the quality of health care services besides evaluating technical performance of health care providers. In addition, this initiative pointed to the importance of creating satisfied receivers of care (Donabedian, 1988). Thus, understanding clients started to be a major concern besides the technical and medical performance of health care providers in most quality improvement initiatives (Little *et al*. 2001a). Client or patient centered approach in health care were developed to achieve more responsive health care services (Mead and Bower, 2000; Little *et al.* 2001b; WHO, 2007b). Many research studies tried to define client-centered health care services, yet, there is no single definition for client-centeredness or client-centered approach (Mead and Bower, 2000; Michie *et al.* 2003; Saha *et al.* 2008). The following sentences will discuss some of the definitions of client or patient centered care according to different authors and research studies.

Levnenstin *et al.* (1986) defined the patient-centered method in family practice as the care that allows the physician to understand the patient as well as the disease (Levenstein, *et al.* 1986). While Hibbard (2004) study mentioned that patient-centered care is the care that would produce better health outcomes through supporting patients to be as their self managers (Hibbard, 2004). On a later stage, Davis, *et al.* (2005) defined patient-centered care as a key component of health care system that assures access of individuals to the kind of care that works for them. This could be interpreted by designing the services that meet the expectations of the clients and the communities. This care should be designed within the available resources and all along with the well established medical standards (Davis, *et al.* 2005). More recent study mentioned that services are client-centered when they are organized around the patient. This would be achieved by developing partnership between health providers, patients and their families to identify and satisfy their needs and preferences (Frampton, *et. al*. 2008). Another study conducted by Shah, *et al.* (2008) said that the patient-centered care is not only about the proper communication with patient but it also guarantees accessing health care

services when required and considering the outcomes the patient are looking for more than the outcome the health care provider are looking for (Saha *et al.* 2008).

Client-centeredness does not mean participation of people in every single detail in the caring process. Stewart (2001) said that patient centeredness means taking into account people desire for information and for sharing decision making and responding according to that (Stewart, 2001). Also, it does not neglect the importance of clinical excellence or technical quality standards that people cannot assess accurately due to asymmetrical information between health providers and patient. In fact, client-centered services enhance the assurance of high quality services through effective communication and partnership with people that would result in improving providers technical performance in general (Stewart, 2001).

Those studies all pointed to the importance of understanding patients rather than focusing only on the diseases. Those definitions go in line with the fact that people want to be seen as human with health problem rather than being such a case on the provider list (Haddad, *et al.* 1998; COPE, 2005). Moreover, health providers and health systems need to listen to a wider range of voices and to consider public opinions on their health needs and their priorities that make them demand the health care services (WHO, 2000). This would pave the way for community contribution to be partners and participants in improving health status rather than being passive receivers of health care services (WHO, 2000).

The WHO raised the importance of people-centeredness rather than patient-centeredness by addressing people needs before being patients (WHO, 2007b). This would happen by increasing the area of health care coverage to a wider space than the health facilities that would empower individuals and communities to protect their own health through enhancing healthier choices and (WHO, 2007b). That's why the researcher prefer to name the receivers of health care services as clients rather than patients as the mandate for each health care system is to improve communities health status and wellbeing rather than curing the diseases. The concept of "client-centered" care is much wider than the "patient centered" care as this care include all types of receivers of health care services starting from mothers who receive people who receive health education and ending by any individual seeking medical care for their illnesses.

2.3 Values and importance of client-centered health care services

It is well-known that illness experience could be one of the most challenging events in people's lives as it carries feelings of hopelessness and fear. It could by the way affect people dignity and derive catastrophic financial impacts (WHO, 2000). The WHO mentioned that patient–centered/or oriented care assures the protection of people from the different effects of illness by improving partnership with health facilities that would alleviate the impacts the diseases could derive to the people (WHO, 2007b).

From these facts, the importance of client-centered practice appears. Davis *et al.* (2005) said that client-centered concepts would set practical steps to identify patient preferences and improve health care services responsiveness to those preferences (Davis, *et al.* 2005). A study that assessed the outcomes of adopting patient centered care approach proved that this approach will create more satisfied patients and will necessarily decrease the burden on the health care system through decreasing number of referral to higher level of care (Little *et al.* 2001b). The American institute of medicine considered the patient-centered care as one of the main six dimensions that the American health care system should adopt in order to improve the quality of the health care services. They considered that the caring process should be more respectful and considering for patient needs and perspectives through the patient-centered approach of health care services delivery (Institute of Medicine, 2001).

In general terms, health care systems all over the world try to enhance the quality of health care services for all their population (WHO, 2000). Client-centered or patient-centred care is one of the approaches that would let the health care systems achieve that goal. Patient centered over all aim is to enhance the quality of health care services for all the patients (Saha *et al.* 2008).

2.4 Challenges facing client-centered care

Although client-centered care is widely accepted as a modern concept of care, implementation of this concept might not be that easy. Laing (2002) pointed to the fact that health care

professionals tend to resist the new initiatives for creating more client-focused health care services in Scotland. The author said that the physicians usually get confused between focusing on the technical aspects of care and meeting patients' needs and preferences (Laing, 2002).

Elwyn *et al.* (2003) said that the application of this approach requires extensive skill development for health care providers. In addition, the time constrains as well as degree of patients' awareness about the harms and the benefits of health care interventions might affect on the applicability of patient-centered care through physician's consultations (Elwyn. 2003). In another dimension, Britten (2003) mentioned that although lots of literature defined the theoretical concepts of the patient-centered care, much less efforts were done by researchers and policy makers to identify measurement tools to assess the presence of this approach of care (Britten, 2003).

The WHO adopted a frame work for assessing health care systems performance and adopted another concept called responsiveness of health care systems. One of the components of this framework was client-orientation, thus, it was necessary to highlight this frame work and define it in this study. The following lines will describe this concept.

2.5 Responsive health care system

WHO measures the responsiveness of health care systems through assessing how well health systems respond to the legitimate expectations of people to the non-health aspects of health. (WHO, 2001). Responsiveness definition also includes all actors in health care systems that interact with population. Responsive health care system protects people from catastrophic impacts of illness and assures protection of people dignity. Systems that are more responsive to what people want and expect can also assure better utilization of health care services as people anticipate being treated well (WHO, 2000).

There are seven elements of responsiveness titled by two main items; the first item is “respect for persons” which includes dignity, autonomy and confidentiality of information (WHO, 2007b). Dignity means the feeling of clients/patients as being worthy or esteemed. Autonomy

means that the client has the right to be involved in making decisions regarding his/her treatment plans. Confidentiality means the protection of clients' personal information (WHO, 2007b). The second item is "client-orientation" which includes communication, prompt attention, quality of basic amenities, access to social support networks during care (related to secondary or in patients care) and finally choice of care provider (WHO, 2000; WHO, 2007b). Communication means the assurance for complete information sharing and the ability to ask the questions they want about their health condition. Prompt attention means the rapid availability of health care services on the time needed without causing any harm or distress for the clients. Quality of basic amenities assures acceptable standards of the physical amenities within the health care facilities. Finally, choice means the clients abilities to choose the health care provider or the health care facility they are comfortable with (WHO, 2001).

Through revising the literature, the researcher linked client-centered health care services with the responsiveness of health care system as the client-centered health care services are integrated under the wider umbrella of responsive health care systems. It is known that responsive health care system always learn about patients' preferences, needs, and values. In the same time, developing a patient-centered PHC could start from understanding how patients view the care they receive from their primary care clinicians, how well that care is addressing their concerns, and what changes in practice would be most effective for them (Davis, *et al.* 2005). Wilkerson *et al*. (2010) proved that the adoption of a patient-centered care approach in the caring process would reduce ethnic health disparities. This will happen due to the fact that patient-centered care approach will deliver respectful and responsive health care services for each individual/patient (Wilkerson *et al.* 2010).

That's why client-centered health care services which always learn about people views and perspectives would improve health care systems responsiveness and allows for ongoing quality improvement in health care services. This study will focus on the client-centered care of the PHC services. The following lines describe the vital role of the PHC services and the importance of adopting client-centered approach in delivering this type of health care services.

2.6 Client-centered primary health care

Primary care plays an important role in health care quality and outcomes and is fundamental to introduce high performance health care services. It is considered as an entry point to the health system in general and it influence people confidence and trust in the system (Schoen, *et al.* 2004)**.** According to the famous Alma Ata declaration (1978), PHC is considered an essential health care component where empowering individuals and communities and ensuring participation in planning and implementing health intervention is a core character of PHC services. According to WHO health report in 2008, people centered care had its positive effect on PHC services in several countries. Those initiatives that made the people in the center of health care through setting a direct relationship between communities and health care providers produced more effective, efficient and equitable health care services (WHO, 2008).

The people-centered PHC services could be characterized by the following; care that focuses on people needs, the care that provides comprehensive and continuous follow up for individuals and families and finally the care that considers people as partners rather than consumers of health services (WHO, 2008). This report raised the importance of integrating the role of PHC centres in its catchments areas as an introduction or people to the health care services. To build a stronger relation between those facilities, health care providers and communities (WHO, 2008).

Other studies pointed to the importance of adopting client-centered care at the PHC practice. Little *et al*. (2001a) study proved that there is a strong desire for patient centered care practice in PHC consultations especially for those who strongly fell unwell and require emotional support. That study found that there is a strong need for proper communication, trusted partnership and health promotion especially for people who require this type of care (Little *et al.* 2001a). In addition, Bauman *et al.* (2003) pointed to the importance of adopting patient-centered practice especially for patients with chronic illnesses in primary care practice. They said that patient-centered care would increase adherence to long term treatment plans and it would reduce morbidity and improve the quality of life for patients (Bauman *et al.* 2003). In contrast, Mead and Bower (2002) reviewed various research studies about patient-centered

care and the possible outcomes on the efficacy of PHC consultations and they did not reach a consensus about the positive impact of client-centered PHC (Mead and Bower, 2002).

After the previously mentioned research studies and articles, the researcher identified three main domains that would indicate client-centered PHC services. The clients' perceptions about the three domains will be affected according to their demographic variations and their different preferences. In addition, those domains reflect the responsiveness of the PHC services according to the WHO responsiveness definition. The three domains are accessibility, involvement and appropriate health care services. The following lines will describe each domain and its sub-domains.

2.7 Accessibility to health care services

Adequate accessibility to health care services is one of the important characteristics of client-centered services (Davis, *et al*. 2005). Assuring proper access would enhance the relationship between clients and health facilities (Davies and Cleary, 2005). WHO considers accessibility for appropriate health care services as one of the pillars of the right to health frame work (WHO, 2002). Good access to health care services would reduce pressure on health care systems and would necessarily provide better services to the communities (Valentine, *et al.* 2001). Joined with general satisfaction with health care services, good accessibility to health care services is considered one of the factors that increase public trust in health care services (Laamanen *et al.* 2006).

Access to health facilities does not mean only the ease of reaching the health facility but also means patients' ability to receive appropriate medical intervention whenever required. Berry *et al*. (2003) identified four main characteristics for patient-centered access; they are availability including physical and financial affordability, appropriateness which means obtaining proper levels of care without affecting medical technical standards, access to preferred provider or specific medical service, and finally timeliness (Berry, *et al*. 2003). They pointed that improving access according to their definition would enhance safety, effectiveness, patient centeredness, timeliness, efficiency and equitability of health care services (Berry *et al.* 2003).

2.7.1 Physical accessibility

The way of reception in the health institution is an important factor that increases or decreases physical accessibility to health care facilities. Generally, people need proper reception and comfort in health facilities; this would increase the utilization of services and improve the outcomes of the health care services (Haddad, *et al.* 1998). In addition, the cleanliness, comfort and availability of basic requirements (such as drinking water) are important factors that could affect on physical access to clinics (Valentine, *et al.* 2001).

In the Palestinian context, the physical accessibility to PHC facilities is relatively good according to the PCBS access to health services survey that was conducted in 2004. The results of that survey showed that almost 98% of the households in GG have a health care center in their neighbourhood. In addition, 83.5 % of Gaza Strip population were able to receive the health care service they needed (PCBS, 2004).

2.7.2 Financial accessibility

Financial accessibility including health insurance coverage is an important accessibility factor. This factor might affect on people ability to utilize and ask for health care services (WHO, 2000). Recently, the sharp deterioration in economic levels for GG population could affect on their contribution in health care financing (Giacaman *et al.* 2009) though it might affect on their access to PHC facilities. In this study, results showed good financial accessibility for the clients who visited the PHC clinics, though, other people who might be in a financial crisis will not reach the health facility form the first place.

2.7.3 Technical accessibility and access to information

Another important determinant of client-centered access is the accessibility to information, it is the ability of the clients to receive the information they want regarding their health, people they care for and general public health concerns (WHO, 2001). People need sufficient, honest,

accurate and clearly presented information especially about possible harms of their treatment methods and medications (Edwards, *et al.* 2001). It is known that the extent to which routine medical consultations improve patient knowledge about their disease and treatment options is essential to assure implementation of health interventions (Labhardt, *et al.* 2009). Moreover, continuity of care depends on ensuring continuity of adequate information (WHO, 2008).

According to the WHO, people have the right to receive all the information they have in mind. Little, *et al.* (2001a) identified proper health promotion and increasing information sharing as well as all the initiatives that would reduce the risks on the patients as one of the dimensions of patient-centered PHC services (Little, *et al.* 2001a). It is not allowed any more to ignore patients' rights to understand well their health and illness conditions (WHO, 2002). Saha *et. al.* (2008) said that client centered interaction could be indirectly through sharing health education materials and meeting clients needs for written documents that would comfort them and let them feel more secure (Saha *et. al.* 2008).

2.7.4 Accessibility to essential medications

Accessibility to essential drugs is another factor that shapes client-centered care and it is considered as an important right for clients (WHO, 2004b). Haddad *et al*. (1998) study tried to assess what are the concerns of the patients who visit PHC clinics; the study found that access to medication was one of the most important concerns of patients (Haddad *et al.* 1998). This study found that availability of drugs is one of the major concerns for the clients as it was considered as the first factor that reflects good quality of services. Accessibility to medications is not only receiving the drug but also sharing the related information for proper drug consumption. In addition, Elliott (2009) pointed to the fact that a patient-centered relationship between health care provider and patient would improve adherence to medication regimen. He also pointed to the fact that general satisfaction with medical consultations would necessarily improve adherence to medication regimen (Elliott, 2009). And hereby, the importance of complete accessibility to medication was an important factor that was assessed in this study.

Regarding the condition in the West Bank and GG, a previous study showed that there were no dispensing rules, and dispensing practices do not facilitate the delivery of any information or message to patients. In addition, dispenser-patient communication hardly exists and this can be noticed by the short average dispensing time which was estimated at 30 seconds. They said that this was probably due to the large number of patients and a lack of structured supervision (Obeidallah *et al.* 2000). Another study showed that adequate labeling by writing drug name, dosage and expiry date was not done properly (El-Afifi, 2008). Furthermore, another assessment of the medicines management in selected central clinics in West Bank and GG showed that dispensing practices are characterized by poor packaging and even some times no packaging at all. In addition, labelling was not adequate and high percentage of sample prescriptions were incomplete with examples of missing information given as diagnosis, age, dosage form, and strength (WHO, 2006c)**.**

From the previous literature, the researcher defined four main factors that reflect client-centered accessibility to PHC services and they were; physical accessibility, financial accessibility, technical and information accessibility and finally access to essential medicines. All of those factors were assessed and the results are presented in the results chapter.

The second domain is the characteristics of health care services delivery. The following lines will describe the main factors that would indicate client-centered PHC services delivery.

2.8 Health care services delivery

The literature identifies several factors that determine appropriateness of health care services delivery. Donabedian (1988) pointed to the importance of interpersonal relationship between providers and patients which should guarantee privacy, confidentiality, informed choice, concern, empathy, honesty and sensitivity. He considered the art of health care delivery and the way of interaction with receivers of health care as an important component in the quality of health care services (Donabedian, 1988). Those factors defined by Donabedian are a direct reflection for the characteristics of client-centered health care services in general.

2.8.1 Waiting time and time spent with health care provider

One of the factors that reflect the appropriateness and the quality of healthcare services is the time factor. In particular, people have the right to expect that the health system will treat them with dignity and their needs will be met without long delays in waiting for diagnosis and treatment. It is not only for better health outcomes, but also to show respect for patients and to reduce their anxiety (WHO, 2000). According to the access to health services survey, 29.5% of persons had to wait for too long before receiving the service (PCBS, 2004). Another study pointed that most of clients complained from long waiting times specially in hospitals out clinics (Abu Dayya, 2000).

Studies show that patients long waiting time (Kuzel, *et al.* 2004), feeling of un respect of their time value and lack of equity in health care facilities (some patients does not have to wait too long as they have someone to facilitate their entrance while others have no option but to wait) would create feelings of disrespect of patient as individuals. In addition, waiting too much time may cause emotional injury to the patients and weakens patients-staff relationships followed by distrust between them (Kuzel, *et al.* 2004). Moreover, long waiting times might decrease patients' access to the health facility, which is very dangerous specially in PHC where immunization, ante natal care services are provided in addition to follow up for chronic diseases happens. Rao *et al.* (2006) study showed that longer waiting time had a progressively large negative effect on both in-patient and outpatient satisfaction and this would affect negatively on the desired health outcomes.

2.8.2 Communication with health care provider

Good communication between health care providers and patients is another factor the researcher will consider. According to Tongue *et al.* (2005) good provider- patient communication is one of the factors that characterize patient-centered care and it is the bedrock of quality medical care (Tongue, *et al.* 2005).In addition, Little *et al*. (2001a) joined between enhancing effective doctor-patient relationship and its positive impacts on empowering patients to make healthier decisions and identified it as an important dimension in the patient-centered PHC services (Little *et al.* 2001a). One of the studies conducted in PHC

clinics in Tunisia recommended the improvement of communication and interaction between health care professionals and clients through adopting a client-centered approach (Letaief *et al*. 2008).

Client-centered communication does not focus only on health care provider communication. Saha *et al.* (2008) mentioned that the client centered communication could include not only client and health care provider direct interaction, but also, indirect interactions through telephone to have the phone answered by a pleasant and responsive receptionist who would respect the client and introduce him to the health facility (Saha *et al*. 2008).

Donabedian (1988) and Haddad, *et al.* (1998) mentioned that interpersonal relation between the patient and the provider is an important part in practitioners' performance side by side with the technical performance. They said that the importance of communication rises from the fact that good interpersonal discussion gives the patient the chance to communicate the necessary information that will help the doctor in diagnosis as well as detecting clients' preferences. This will help in selecting the most appropriate methods of care; In addition, it allows the provider to clarify the nature of the illness and its management this would motivate the patient for active collaboration. Collaboration is the vehicle by which technical care is implemented and on which its success depends (Haddad *et al.* 1998). However, most of the times the component of interpersonal communication is ignored when evaluating health services as it depends on people perceptions rather than fitting to specific standards (Donabedian, 1988).

Regarding health care services in Palestine, Abu Dayya (2000) study about people satisfaction with governmental health care services in Palestine showed that lots of clients felt that health providers didn't listen to their complains in an adequate way, they felt that they were not given adequate time to discuss their complains to the physician (Abu Dayya, 2000). Hamad (2009) paper considered communication and information sharing as weakness points that should be enhanced in order to improve interaction between health providers and patients (Hamad, 2009).

2.8.3 Respect (privacy and confidentiality)

Another factor is respect and confidentiality, WHO considers patients privacy as one of the basic rights to health for every person (WHO, 2002). Moreover, respect for clients is considered one of the factors that present a responsive health care system (Valentine *et al.* 2001). Respecting the clients who seek medical service is an important factor that indicates good relation between the health provider and the client. According to Edwards *et al.* (2001) people like to be talked as persons who can make decisions with respect for their knowledge and feelings about their condition (Edwards, *et al.* 2001).

One study showed that the lack of privacy during clinical consultations was one of the negative aspects perceived by clients who approached PHC clinics in Egypt (Gadallah *et al.* 2003). In contrast, the situation in Palestinian health care facilities was different in Abu Dayya (2000) study which showed that most of the clients (65%) were satisfied with the respect for their privacy while 7% only of them were not satisfied.

2.8.4 Freedom of choice

Another important domain that reflects client-centered health care services is the freedom of the clients to choose the health care provider who will follow up their health condition. It is one of the factors that reflect client-orientation in the WHO responsiveness definition (WHO, 2002). According to Davies and Cleary (2005), scheduling patient's appointments with their preferred doctor was a method used in UK and USA in order to increase patient-centeredness of health care services (Davies and Cleary, 2005).

According to the WHO measurements of health care systems responsiveness, the choice of health care providers through outpatient clinics was the highest attained score for client-orientation domain (WHO, 2001). However, other international and national studies reflected different situation. Kerssens *et al.* (2004) stated that key informants in 14 European countries ranked the freedom of choice the least important factor of responsiveness in comparison with other responsiveness factors (Kerssens *et al*. 2004). A study conducted in Lithuania mentioned that 40% only of the health facility visitors could choose the health care giver (Ducinskiene *et al.* 2006). The authors considered this as a low score for choice (Ducinskiene

et al. 2006). At the national level, Abu Dayya (2000) showed that 81% of patients in inpatient and outpatient health care did not choose their heath care provider (Abu Dayya, 2000). This goes along with the results of this study where 72% of the respondents did not chose the health care provider.

2.8.5 Smooth referral between health care levels

The literature points to other important factors for appropriate client-centered health care such as smooth referral between various health care levels (Davis, *et al.* 2005). Coordination of care is an important factor that indicates patient-centered care specially for patients with chronic diseases face multi-providers and transport between levels of care (Bergeson and Dean, 2006). Another important factor is the continuity of service delivery (Davis, *et al.* 2005; Laamanen *et al.* 2006). According to Alma Ata declaration (1978) PHC services in particular should be sustained by functional and supportive referral systems that assure continuity of care for the patients.

This study did not assess this factor as most of the respondents were not referred to another health care facility. The researcher thought that this domain will not be well reflected from the available data. A previous assessment in Palestine showed that are problems in the referral between PHC and hospital levels due to possible lack of confidence with PHC services which might have resulted from diagnostic limitations, lack of drugs, inadequate specialized staff and finally, unavailability of afternoon shifts in most of PHC facilities (Abed, 2007). This situation might be different since that assessment.

2.8 6 Quality of basic amenities

The general clinic environment should be suitable and comfortable for the clients. The WHO appraised the importance of non-health related dimensions of care besides the technical performance of health care providers (Valentine, *et al.* 2001). Though, the good quality of the basic amenities in the PHC clinics is one of the main domains that reflect responsiveness of health care systems and it will have its effects on the overall caring process. Clean surroundings, sufficient ventilation, clean water, clean toilets and adequate furniture is

important to provide acceptable health care services for the clients (Valentine, *et al.* 2001). Gadallah *et al.* (2003) study assessed clients' perceptions about the basic amenities in PHC clinics in Egypt. Most of the clients were satisfies with the cleanliness of the clinics environment and the seats in the waiting areas as well as clinic lightning and ventilation (Gadallah *et al.* 2003). This study reviled general satisfaction with the basic amenities within the PHC clinics in the GG.

In conclusion, the researcher defined six main factors that reflect the client-centeredness of the PHC services. Those were adequate waiting time and time spent with health care provider, proper communication, freedom of choice, assurance of privacy and confidentiality of clients and finally the quality of the basic amenities within PHC clinics. The following lines will describe the third domain of client-centered care that is the degree of clients' involvement in planning, evaluation and implementation for health care interventions.

2.9 Clients involvement in heath care

According to WHO (1999) community and individuals involvement in the decisions and actions that would affect on their health is a basic right for all. This involvement encourages their sense or responsibility for attaining better healthy conditions, thus improving health of the population (WHO, 1999). Mead and Bower (2000) identified "sharing power and responsibility" through shifting the physician-patient relationship from guidance into mutual participation in the health caring process as one of the dimensions of patient-centered care. Both Stewart (2001) and Little, *et al.* (2001a) considered finding common ground that pave for partnership between the patient and the provider as an important factor that reflects centeredness of health care services (Little *et al.* 2001a; Stewart, 2001).

All quality improvement initiatives necessitate the participation of individuals and communities within the health care process. WHO (2006a) considered engaging patients and population in health care as one of the domains of quality improvement procedures. The importance of this domain rises from the fact that individuals and communities play vital direct and indirect roles within health systems. Consistency of services with public will

increase its chance of success (WHO, 1999). For example, people can participate in financing of health care services through insurance and co payments. Moreover, patients should work in partnership with health providers to manage their own care and adopt healthier choices to improve their health.

According to Michie *et al*. (2003), it is not only important to have a patient-centered communication between health care providers and patients, but also to develop patients' awareness and skills to activate patients' participation in the caring process (Michie *et al.* 2003). By the end of the day, people decide what the acceptable and beneficial things in health care are and what the unacceptable things in the whole care process are. Bergeson and Dean (2006) pointed to the importance of increasing patients' participation by allowing more space for patients to express their concerns and involving them more actively in the design of their care (Bergeson and Dean, 2006).

Health care services in developing countries usually depend on limited resources, thus, community involvement in health would possibly increase the responsiveness of the limited resources to the actual needs for the communities (WHO, 1999). However, within the Palestinian context, Health Sector Review (2005) mentioned that all the PHC facilities which were included in the assessment of health services delivery showed no interaction with local communities which indicate some isolation between the facility and community around it. In addition, there are low levels of clients participation in decisions related to treatment plans, choosing health provider and health facility regardless of their education levels (Abu Dayya, 2000). The researcher identified three main factors that characterize people involvement in health care, thus reflect client-centered services. Those factors will be mentioned in the following lines.

2.9.1 Involvement in planning

The first domain is the participation in planning and decision making. Donabedian (1988) pointed that patients and families should share some responsibility for the success or failure of care. Edwards *et al.* (2001) study about consumers' views of quality of PHC consultation reflected that people favored to have some involvement in treatment decisions; however, they

don't usually find this. In the other hand, people do not always prefer their direct involvement in health decisions especially in emergency cases, while they prefer their involvement in treatment decisions for long term disease such as chronic diseases which require adopting new life style and prolonged use of medications (Edwards *et al.* 2001).

Litva *et al.* study (2002) assessed the extent of public preferences for being involved in decisions related to health care services provision. The public showed a high desire for participation in deciding places for emergency services and choosing between two different health care services to be opened in their areas. In the other hand, People did not show the same interest for decisions related to distribution of treatment among two different illnesses/patients. Some individuals preferred to be consulted rather than being responsible for decisions especially in decisions that requires adequate technical knowledge (Litva *et al.* 2002). Cheraghi-Sobi *et al.* (2008) identified that the patients are more concerned about good communication with a qualified health care provider rather than being involved in decisions related to their health. Patients also preferred to be examined by a physician who knows them well (Cheraghi-Sobi *et al.* 2008). This study assessed patients' perspectives about the most important factor the patients are looking for in primary care consultations. The study asked about several factors including the ease of access, choice, technical quality, interest in patients ideas, concern about patients social well being and involvement in decision making (Cheraghi-Sobi *et al.* 2008).

2.9.2 Involvement in implementation (Autonomy)

Shared decisions between health providers and patients are considered one of the key components of patient-centered practice (Elwyn *et al.* 2003). The second factor identified by the researcher is people involvement in implementing health care interventions. It is the way of sharing responsibility between the health providers and the clients after providing them with the required information that assures their informed choice and good adherence to treatment plans. In other terms, this could be described as clients' autonomy where the client has the right to be involved in decisions related to his own health (WHO, 2001).

Lots of studies pointed to the importance of clients' involvement in deciding their treatment plans. Davis, *et al.* (2005) considered patient engagement in care through active participation as well as ongoing routine patient feedback (patient-centered surveys) that would reflect patients' perceptions about the services in general as important factors that indicate the patient-centeredness of the PHC services. According to Kerssens *et al.* study (2004), there was a strong relation between the high responsiveness and over all performance of health care system and the extent of physician understanding of client problem as well as allowing client to contribute in deciding the best treatment (Kerssens *et al.* 2004). Elliott study (2009) showed that health care providers might see involving the patients in decision making as a time consuming process, however, this type of involvement would improve patients adherence with their treatment plans and medication regimen (Elliott, 2009).

Another study considered shared decision making between the client and a care provider who care about the client as an important demand for any client. This approach joined with good access to information and expert knowledge will necessarily improve health care delivery (McLaughlin and Kaluzny, 2000).

A study pointed to the fact that some health care providers usually rely on their assumptions about the patients' preferences in being involved in decision making regarding their treatment plans. Those assumptions might lead to the development of different interaction methods for people with different education levels (Elwyn *et al.* 2003). In this case, enhancing health care provider's ability to increasing patients' capacity in participation in health decisions through appropriate transition of knowledge to the clients would be necessary (Hibbard, 2004).

2.9. 3 Involvement in evaluation

The third factor is clients' involvement in health care services evaluation by conducting sustainable satisfaction surveys to ensure representation of client's opinions about the services and evaluating providers' performance as well. This is the key to detect people preferences and considering their needs which is an important determinant of client-centered care. According to Saha *et al*. (2008), Clients should take their opportunities to provide their

feedback about the health care services in order to fully understand their needs and to study the outcomes the clients are looking forward to (Saha *et al.* 2008).

Davies and Cleary (2005) study that assessed the methods used both in UK and USA for developing patient centered health care services identified gaining feedback from the patients and documenting their complains followed by feeding patients opinions back to the health care providers as an important method to improve health care services (Davies and Cleary, 2005). Gaining patients' feedback was through conducting patients surveys, exit interviews and telephone and websites messages and comments (Davis and Cleary, 2005).

Within the PHC clinics in Palestine, Hanan (2005) report pointed to the fact that more than the half of the surveyed clinics (including MOH, UNRWA and NGO clinics) did not conduct any assessment measures for their beneficiaries satisfaction with the services (Hanan, 2005). This study results showed that most of the clients did not participate in any activity related with evaluating the health care services they received. This area reflected a weakness point in clients involvement in general.

2.10 Clients perspectives and preferences

Identifying patients' expectations and what their preferences would be the first steps in order to reach the ultimate goals for improving health care services (Zebiene, *et al.* 2004; Johnson, 2008). However, understanding people's preferences is not an easy process for health care providers for different reasons. First, both clients and health care providers have different preferences and expectations. Health care providers concentrate on technical performance and adherence to standards while receivers of health care services evaluate its quality from a different angle (WHO, 2000). McKague and Verhoef (2003) explained the difference between providers and clients perspectives where clients usually focus more on their experience in illness, their feeling of symptoms and the financial impacts of the disease. On the other hand, health care providers usually focus on their role in changing the determinants that might affect on people health such as life style and daily behaviours (McKague and Verhoef, 2003). This information asymmetry between health care providers and the clients creates the

misunderstanding of different views. Second, technical care could be standardized while interpersonal interaction differs from one individual to other and this raises the challenge for identifying individual's characteristics and the best way for interacting with them (Campbell *et al*. 2000). Finally, people perspectives and preferences differ according to the surrounding factors that shape people's opinions (WHO, 2000). Providers do not always manage to understand all the determinants surrounding their patients and this makes dealing with patients as persons rather than cases hard to be achieved (McKague and Verhoef, 2003).

Understanding the receivers of health care services and identifying the factors that would affect their behaviors are considered one of the dimensions of the patient-centered care (Mead and Bower, 2001). It is worth mentioning that client-centered care approach in health care it do not necessarily suit all clients or all health care services. Clients' preferences and conditions differ, thus, client-centered care domains could be applied according to the factors surrounding the receivers of health care services as well as health care providers (Little *et al.* 2001a). For example, Little *et al*. (2001) said that patients who are not feeling well usually want more patient-centered care than others as they are usually more anxious and require more emotional support than others.

However, every country has its unique situation that shapes different needs and expectations. Regarding people living in Palestine, under the occupation constrains, lack of stability, economic deterioration and political division might shape different needs and preferences regarding health services. For example, this study figured out that clients in GG are concerned about the availability of medications in the health care facilities more than the actual communication and interaction with health care providers. Other studies tried to identify the factors clients are concerned mainly about in the health care services. Haddad, *et al.* (1998) study found that the patients are mainly concerned with good diagnosis and adequate treatment in addition to receiving sufficient information on their health problems and treatment (Haddad, *et al*. 1998). This goes along with another study that found that the most important expectations for patients were good understanding and informative explanation of their condition (Zebiene, *et al.* 2004). For those reasons, further research studies are needed in order to understand the factors that would shape people's expectations and preferences.

2.10.1 Clients' characteristics and differences in preferences

The clients' preferences and perspectives about health care services differ according to internal factors (personalities) and external factors (environment, living conditions) (Haddad et al. 1998). Also, Berry and *et al.* (2003) study figured that clients' preferences are shaped by their previous experiences in receiving health care services, other people recommendations and the effecpts of media (Berry, *et al.* 2003). The following are some of the characteristics that might shape different preferences and perspectives regarding health care services.

Clients' characteristics have its impacts on their perceptions (Hamad, 2009). Several national and international studies that assessed clients' satisfaction with health care services raised the presence of these differences. For example El Haj (2008) mentioned that females usually have better perceptions about the health care services than males (El Haj, 2008). Haddad *et al.* (1998) study that assessed the meaning of quality of health care services to lay people through multiple focus groups found that female clients usually ask for the availability of good drugs, clean rooms and better food in the health facilities more than males. On the other hands, males asked for good accessibility, availability of prescribed drugs, attention given to the patients and rapid cure. This reflects different views and expectations from males and females. In contrast, Margolis et al. (2003) study that assessed clients' satisfaction with PHC services in the United Arab Emirates found no differences between males and females perspectives regarding the quality of PHC services. Also, Gadallah *et al* (2003) study found the same results.

Generaly speaking, clients with high education levels usually have higher expectations (Hamad, 2009). According to El Haj (2008) study, clients with lower education levels reported higher scores of satisfaction with hospital services than clients with higher education levels (El Haj, 2008). In addition, Margolis *et al.* (2003) study found that clients with higher education though that the services are less effective than clients with lower education level.

Clients with different age could have different preferences and perspectives about health care services. El Haj (2008) said that most studies showed that older age are more satisfied than

younger ones about the services they receive (El Haj, 2008). WHO (2001) responsiveness measures among various countries stated slight increase of responsiveness scores with the increase in respondents' age. These differences did not reach any sisgnificant levels either (WHO, 2001). Also, Margolis *et al*. (2003) study showed that clients with older age perceived the PHC services as more comprehensive than clients with younger age. This might be a result of different preferences in the caring process. For example, Little *et al*. (2001b) said that Patients with old age are less likely to desire good communication with health care providers as well as older patients are more likely to receive a drug prescription as a major concern (Little *et al.* 2001).

2.11 PHC clinics characteristics

In the GG, there are 56 PHC clinics distributed among the governorates. Each clinic have its own characteristics such as the level of the clinic (the clinics are classified according to health services provided through it and number of workers and beneficiaries coverage) number of staff, relationship between the clinic and the community, infrastructure and the availability of drugs and supplies and so on. Such variables would have their impacts on the health care services delivery and the clients' perspectives on the services. Thus, those factors might affect on the overall clients perceptions about the health care services (El Haj, 2008). For example, Al-Hindi (2002) pointed that organizational factors such as number of visits of beneficiaries to the radiology center have its impacts on the overall clients' satisfaction with the services. Thus, it was important to consider different clinics characteristics' in this study.

The infrastructure and the available basic amenities within the health care facilities have their impacts on the health care services delivery (WHO, 2001b). Margolis *et al*. (2003) study found that the satisfaction levels with PHC services increased as well as the capabilities of the clinics to provider more advanced and complete services and medications with good quality increased (Margolis *et al*. 2003). This reflects the importance of appropriate staffing and availability of drugs and supplies in the clinics. At the local level, Elkhatib (2010) study that assessed clients' satisfaction with PHC services at UNRWA clinics found that the convenience of the clinic environment improves clients satisfaction with services.

Chapter (3)

Methodology

This chapter presents the study methodology. The chapter illustrates the study design, study population and the study setting. In addition, it presents the study, pilot study, data collection technique, data entry and data analysis. It also presents ethical considerations and the study limitations.

3.1 Study design

The design of this study is analytic cross-sectional one. It was used to describe the extent to which PHC services are clients' centered. Analytic research generates new knowledge about concepts and identifies relationships between variables (Burn and Grove, 2010). Cross sectional design reflects the existing facts at the same point of time of data collection, it consumes less time than other longitudinal studies (Fathalla, 2004).

3.2 Study population

The study population was the clients visiting governmental PHC facilities for receiving services from these facilities.

3.3 Study setting

The study was conducted in 10 randomly selected governmental PHC facilities which are distributed among the five GG. The total number of governmental health centres was 56 at the time of conducting this study.

3.4 Study period

The study started in March 2010. The School of Public Health at Al-Quds University, has approved the study proposal and sent an administrative letter to the Human Resources Development Directorate of the MOH and the General Directorate of the PHC of the MOH in June and July 2010.

The pilot study was conducted in September 2010 while the data collection started in October 2010 and completed in December 2010. Data entry was conducted alongside the data collection and completed in early January 2011. Data analysis was conducted in January 2011. Compiling and writing was the report completed in April 2011.

3.5 Sampling

3.5.1 Sample calculation

The researcher calculated the estimated monthly visits for the PHC according to the registry of clients' visits for PHC clinics (2008). The study setting was ten PHC facilities and the data collection was estimated to be for two months, thus the total study population was estimated to be the average of visitors for two months among the ten PHC clinics. The researcher used the Epi-Info sample size statistical calculator and considered that the lowest expected frequency for clients' participation in their treatment plans and choosing health care providers as 20% and the worst acceptable answer as 15%. The sample size was 245 at 95% confidence level. The researcher increased the sample up to 300 individuals among those presenting to PHC centers to cover for possible non-respondents.

3.5.2 Sampling process

Multi-stage sampling technique was used to select the 10 PHC clinics from the 56 clinics. First, GG areas were divided into five governorates) according to the PCBS. In each governorate, the clinics were categorized into two categories; level 4 clinics categories and level 2&3 clinics category. Then, a simple random selection was done for each category within each governorate (Annex 2).

The selected sample of the 300 clients was proportionally divided among GG according to services statistics in the PHC database. Also, the proportional sample from each governorate was divided between the two selected PHC clinics. Sixty percent of the sample was taken from level 4 clinics and 40% was taken from level 2 or 3 clinics. Then, systematic random selection for clients was done depending on visits schedules per each clinic during the data collection dates at the beginning, middle and end of the month. Accordingly, the Kth was determined and the selected clients were interviewed as they exit the clinic (an exit interview).

3.6 Eligibility criteria

The inclusion criterion was clients visiting the selected governmental PHC clinics for receiving any kind of health services during the data collection period.

Exclusion criterion was visitors to the governmental PHC clinics who did not receive any health care services and/or were companions with clients during the data collection period.

3.7 Study instruments

Self-constructed interviewed structured questionnaire for clients exiting PHC clinics (Annex 3) were used. Additionally, questionnaire for PHC clinics (Annex 4) that were selected for this study has been also implemented. The main items for the questionnaire were:

Clients Questionnaire

- General information and demographic variables for clients; including age, sex, employment status, average monthly income and education level.
- Items describing accessibility domains (Physical, financial, technical and information and accessibility to essential medications.
- Appropriateness of service delivery domains such as waiting times, times spent with health care provider, communication, respect, choice and finally quality of basic amenities.
- Statements for the degree of involvement of clients in PHC; as involvement in planning, implementation and evaluation of health care services
- Clients general views about PHC services in addition to the most important factors that indicate good quality of PHC services.

Facility Questionnaire

- PHC facility general information including clinic level, number of staff, available services, and presence of representative committees for clinic beneficiaries.

3.8 Scientific rigor

3.8.1 Reliability

The following steps was done to assure reliability

- Training of data collectors on the client interviewing steps and the way of asking questions was assured and standardization of questionnaire filling was done.
- Standardization of implementation

- Daily Checking and review of questionnaire
- Data entry has been conducted in parallel with data collection which allowed for immediate checking of data quality and control.
- Researcher entered all the data herself followed by a re-entry for 5% of the data. This assured a correct entry procedure and decrease entry errors.
- The statistical test used for measuring the internal consistency is Cronbachs Alpha coefficient that assesses the internal consistency of the categorised questions. The total reliability test for all the domains combined was 0.911 which reflects high reliability (table 3.1).

Table (3.1) Reliability of categorized questions

Domains	No of items	Reliability (Cronbachs Alpha)
Health care services delivery (Choice, Respect and communication)	12	0.764
Involvement (Planning and implementation)	11	0.973
Overall	23	0.911

3.8.2 Validity

Face validity

The questionnaire was organised to allow smooth data collection. The questionnaire lay out was modified several times to assure the final professional look it appeared with.

Content validity

The questionnaire was evaluated by 10 experts (health care professionals at the PHC level, academic health professionals and other health care professionals in international health organization) to assess its relevance of the domains and the questions with the overall aim of the study.

The researcher considered all the experts comments and made the necessary modifications on the questionnaire. Also, a pilot study was conducted before the actual data collection to

examine clients' responses to the questionnaire and how they understand it. This enhanced the validity of the questionnaire after modifying it to be better understood.

3.9 Ethical and administrative considerations

An academic approval was asked for from School of Public Health at Al-Quds University (Annex 5) and an ethical approval was obtained from Helsinki Committee (Annex 6). Additionally, an administrative approval was obtained from the Directorate General of Human Resources Development Directorate and the Directorate of PHC in GG (Annex 7).

To guarantee participants human rights, a covering letter indicating that the participation is voluntary was provided and confidentiality were assured. All the selected clients were asked for their approval to participate in the study. Respect for truth and academic honesty were also maintained during analysis, interpretation and writing up.

3.10 Pilot study

A pilot study on 15 clients was done by the researcher to explore the appropriateness of the study instruments and let the researcher train for data collection. This step improved the validity and reliability of the study. Minor modifications were done such as changing the arrangement of some questions, rephrasing two questions and finally modifying additional options for two non-prompted questions as they were mentioned by most of the pilot sample. The piloted cases were included within the study sample.

3.11 Data Collection

Two meetings was held with the two skilled data collectors to introduce the overall aim of the study and go through all the questionnaire questions to clarify them and unify the data collection methodology as sample selection, way of phrasing the questions with the local argot.

After that, the researcher and the two professional data collectors conducted exit interviews for clients visiting the selected PHC clinics. Regarding the timing of data collection, it was done

in the first days (1, 2, 3) middle days (14, 15, 16) and last days (27, 28, 29) of the month (along October and November). Random selection for the clients exiting the health care facilities during that dates were done. This would assure equal chances for sample selection and also represent various days of the month where different clients flow could be captured. Annex 2 describes the actual sample distribution and data collection plan.

Interviews with selected clients were done. The researcher and data collectors asked if the client would like to participate in the study or not after introducing the aim of the study. Then, clients response rate were measured according to clients acceptance or rejection for participation.

The clients were asked the questions in the questionnaire, some questions have specific options (answers) others have non-prompted answers while others were open ended questions. Each questionnaire required from 20 to 25 minutes to be completed.

Regarding the PHC clinics questionnaire, data collectors interviewed the clinics administrative manager to answer the questions.

3.12 Response rate

The general response rate was 91% (274 out of 300). The lowest response rate was in Gaza (83%) while the highest response rate was in the northern governorates (100%). It was noticed that clients presented to small clinics had a higher response rate than clients presented to the big clinics. In addition, response rate among females was higher than response rate among males.

3.13 Data entry and analysis

The researcher used Statistical Package of Social Science (SPSS – 13) program for data entry and analysis. The first sage of data entry was through constructing the data entry base with codes for questions and answers, followed by the actual data entry then followed by data cleaning.

The data analysis included; forming frequency tables that show the study variables. Some of the variables required recoding and grouping while others required special computing. Then, general scores for some variables with scale related answers were computed and the differences in the scores between various GG PHC clinics (such as clinic area, clinic level, and clinic interaction with community) and clients' characteristics variables (clients sex, age group and attained education levels) were done.

The significances of the differences between the independent variables with two categories (such as clinic level, clinics have representative committees or not, client sex) were done by t-test while the significance of the differences between independent variables with three or more categories (clinic area, client's age group and clients attained education levels) were done by one way-ANOVA test.

3.14 Limitations of the study

- This study included a sample from the MOH clinics while and there are other PHC clinics for UNRWA and NGOs were not included
- The study included only clients visiting the PHC setting within the study period while the opinions of people who don't come to the PHC could be important to reflect better image for reality.
- The study is cross sectional and most likely clients' responses reflected their experience in their last visit. Monitoring clients perspectives over a longer period of time most likely will provide more reliable estimates
- Because the theme under investigation is related to perceptions, it is preferable to consider a qualitative research designs as complementary to the utilized quantitative design.

Chapter (4)

Results and Discussion

This chapter illustrates the main findings of this study. The first part presents the descriptive analysis of the study domains. The second part presents inferential analysis that compares between the clinics and the clients' different characteristics variables and the scores of some selected sub-domains.

4.1 Descriptive analysis

4.1.1 General characteristics

4. 1.1.1 Demographic characteristics

Results showed that 66.4% of the respondents were females while 33.6% were males (Table 4.1). Higher female percentage could be explained as females usually visit the clinic for ante-natal care and family planning and they bring their children to get their vaccination and receive other health services. In Mataria *et al.* study (2004) on the West Bank PHC clinics, the percentage of females was 76.8%. Similar to neighbouring countries, most of the PHC clinic visitors were females. In Egypt, the percent of females among the PHC visitors was 70% (Gadallah, *et al.* 2003) while in the United Arab Emirates, females comprised from 57 up to 71% of the clinics visitors (Margolis, *et al.* 2003). This points to the importance of including females in efforts aiming to increase clients centeredness of health services. Table 4.1 illustrates the general demographic characteristics of the study respondents.

Regarding the education level, 47.8% of the respondents attained secondary education certificate while 20.4% attained less than secondary education level. Almost one third of the respondents had university degree or higher (figure 4.1). People who access PHC clinics do not necessarily reflect the actual population as most of the PHC clinic visitors are females from certain age category who do not represent all the age groups of the entire population. According to PCBS (2010), 63.4% of GG population have had less than secondary education, 20.5% have secondary education while 16% have higher than secondary education. According to WHO series on health care responsiveness (2000), the higher the education level for population, the higher the utilization for health care services. This finding is important in order for the health care systems to respond to population demand (WHO, 2000).

Table (4.1): Distribution of respondents by characteristics variables

#	Variables	No.	%
1	**Sex**		
	Male	92	33.6%
	Female	182	66.4%
	Total	274	100%
2	**Attained education level**		
	Less than secondary	55	20.4%
	Secondary	129	47.8%
	University	86	31.9%
	Total	270	100%
3	**Citizenship**		
	Non-refugee	207	76.1%
	Refugee	65	23.9%
	Total	272	100%
4	**Current employment status**		
	Employed	79	28.8%
	Not-employed	195	71.2%
	Total	274	100%
5	**Marital status**		
	Married	254	93%
	Not-married	19	7%
	Total	273	100%
6	**Average age**		
	20 and less years	22	8.2%
	21-30 years	112	41.8%
	31-50 years	94	35.1%
	51 and more years	40	14.9%
	Total	270	100%
	Mean : 34.1 $\pm$12.5 years	Median:30.5 years	
7	**Average income**		
	Less than 1000 NIS	46	23%
	1000-1500 NIS	66	33%
	More than 1500 NIS	88	44%
	Total	200	
	Mean : 1549 $\pm$ 830 NIS	Median : 1500 NIS	

Regarding clients citizenship status, 76.1% of the clients were non-refugees while 23.9% were refugees. Refugee population are also allowed to access free of charge UNRWA PHC clinics and they have the option to utilize governmental PHC clinics services too if they are medically ensured (children up to three years are exempted). Regarding marital status, 93% of the clients were married and 7% were single, divorced and/or widowed; reflecting higher utilization rates among married people. This is in line with the literature which indicates higher utilization among married.

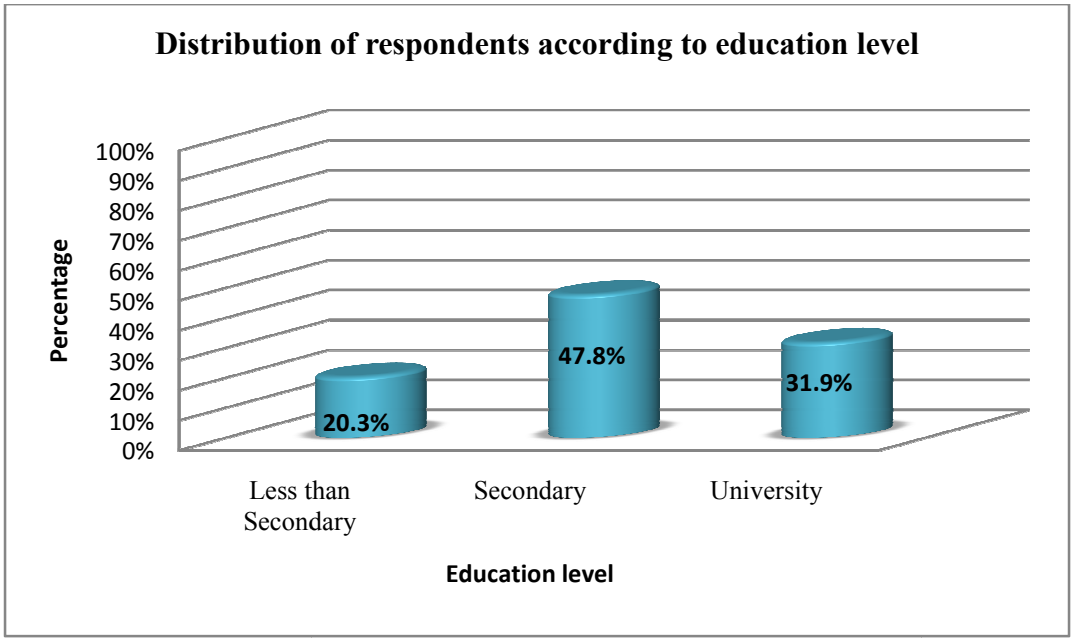

Figure (4.1) Distribution of respondents by their education levels

The general employment status among visiting clients was low (28.8%). However, when disaggregated by sex (figure 4.2) results showed that 69.7% of males were working and only 8.2 % of females were working. According to PCBS (2010) women constitute 11.6% of the total working labour force in the GG. It is worth to mention that the unemployment rates among the workforce in GG are considered high in comparison with neighbouring countries. According to PCBS (2010), 33.9% of people included in the working force are unemployed (PCBS, 2010).

The average age among the respondents was 34 (SD $\pm$12.5) years. In a study conducted in the West Bank PHC clinics, the average age was 35.9 (SD $\pm$ 13.7) (Mataria *et al.* 2004). The young age group (20 year and less) represented 8.2% of the respondents. The age group between 21 and 30 years represented the highest percentage (41.8%) of the respondents while the age group between 31 and 50 years represented 35.1% of the respondents. The least age group; was more than 50 years old and represented 14.9% of the respondents. Among females, the age group between 21 and 30 represented the majority of the respondents (52.2%) while among males; the age group between 31 and 50 presented the highest percentage among the age groups of males (44.3%). As mentioned earlier, women usually are visiting PHC

centers for antenatal care and vaccination for their children while males are visiting PHC clinics for actual illnesses for themselves and/or for their families. This might create a diverse relationship with the PHC clinics for both men and women. Thus, their perceptions and understanding of health care services might be different.

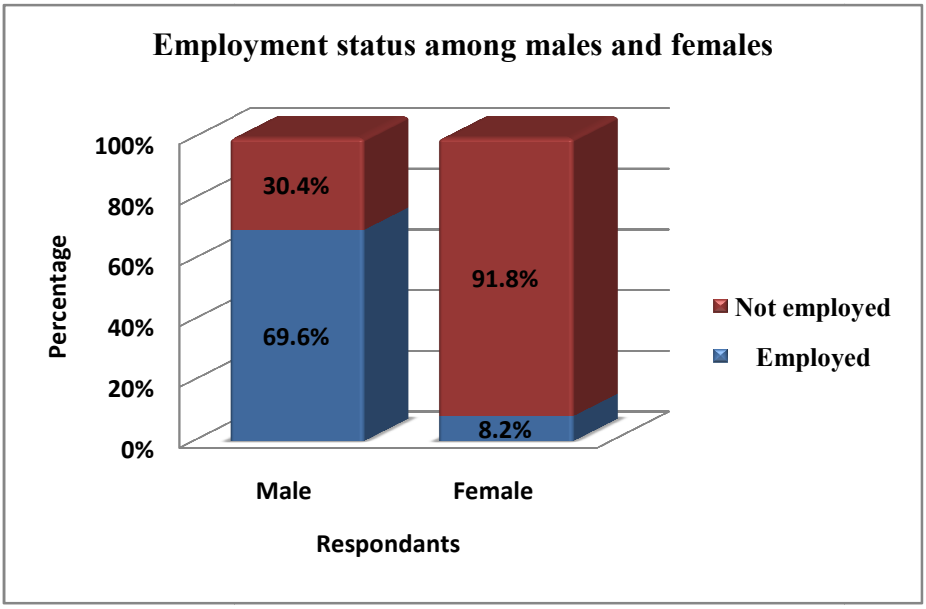

Figure (4.2) Distribution of respondents by their employment status

The reported average income of respondents was 1549 New Israeli Shekel (NIS) (SD was ± 830 NIS; Median was 1500 NIS). After categorizing income into groups, the first group (less than 1000 NIS) constituted 23% of the respondents. The percentages of the second group which represent the income group between 1000 and 1500 NIS was 33% and the third group (more than 1500) was 44%. It is worth mentioning that 27% of the respondents refused to provide any information about their monthly income. These percentages do not necessarily indicate the factual income, but however, may give a signal in this regard.

4.1.1.2 Reasons for visiting and choosing PHC clinics

Most of the clients visited the clinic to receive care themselves (62%) while 33.2% visited the clinic seeking medical services for their children specially females (43.9 % of females visited

the clinic for their children while only 11.9% of males visited the clinic for their children). This might raise the importance of sharing enough health information especially with women as they are the main caregivers for their children's health condition.

Table (4.2.): Distribution of responses by the reported reasons for visiting and choosing the PHC facility

	Variables	Frequency	Percentage
1	**Reasons for the current visit**		
	Seeking health care for the client him/herself	170	62%
	Seeking health care for the client's child	91	33.2%
	Seeking health care for both the client and his/her child	10	3.6%
	Others	3	3%
2	**Health care services provided by**		
	Physician	214	78.1%
	Nurse	77	28.1%
	Midwife	23	8.4%
	Assistant pharmacist	19	6.9%
	Pharmacist	18	6.6%
	Dentist	14	5.1%
	Others	4	1.5 %
3	**Reason for visiting the PHC clinic**		
	Curative care	137	50%
	Drug prescription	61	22%
	Ante-natal care	41	15%
	Vaccination	35	13%
	Chronic disease follow up	30	11%
	Visiting a specialist	16	6%
	Dental care	14	5%
	Family planning	10	4%
	Others	20	7%
4	**Reasons for selecting the PHC clinic**		
	Nearest facility to client's house	195	71%
	Availability of medications	93	34%
	Availability of services-big clinic	89	33%
	Health insurance coverage-cheaper than others	84	31%
	Good reception	47	17%
	Good quality of services	31	11%
	Knowing the clinic staff	18	7%
	Availability of a specialist	15	6%
	The only available clinic in client's neighborhood	14	5%
	Advice from a healthcare provider	7	3%

Most of the clients reported that health care services were provided by a physician (78.1%) followed by a nurse (28.1%). This might reflect that clients mainly focus on physicians as they are the target for their visits to the clinic and do not recognize the roles of other health care

providers or they do not usually recognize the identity of health care providers as most of them do not introduce themselves to the clients (Table 4.2).

Regarding the reported reasons for visiting the PHC facility, half of the clients visited the clinic for receiving curative care (50%) followed by drug prescription (22%) while 15% of the respondents visited the clinic for antenatal care (Figure 4.3). In comparison with a study conducted in PHC clinics in West Bank, 65.5% of the clients visited the clinic due to acute illness, 21.8% because of having chronic illnesses and 4.2% of them to receive antenatal care services (Mataria and *et al.* 2004). In Gadallah and *et al.* (2003) study, most of the PHC visitors in Egypt requested outpatient's curative services (77.1%) followed by vaccination (8.8%) and Antenatal care (6.3%). It is noticed that the percentage of antenatal care visits in GG was higher than both the WB study and the study in Egypt. This might reflect better utilization for antenatal care services in GG.

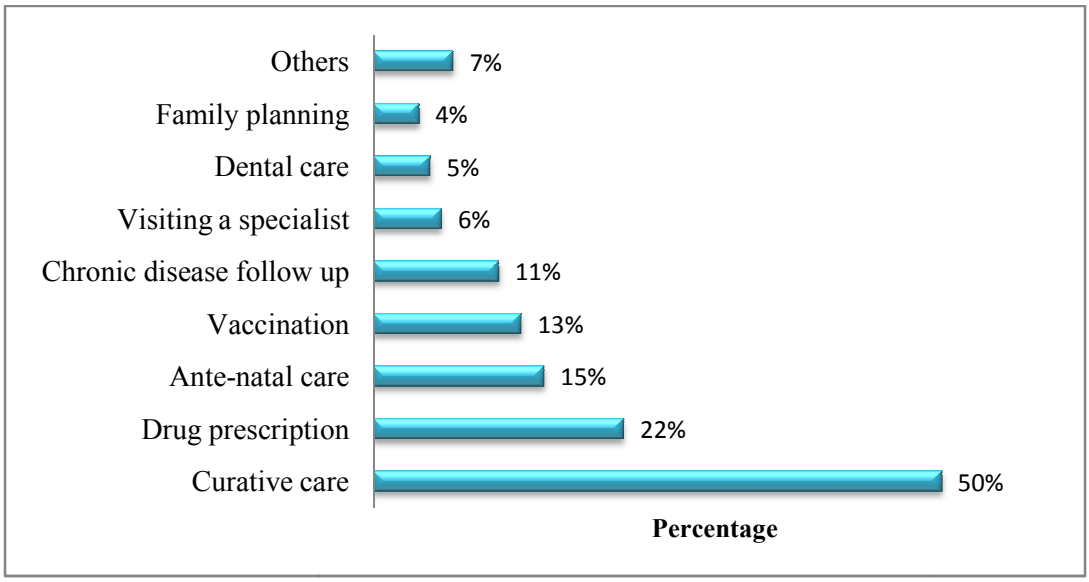

Figure (4.3): Reason for visiting the PHC facility

Regarding the reasons for selecting the PHC clinic, most of the clients (71%) said that they visited the nearest facility to their homes (Figure 4.4). The second reason was the availability of medications (34%), followed by the availability of comprehensive services (33%) and

health insurance coverage through the clinic (31%). Good reception in the clinic presented the forth reason (17%) followed by high quality of the provided services (11%).

Results reflect that the clients have limited room for selecting the governmental clinic that suits their preferences. This is related to MOH strategy for distributing the clients according to their place of living. The researcher thinks that asking people outside the governmental clinics would more accurately reflect the specific reasons for selecting health care facilities in general. A small survey conducted by Graduate Institute of Development Studies in 2005 showed that the first reason for selecting the health facility is the availability of free or cheaper services (42%) followed by being the only available clinic (23%). The quality of services represented the third reason (18%) while the availability of drugs was the forth reason representing 6% of the clients (Graduate Institute of Development Studies, 2005).

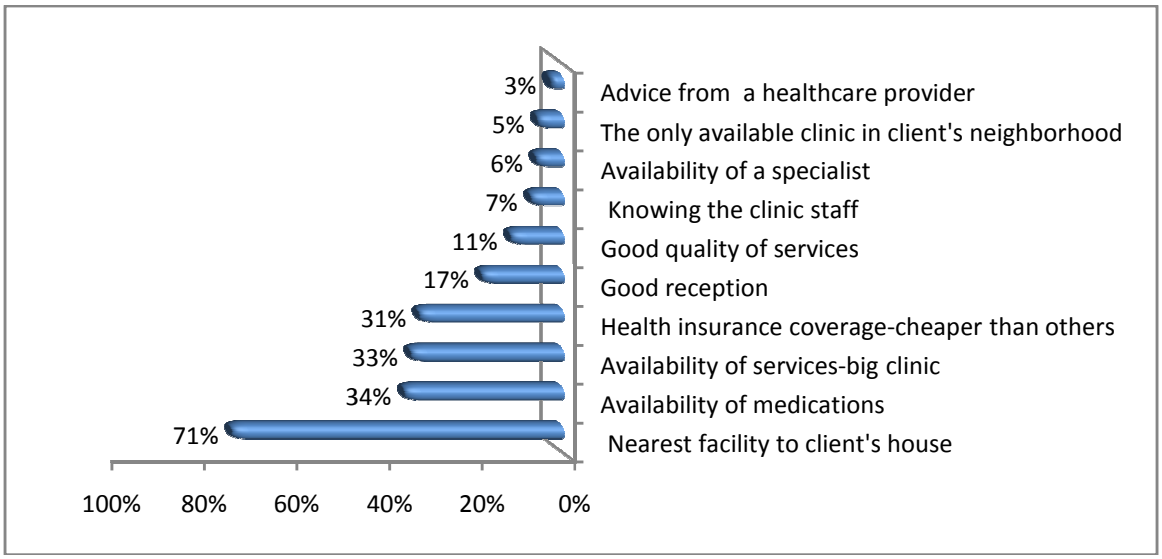

Figure (4.4): Respondents reasons for choosing the PHC clinic

4.1.1.3 Factors that indicate good quality of PHC services

The clients were asked a non-prompted question about the factors that indicate good quality of PHC services. Availability of medications was the first factor that indicates good quality of services from clients' perspectives (67.3%). Respectful interactions with health care provider was the second mentioned factor that indicates good quality of services (46.5%) followed by

being cured from the disease (34.6%). Other reported factors that indicate good quality of services include the availability of qualified physicians, short waiting times and the availability of comprehensive services in the same health facility (figure 4.5).

This reflects that clients consider the availability of medications is strong attribute upon deciding where to go in order to seek medical attention. This also may indicate clients' dependency on the prescribed medications they receive from PHC clinics and any changes in the availability of drugs will affect clients' satisfaction about the PHC services in general.

The second most reported factor was the respectful interactions with clients indicating the importance of this issue in collective communities like the Gaza one. In fact, both in North area and Gaza (Annex 8), the first factor that indicates good quality of care was respectful interactions with health care providers (39% and 34.4% respectively) while in Midzone, Khanunis and Rafah the first factor was the availability of medications (41.7%, 37.8% and 62.3% respectively). Interaction is very important to be considered as it will have its direct impacts on clients' perceptions about health care services.

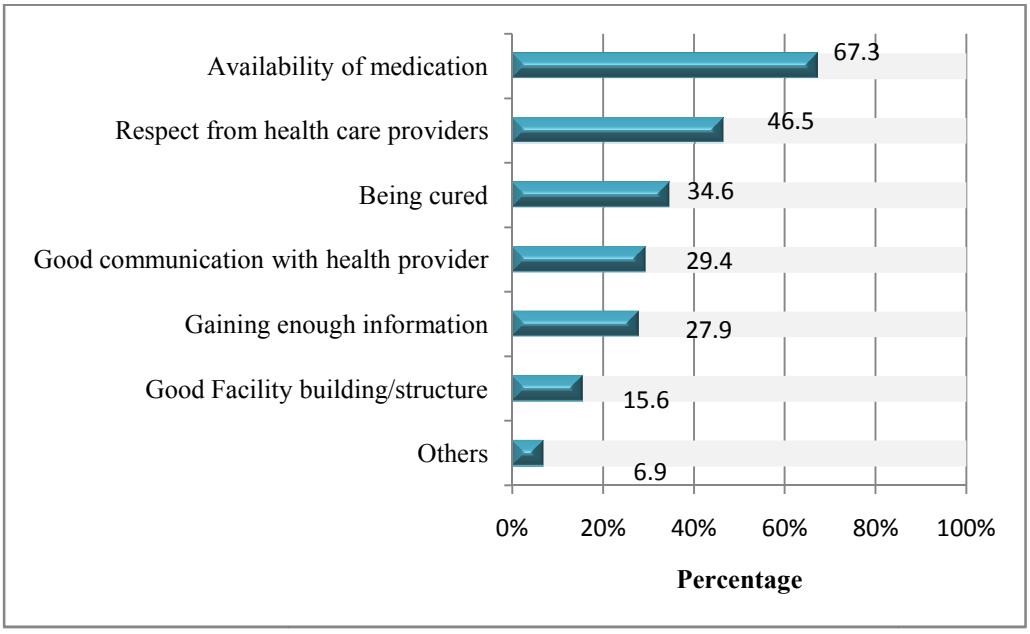

Figure (4.5): Factors that indicate good quality of PHC services.

Respectful interaction includes assurance of clients' privacy and confidentiality which is not fully assured according to clients' perceptions will be mentioned below (Respect sub-domain). In addition, the Palestinian society with its cultural and social norms creates an additional demand to consider respecting privacy as it touches dignity. It is noticed that good communications with health care provider was the fourth factor that indicates good quality of services and this strengthens clients need for more respectful interaction with health care providers and PHC staff in general. Enhancing positive interactions and communication with clients is important and health care providers need to be trained in this regard.

4.1.2 Client-centered care domains

4.1.2.1 Accessibility

Good accessibility to health care facilities is considered an important factor that reflects quality of health care (Berry *et al.* 2003) and it is also one of the characteristics of client-centered care services (Davis, *et al*. 2002). In addition, it is one of the main four pillars for human rights for health (WHO, 2002). WHO (2001) through global monitoring of the responsiveness of health care systems proved that the better access reduces the pressure on health care systems to reach target population, thus, people will be treated better (WHO, 2001).

As identified by the researcher, accessibility includes several dimensions; physical, financial, technical, access to information and access to essential medications. The following results illustrate the current accessibility status of PHC facilities reflecting all of these dimensions.

4.1.2.1.1 Physical Accessibility

The results of this study showed that 44.5% of the clients reached the clinics walking while 48.5% used public transportation. In addition, 44.3% of the respondents said that the distance is reasonable between the clinic and their houses. Only 15% of the respondents said that the clinic is far away from their houses. The average transportation cost was 2.2 NIS (SD= 1.8 NIS) which indicates that most of the clients who depend on transportation do not cut long distances to reach the clinic (Table 4.3). These results reflect good physical accessibility to the

PHC clinics. According to PCBS access to health services survey (2004), physical accessibility to PHC facilities in the GG was good. Results of that survey showed that 97.7% of households in the GG have a health center in their locality (PCBS, 2004).

Table (4.3): Distribution of the reported responses about the physical accessibility of the governmental PHC clinics

#	Variables	No.	%
1	**Methods used to reach the PHC clinic**		
	Public transportation	132	48.5%
	Walking	122	44.5%
	Private car	16	5.8%
	Others	4	1.5%
2	**Average transportation cost**		
		Mean: 2.28	SD: ±1.843
3	**Perception about the distance from client's house to the PHC facility**		
	Distance is reasonable	121	44.3%
	Clinic is near client's house	111	40.7%
	Clinic is far away from client's house	41	15%
4	**Satisfaction about the reception in the clinic**		
	Yes	241	88%
	No	33	12%
5	**Returning back clients home without receiving the health care services they came to receive**		
	No	177	64.6%
	Yes	95	34.7%
	NA	2	0.7%
6	**Reasons for returning back clients home without receiving complete health care service**		
	Lack of medications	75	79.8%
	Unavailability of lab tests	13	13.7%
	Crowded clinic	9	9.6%
	Specialist doctor was not in the clinic	7	7.4%
	Long waiting time	7	7.4%
	No qualified health provider is available	6	6.4%
	Couldn't afford to pay the fees	3	3.2%
	Others	3	3.2%

Clients were asked if they have been returned back home from any governmental health care clinic (during the last six months at the data collection time) without receiving the services they approached the clinic for. Almost 35% of the clients responded by yes. The main reason

for that behaviour was the lack of medications (79.8%) followed by unavailability of lab tests (13.7%). This is a direct effect of the shortages of essential drugs and disposables during the year 2010 (WHO, 2011). The third reported reason for turning back clients was the crowdedness of the clinic (9.6%). This might be related to the early mentioned phenomenon that most of the drug prescriptions are prescribed in the first four days around the period where the monthly drug supply reaches the PHC clinic (Palestine, MOH, 2005). Seven clients said that they visited the clinic in a day where the specialist doctor was not available and/or the clinic has changed the schedule of the specialist doctor. This reflects that changing the work schedules abruptly without appropriate coordination may disturb clients' accessibility to the services they need.

Those results show that there is a good physical accessibility to PHC services. However, other accessibility dimensions are important in order to consider the comprehensive accessibility conceptualization. The following pages will present other accessibility dimensions results.

4.1.2.1.2 Financial accessibility

Table (4.4): Distribution of the reported responses regarding financial accessibility of the governmental PHC clinics

	Variables	No.	%
1	**Client has a governmental health insurance**		
	Yes	258	94.5%
	No	15	5.5%
2	**Health insurance is paid**		
	Yes	246	95%
	No	13	5%
3	**Co-payment makes a financial burden on the client**		
	Yes	13	7.1%
	To some extent	61	33.5%
	No	108	66.4%
4	**Average Co- payments for health care services**		
	Mean	5.54 NIS	-
	SD	±3.9 NIS	-

Regarding financial accessibility (Table 4.4), 94.5% of clients were medically-insured through a governmental health insurance. This figure reflects only the insurance coverage among

clients who usually utilize PHC services. On the other hand, other clients would not access PHC clinics because they don't have the governmental health insurance except children under three years old.

Regarding co-payments, 207 clients out of the 274 (75.5 %) reported paying fees for the PHC clinic. The reported average co-payment was 5.5 NIS (SD $\pm$ 3.9 NIS) including fees for drugs, lab tests, dental care and dressing change. Small percentage of the clients said that the fees constitute a financial burden for them (7.1%) and 33.5% of clients said that copayment fees creates a burden on them to some extent.

This indicates that clients have good financial accessibility to the PHC services in general. However, some vulnerable groups might have financial access problems. For example, clients with an income less than 1000 NIS were the most dissatisfied clients with the fees. Moreover, clients who usually receive more than 3 drugs (especially clients with chronic diseases) also complained from the fees. Further studies for those vulnerable groups might be beneficial for identifying their financial accessibility problems. Still, it is not clear whether the financial accessibility for those not presenting to PHC is similar to those who do or not, indicating the need for further investigations in this regard.

4.1.2.1.3 Technical and information accessibility

Table 4.5 illustrates the responses of respondents to both technical and information accessibility questions. Technical accessibility is one of the client-centered accessibility domains (Berry, *et al*. 2003). Technical accessibility means approaching qualified health care providers and receiving the suitable care at time of demand. Almost 89% of clients reported receiving health care services by a qualified health care provider. This indicates that most of clients think that health care providers are qualified. However, the definition of qualified health care provider differs from one client to another. Some clients believe that qualified health care providers are those who prescribe more medications (Beckerleg *et al.* 1999). Others might perceive the qualified provider as the one who shares more information with them. Further investigations about this definition might develop better description for this reported high satisfaction.

Access to information is important to guarantee clients full participation in the health care process. Empowering clients with appropriate health information will help in gaining the full advantage of health care services through better understanding of their health conditions (Labhardt, *et al.* 2009). Regarding this domain, 70.4 % of the clients said that they were able to ask the health provider all the questions they want and 20.4% were able to ask the questions to some extent. In comparison with Nanbakhsh *et al.* (2008) study in Iran, 82% of the clients thought that they were able to ask all the questions they want (Nanbakhsh *et al.* 2008). Further improvements in this domain could be done.

Table (4.5): Distribution of the reported responses about technical and information accessibility

#	Variables	No.	%
1	**Client received health care services\by a qualified health care provider**		
	Yes	240	88.9%
	To some extent	24	8.9%
	No	6	2.2%
2	**Client was able to ask all the questions he wanted**		
	Yes	193	70.4%
	To some extent	55	20.1%
	No	17	6.2%
	Not applicable	9	3.3%
3	**Client received the required information**		
	Yes	185	67.5%
	To some extent	55	20.1%
	No	22	8%
	Not applicable	12	4.4%
4	**Client got a clear explanation about his/her condition**		
	Yes	170	63%
	To some extent	55	20.4%
	No	32	11.9%
	Not applicable	13	4.8%
5	**Client thought that the health care provider was concerned that shared information are understood**		
	Yes	200	73%
	To some extent	39	14.3%
	No	19	7%
	Not applicable	15	5.5%

Regarding receiving the required information, 67% of clients thought that they received the required information about their health condition and 20.1% of them to some extent. On the other hand, 8% of the clients were not able to ask about their health condition. Most of the

clients (63%) said that they got a clear explanation about their health condition and 20.4% reported getting explanation to some extent. Almost 12% of the clients said that they did not receive a clear explanation about their health condition. The researcher asked another question about health care provider's concern about sharing the information with the clients. Results showed that 73% of the clients said that the health care provider was concerned to let them understand well their health condition. In general terms, the reported results indicate good technical and information accessibility. Sometimes, clients themselves are in a hurry for getting out from the clinic and they might not be concerned to get adequate information about their health condition. Some clients' main concern is to get the drug prescription and go home and this is apparent in the fore coming results of this study.

The researcher asked the clients about their main source for health information in general (Figure 4.6) and results indicate that the PHC physicians are the main source for health information for 75% of the clients followed by PHC nurses (37.9%). Some clients said that they trust their PHC physicians (especially at level 2 and 3 clinics). The ease of access to PHC facilities might explain the aforementioned results. This reflects that clients generally trust PHC providers especially physicians and nurses.

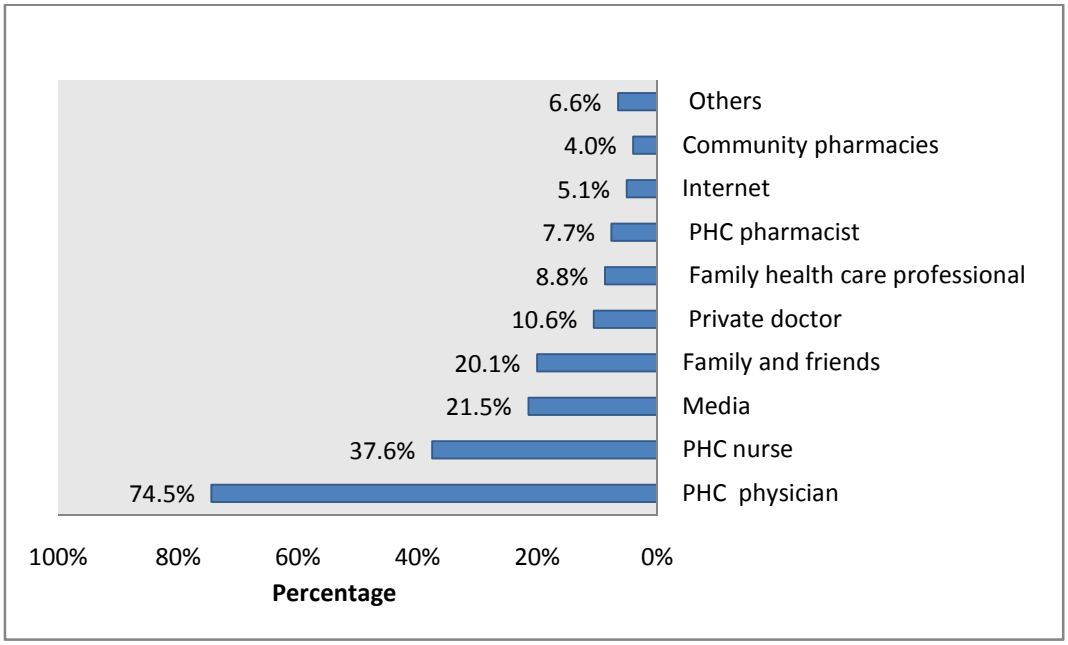

Figure (4.6): Main source of information for PHC clients

Media constituted the third source of health information for the clients (21.5%). This is a reflection for the possible effect of media on community knowledge about health. Furthermore, 20.1% the clients (especially females) had considered family and friends as their main source for health information (more than private doctors and family members' health professionals). This result might raise the importance of increasing awareness among communities; impacting behaviours and attitudes of individuals and groups. It is worth noting that 5.1% of the clients reported considering the internet as their main source for health information which might encourage policy makers to establish health promotion activities through the internet.

4.1.2.1.4 Accessibility to essential medications

The Accessibility to essential drugs is one of the basic human rights to health (Alma-Ata declaration; 1978; WHO, 2002). Essential medicines should be available in adequate amounts, in appropriate dosage forms with assured quality, efficacy and adequate information on proper use (WHO, 2004b). Adherence to the prescribed regimen is less likely when health worker does not explain the need to complete treatments, the dosages required, and ways to handle side-effects (WHO, 2004b). It is also considered as one of the most important concerns of patients (Haddad, *et al.* 1998). Table 4.6 illustrates clients' responses on the access to medications questions.

More than two thirds (78.8%) of the clients received a drug prescription in their visit to the PHC clinic. This is related to the fact that clients who receive antenatal care and vaccination do not receive drug prescriptions and they composed 28% of the respondents. This figure is less than the results of Mataria *et al.* study (2004) which figured that 93% of the visitors for PHC in the West Bank have received drug prescriptions (Mataria *et al.* 2004). According to Obiedallah *et al.* (2000), the consumption of drugs in the West Bank and GG is very high in comparison with neighboring countries at the same level of economic situation. Also, there are problems of irrational prescribing and over prescribing (Obiedallah *et al.* 2000; Fattouh and Abu Hamad, 2010).

Table (4.6): Distribution of the reported responses regarding the accessibility of medications

#	Variables	No.	%
1	**Client has been given a drug prescription**		
	Yes	201	78.8%
	No	73	21.2%
	Total	274	100%
2	**Availability of medication**		
		Mean: 91.7%	± 17.4%
3	**Client found all drugs in their previous visit to the PHC clinic**		
	Yes	164	65%
	No	88	35%
4	**Client sources for getting drugs not found in the Governmental PHC**		
	Community pharmacy	217	81%
	UNRWA Clinic	32	12%
	Wait until the drug is delivered to the clinic	25	9%
	NGO	20	7%
	Charitable association	20	7%
	Another Gov. Clinic	16	6%
	Do not obtain the drug	16	6%
5	**Average prescribed drugs per prescription**		
	Average drugs per prescription	1.7 drug	-
6	**Client received enough information about the proper drug use method**		
	Yes	144	77%
	No	36	19%
	Don't know	8	4%
7	**Client was asked by the physician if he/she is currently utilizing a drug before he/she is provided with a new drug**		
	Yes	86	47%
	No	96	52%
	Don't know	3	2%

By comparing the number of prescribed drugs with the number of drugs the client actually received, the general drug availability score was 91.7%. However, this figure does not necessarily reflect the reality. During the last year, the governmental central drugs store in the Gaza Strip faced severe shortages in essential drugs. Almost 24% of the essential drugs were at the zero stock level compared with 18% in 2009 (WHO, 2011). This high drug availability figure could be explained by the fact that physicians already know the available drugs, thus, they prescribe only the available medications and ask clients to buy the required drugs from other places. In comparison with Mataria et al. Study (2004), three quarters of the clients were

able to find all the prescribed drugs in the PHC clinics in WB while 16% found some of the drugs and 8% did not find their drugs at all. The reality is well reflected in the result that showed that only 65% of the clients found all the drugs that were prescribed for them in their previous visit to the clinic (Table 4.6).

Clients reported getting the missing drugs from other sources. Most of the respondents (81%) said that they usually buy the missing medications from community pharmacies. This would absolutely add an additional financial burden on clients especially with the deteriorated economic situation. Other respondents coping behaviour was obtaining the medications from UNRWA clinics (12%) followed by 9% who reported waiting to receive the drug form the health facility later on. Almost 6% of the clients said that they do not bring the medications at all and this might be dangerous especially for clients with chronic illnesses or patients with acute illnesses which require drug therapy. Equitable access to essential medicine is considered one of the main obligations of the governments towards their citizens in terms of their right to health (Cameron *et al.* 2011). Average drugs per prescription were 1.7. In comparison with a previous study that measured this indicator (Fattouh and Abu Hamad, 2010); general average for drug prescriptions per individual was 1.9. This small decrease in average drugs per prescription might be linked with the previously mentioned drug shortages the MOH in GG had faced during the last year. According to WHO report in 2006, the general average for drugs per prescription was from 2-3 in middle income countries (WHO, 2006b).

Regarding the factors that are necessary to assure good compliance with medicine use, 77 % of the respondents said that they received adequate information about the drug use. Though some clients said that they wish if the physician has told them what he/she will prescribe them before paying the copayment fees. They said that they might already have the medications in their houses. More than the half of the clients (52%) reported that prescribing had taken place without asking them if they were utilizing drugs at the time of the visit. This indicates high prevalence of possible drug interactions and drug over consumption.

The researcher examined the dispensed drugs the clients got before leaving the clinic. The researcher observed the number of drugs in the prescriptions and observed the prescribed

drugs that were actually given to the clients. Drugs in each prescription were coded as drug number 1, 2, 3 and so on (according to number of drugs each client had received). Then, the number of drugs packed alone was divided by the total number of the received drugs by clients and the same was done for drug name and drug use domains. After that, the general average for the drugs was calculated. Table 4.7 and figure 4.7 illustrate the results of this process as illustrated below.

Table (4.7): Distribution of dispensed drugs by appropriate practices

	Drug is packed alone (separated from other drugs)	Drug name was written on the envelope	Drug use was written on the envelope
Drug 1	91.5%	89.9%	39.9%
Drug 2	91.9%	92.5%	30.8%
Drug 3	91.5%	78.9%	22.8%
Drug 4	83.3%	50.0%	16.7%
Average	89.55%	77.83%	27.55%

It was noticed that most of the drugs are delivered to clients are within the original drug box (average of 89.5%) that includes all the information related to drug name, dose and scientific names are available to the clients. Results showed that the drug use instructions were not written on 72% of the dispensed drugs. Clients said that they usually return back to the physician or the pharmacist to ask them about the drug use if they did not know or if they were not informed verbally about the drug use. This indicates that clients rely on their memories to recognize the drug use regimen rather than depending on written instructions as the standards specify. It is worth noting that writing drug use instructions is one of the most important factors that reflects good dispensing of medications (WHO, 2004b). A previous study showed that labelling practices such as writing drug name, dosage and expiry date was not done properly (El-Afifi, 2008).

The previously mentioned results indicate inappropriate dispensing practices in the governmental PHC. According to Obiedallah, *et al.* (2000), dispensing practices do not allow for the delivery of any information or message to patients. They also mentioned that dispenser-patient communication hardly exits (Obiedallah, *et al.* 2000). In addition, they raised the importance of increasing patients' knowledge regarding the value of drugs and the

harm of their misuse (Obiedallah, *et al.* 2000). This study also raises the same flag. More efforts are required to enhance the good prescribing and dispensing practices in the governmental PHC clinics.

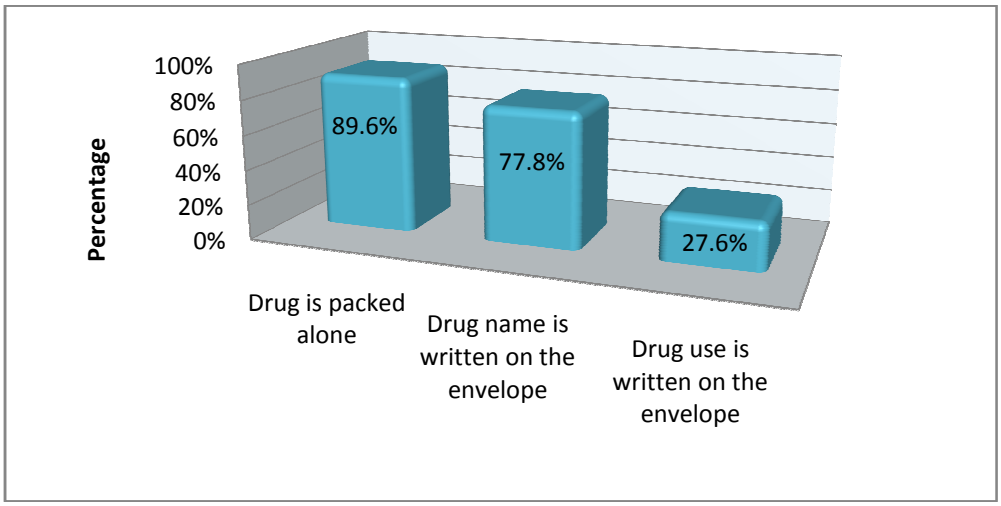

Figure (4.7): Average labelling scores for dispensed drugs

4.1.2.2 Health care services delivery

4.1.2.2.1 Waiting time and time spent with health care provider

Operationally, in this study, waiting time has been defined as the total time spent from reaching the health facility until receiving the desired care by a health provider. Long waiting times might decrease patients' access to the health facility, which is very dangerous especially for ante natal visits. Rao, *et al.* (2006) study showed that longer waiting time had a progressively large negative effect on both in-patient and outpatient satisfaction and this would affect negatively on the desired health outcomes. Hansen *et al.* study (2008) proved that the higher the waiting time the lower the perception about quality of services specially among females (Hansen *et al.* 2008).

Table 4.8 illustrates responses to the questions related to this sub-domain. The average waiting time for physician consultation was 31 minutes (SD= $\pm$ 24 minutes). Annex (9) presents average waiting times for PHC different services. The longest reported waiting time was for dental care (62 minutes) and family planning (50 minutes) while shortest waiting times were for nebulizer and dressing (20 minutes).

Table (4.8): Distribution of the reported responses regarding waiting time related variables

	Variables	No.	%
1	**Waiting time**		
	Less than 30 minutes	123	44.9%
	30-60 minutes	137	50%
	More than 60 minutes	14	5.1%
	Total	274	100%
	Average waiting time	31.7± 24.4 minutes	Median: 30 minutes
2	**Satisfaction with waiting time**		
	Satisfied	195	71.2%
	To some extent	44	16.1%
	Not satisfied	35	12.8%
	Total	274	100%
3	**Spent enough time with health provider or not**		
	Yes	188	70.9%
	To some extent	62	23.4%
	No	14	5.3%
	Total	264	100%

The average waiting is similar with previous local studies where the average waiting time for ante-natal care in PHC clinics in GG was 34.5 minutes (MARAM, 2003) while in the West Bank PHC clinics it was 35 minutes (Mataria *et al.* 2004). In comparison with regional studies, Gadallah *et al.* (2003) study in PHC clinics in Egypt showed that the average waiting time was 22.2 minutes (Gadallah *et al.* 2003). Another study in Tunisia found that most of the PHC clients experienced long waiting time with an average of 55.8 minutes (Letaief *et al.* 2008). Kerssens *et al*. study that assessed responsiveness domains in 12 European countries found that the waiting time score was the lowest one where the clients usually wait more than 15 minutes to meet the physician in PHC clinic (Kerssens *et al.* 2004). This reflects that clients waiting times are a concern all around the world. During the data collection period of this study, it was noticed that clients with chronic illnesses usually wait longer than other patients. This might be due to the fact that specialists are not available in all the days of the week. But it is worth to shed the light on this issue to study the ability to establish specific appointment systems that allow for distributing the clients during the working hours to decrease their waiting times.

Satisfaction about the waiting time for physician consultation was good where 71.2 % of the clients were satisfied with their waiting time while 12.8% were not satisfied. In contrast, Abu Dayya study (2000) mentioned that 72.3% of the clients were not satisfied with the waiting time in the PHC facilities. Also, Abu Mourad *et al.* (2007) study showed that waiting time for physicians was one of the poorest areas in performance as well as helping clients in dealing with emotional problems (Abu Mourad *et al.* 2007). Almost 71% of the clients were satisfied with the time they've spent with the health provider while 23.4% were satisfied to some extent. A small percentage (5.3%) of the clients was not satisfied with the time they had spent with the health care provider.

The results reflected general satisfaction with time spent with health care provider in contrast with the previously mentioned results that reflected dissatisfaction with time spent with health care providers (Abu Dayya, 2000; Palestine, MOH, 2005). This result might be related to the clients' expectations from their previous visits or it is related to their preference where they might mainly ask for the drug prescription more than their concern with discussing their condition with the health care provider.

4.1.2.2.2 Freedom of choice

Basically, clients have the right to choose the health care provider and the health care facility they feel comfortable with (WHO, 2001). The caring process is not only about a good prescription, but also good communication between the client and trustworthy health care providers.

In GG clinics, clients are usually referred to certain examination rooms to avoid crowdedness on certain physicians' door and to avoid work overload on certain physicians. Almost 72% of the clients didn't choose the health care provider they will see (Table 4.9). In comparison with a previous study that assessed clients' satisfaction with health care services in Palestine, most of the clients (81%) did not choose the heath care provider (Abu Dayya, 2000). Another study conducted in Lithuania mentioned that 40% only of the health facility visitors could choose physician or nurse staff members (Ducinskiene *et al.* 2006). Another study in three PHC clinics that provide reproductive health care services in Iran found that 33.9% of the

respondents was satisfied with choosing the health care provider while 25% of them were not satisfied (Nanbakhsh *et al.* 2008).

Table (4.9): Distribution of clients' responses regarding their freedom of choice

#	Variables	No.	%
1	**Choosing health care provider**		
	Yes	72	28.1%
	No	182	71.9%
	Total	254	100%
2	**Consent was obtained before examination**		
	Yes	132	62.9%
	No	78	37.1%
	Total	210	100%
3	**Consent was obtained before conducting any other procedure**		
	Yes	103	60.2%
	No	68	39.8%
	Total	103	100%
4	**Choice total score***	Mean 0.47±0.41	
*Calculation of score: Yes answer scores 1 and No answer scores zero, then average scores for each question were calculated forming the general average for this theme (choice)			

It is worth noting that PHC physicians didn't introduce themselves for 77.9 % of the clients (Table 4.2). Clients usually know doctors names from their stamps on the drug prescriptions. Some patients identify their physician through his/her room number rather than his/her name. This figure is lower than Lataief *et al*. study in Tunisia where 87% of the clients attending family planning services said that the doctor did not introduce himself before examination (Letaief *et al.* 2008). In general terms, this issue could be seen as a weakness point in the system. The efforts that try to organize work should not ignore clients' rights in choosing "when possible" the health care provider who will follow up their condition. Or at least to let the clients know what are the reasons for establishing the policy of equal distribution of beneficiaries on physicians' examination rooms.

4.1.2.2.3 Communication with health provider

Communication between clients and PHC clinic team is an important factor that reflects health care delivery quality. Proper communication would enhance the caring process, allow for

more information exchange and finally reaching the best clinical decisions. Large percentage of clients felt that they had good communication with the health care providers (81.3 %) while 1.8 % only said that they experienced communication problems with health care providers (Table 4.10).

Table (4.10): Distribution of clients' responses regarding communication with health care provider.

#	Variables	No.	%
1	**Client communicates freely with the health care provider**		
	Yes	220	81.3%
	To some extent	46	17%
	No	5	1.8%
	Total	271	100%
2	**Client thinks that health care provider listened carefully to him/her**		
	Yes	213	79.2%
	To some extent	48	17.8%
	No	8	3%
	Total	269	100%
3	**Health care provider was doing something else besides talking with the client**		
	Yes	28	10.2%
	No	241	88.8%
	Total	269	100%
4	**Provider attitude was positively perceived by clients**		
	Yes	204	77.5%
	To some extent	61	22.3%
	No	9	3.3%
	Total	274	100%
5	**Communication with health provider score***	**Mean : 1.7±0.38**	
*Calculation of score: yes =2, to some extent = 1, no = 0 **except** question 3 yes= 0 and no = 1).			

Almost 79% of the clients agreed that the health care provider listened carefully to them while 17.8% evaluated this variable as "to some extent". Small percentage (3%) did not think that the health care provider was listening carefully for them. Through probing with other questions, the researcher asked if the health care provider was doing any other activity besides listening to the client and only 10% of the clients said yes. Furthermore, almost 78% of the

clients positively perceived health care provider attitudes during their conversation with them and 22.3% reported positively perceived health care provider attitudes to some extent.

Clients' responses on these questions reflect general satisfaction about the communication with health care providers. However, satisfaction about health care services doesn't only depend on the care provided by physicians, rather it is a complete image about all the PHC team and their way of dealing with clients. Some of the clients complained from the way they were treated by admin staff and clerks. Someone mentioned "I *hate the part before I meet my physician; we are not the employee's slaves".* This would raise the importance of developing communication skills among all the PHC teams. Improving health personnel technical skills as well as improving clinics teams' communication skills would create better care for the clients.

El Haj (2008) study that assessed patients' perceptions about European Gaza Hospital health care services recommended enhancing the communication and the information sharing between the health care personnel and patients. At the PHC level, the interaction time between the health care providers and the patients is less than the admitted patients. Though, the importance of better communication and interactions rises where the clients will depend on themselves to complete their treatment and/or their children's treatment plans when they return back home. Hamad (2009) reviewed several research findings about the clients satisfaction about health care services in the GG during the last ten years and recommended further improvement in the communication and interaction between health care providers and the clients in various health care facilities (Hamad, 2009).

4.1.2.2.4 Respect (dignity/privacy and confidentiality)

Assurance of client privacy in health care facilities is one of the basic human rights (WHO, 2002). In this study, 84.5% of the clients said that their privacy was assured. By probing with another question, 60.2% of the clients were alone with the health provider while other clients (13.9%) complained that there were two physicians with different patients in the same room, thus, their privacy was not assured (Table 4.11). In addition, 13.4% of the clients were with more than one health provider in the room and 12.5% were with one health provider and other clients too. The different percentage between the first and the second question reflect that the clients were not fully aware about their rights**.**

Table (4.11): Distribution of the reported responses regarding patients health rights related varibles

	Variables	Frequency	Percentage
1	**Client perceptions about assuring his/her privacy**		
	Yes	203	84.5%
	No	37	15.5%
	Total	240	100%
	Who was with the client in examination room		
	Alone with health care provider	130	60.2%
	Two physicians in the same room	30	13.9%
	More than one health provider	29	13.4%
	With health provider and other clients	27	12.5%
2	**Health care providers would keep the confidentiality of client condition**		
	Yes	203	76%
	No	9	3.4%
	Don't know	55	20.6%
	Total	267	100%
3	**Client perceptions about being treated respectfully by health care providers**		
	Yes	259	94.5%
	No	3	1.1%
	Don't know	11	4%
	Total	273	100%
4	**Client was asked to sit before starting talking with health provider**		
	Yes	158	59.8%
	No	106	40.2%
	Total	264	100%
5	**Client felt any kind of discrimination between him and any other clients**		
	Yes	32	11.7%
	No	200	73%
	Don't know	42	15.3%
	Total	274	100%
6	**Respect score ***	**Mean :0.68±0.22**	
*Calculation of score : yes = 1 , no = zero don't know= no count; **exept** question 5 yes=0 and no = 1.			

Both El Haj (2008) and Abu Dayya (2000) studies pointed to the fact that most of the patients in PHC and/or admitted into hospitals in the GG did not know their health rights well. This reflects the need to enhance patients' knowledge about their rights as well as their responsibilities. The results of this study coincided with those previous studies indicate that more efforts should be done to assure clients privacy and confidentiality.

Regarding clients' trust for health providers, most of the clients (76%) said that the provider will keep the confidentiality of their condition while 20.6% of them didn't know if the provider will keep their confidentiality. Very small percentage (3.4%) didn't think that health provider will keep the confidentiality of their conditions. This reflects the trust between clients and health care providers. In comparison with Nanbakhsh *et al.* (2008) study in PHC clinics in Iran, most of the respondents (90.6%) had confidence with their health care providers. Clients trust for health care providers could be improved through adopting better privacy assurance practices for PHC clients and enhancing better communication between the health care providers and the clients.

Most of the clients said that they were treated with respect (94.5%) only 4% of them said that they were not sure. Another proxy indicator for respect is offering the client a seat before receiving the health care service. Almost 60% of the clients reported that they were offered a seat while 40% were not offered a seat (Table 4.11). Almost 12% of the clients felt that they were treated differently (with discrimination) than other clients. Some of the clients said that some clients can reach health care provider before them because they know some of the clinic staff. Other clients said that they were treated better than the other clients because they know some of the clinic staff. However, most of the clients (73%) did not feel any discrimination which reflects a general feeling of equity.

In general terms, clients' responses for questions reflecting the respect towards the clients were somehow positive. However, further improvement in privacy assurance for the clients is required to increase clients' confidentiality especially in a conservative cultures as GG one. Lack of privacy might hinder honest information sharing with health care provider, thus, it might affect diagnosis and prescription. Confidentiality of clients' information should be more guaranteed in order to enhance clients trust in health care providers and health care facilities.

4.1.2.2.5 Quality of basic amenities

Quality of basic amenities is one of the main domains that reflect responsiveness of health care systems. This domain focuses on non-health elements that would affect on health care services such as clean surroundings, sufficient ventilation, clean water, clean toilets and adequate furniture (Valentine, *et al.* 2001). Annex 10 represents clients' perceptions about the basic amenities (drinking water, places to sit, cleanliness of toilets, cleanliness of clinic, lighting and ventilation) in the different PHC facilities levels. Table 4.12 below presents the general scores reflecting clients' perceptions about the basic amenities. Each basic amenity score was calculated as follows; good=3, moderate=2 bad=1, not available= 0 and don't know= not counted**.** Then the mean score was divided by 3 to calculate the percentage.

Table (4.12) : Clients reported responses (scored) regarding the quality of basic amenities within PHC clinics

1.	**Clients perceptions about the quality of basic amenities**		
1.1	**Basic amenity**	**No.**	**Score**
1	Drinking water	212	77.4%
2	Comfortable waiting area	270	78.8%
3	Cleanliness of toilets	273	87.8%
4	Cleanliness of clinic	273	61.5%
5	Lightning	274	90.4%
6	Ventilation	274	87.3%
1.2	**Basic amenities general scores in different PHC levels**		
1	Level 2/3	58	80.14%
2	Level 4	216	80.18%
	Total	274	80.17%

Results showed that drinking water availability score was 77.4%. However, it was noticed that some clients didn't know about the availabilty of drinking water in the facility while others said that there were no clean cups for drinking. The lowest score was for the general cleanliness for the clinics (61.5%) while the highest score was for adequate lightning (90.5%) despite the frequent electricity cuts. This indicates either good understanding for the current

situation in the GG (adaptation with the electricity cuts) or low expectations about the availability of adequate lightning in the PHC clinics. It is worth mentioning that the efforts that were done to supply each PHC clinic with electricity generators in order to cope with the frequent electricity shortcuts GG is facing had resulted in equipping health facilities with generators. In comparison with clients perceptions about basic amenties in PHC clinics in Egypt, 89% of the clients said that there are avaialable seats and 87% of them said that these seats are comfortable. Most of the clients in the respondents were satisfied with clinic cleanliness and ventilation (Gadallah and *et al.* 2003).

The same table (Table 4.12) presents general score for all basic amenities in PHC clinics with different levels (Annex 10). It was calculated by summing the score for each area as (Good=3, moderate=2, bad=1, not available= 0 and don't know= not counted). Where the score reaches the 100% when the mean of all the factors comes closer to 3. The total score is 80.17% reflecting good satisfaction with basic amenities. Both level 2/3 clinics and level 4 clinics scored the same which indicate that there are no differences in the quality of basic amenties between big and small clinics (Annex 10).

4.1.2.3 Involvement of clients

4.1.2.3.1 Involvement in planning

The first domain of clients' involvement is their participation in planning for health care services. Donabedian (1988) in his quality improvement in health care revolution pointed that clients and communities should share some responsibility for the success or failure of health care systems.

Table 4.13 shows clients responses to the questions related to participation in planning. More than the half of the clients (53.3%) said that they did not hear about any representative committee for the local community while 38.7% did not know if there is a representative committee or not. On the other hand, 8% reported hearing about the existence of representative committees. Among the randomly selected clinics, three clinics out of the ten clinics small clinics said that there is a representative committee for the clients (30% total) and they were level2/3 clinics. These three clinics conduct meetings on ad hook bases. One PHC

clinic administrative director said that they conduct weekly meetings with clients (Annex 11). Almost 50% didn't know about any participation in health planning (deciding modifications of services, opening of new services…etc) while 32% said that they never heard about this activity. On the other hand, 11% of the clients said that they heard about a previous activity like that.

Table (4.13): Distribution of clients' responses about their involvement in planning

#	Variable	Responses				
		Yes	To some extent	No	Do not know	Total
1	**Knowledge about the availability of a representative committee for the clinic from the local community**					
	No.	22	0	147	106	275
	%	8%	0	53.3%	38.7%	100%
2	**Knowledge about previous participation of the local community in any health planning activity**					
	No.	30	21	87	134	272
	%	11%	7.7%	32%	49.3%	100%
3	**Presenting information about the clinic services to the clients of the clinic**					
	No.	66	53	88	64	271
	%	24.4%	19.6%	32.5%	23.6%	100%
4	**Health care providers are oriented towards the current health problems in the clinic area**					
	No.	96	49	42	85	272
	%	35.3%	18%	15.4%	31.3%	100%
5	**There is an obvious partnership between the clinic and the community**					
	No.	33	26	80	133	272
	%	12.1%	9.6%	29.4%	48.9%	100%
6	**It is important to involve people in planning for health care services**					
	No.	147	24	18	83	272
	%	54%	8.8%	6.6%	30.5%	100%
7	**Total score***	**Mean: 1±0.63**				
*Calculation: Yes = 2, to some extent = 1, no = zero, don't know = not counted						

Almost 33% of the clients said that the clinics did not introduce/advertise the available services in the clinic to the clients while 24.4% of the clients said that the clinics have introduced the services and 16.9% think that the clinics have introduced the services to some

extent. In comparison with a study in Tunisia, 84.2% of the clients of primary health care and reproductive health services said that they did not receive or received incomplete information about the available services in the health center (Letaief *et al.* 2008). Almost 31% of clients said that they didn't know if the health care providers knew the frequent health problems in the served area while 15.4% of them did not think that they were adequately oriented. On the other hand, 35% of the clients agreed that health care providers in the clinics are well oriented towards the frequent health problems in their communities. Regarding partnership between clients and the PHC clinics, 49% of the clients did not know if there is an obvious partnership and 29% of them did not think that there was a partnership. In contrast, 12% and 9.6% said that they were thinking that there is a partnership and there is a partnership to some extent respectively. Those figures reflect the gap between PHC clinics and the clients.

The figures showed that clients have a strong will to participate in the planning for improving health care services. More than the half of the clients raised the importance of their involvement, yet, 30.5% of them did not know the advantage of being involved in planning for health care services. These results go along with Litva *et al.* (2002) study in developing countries where 50% of the respondents said that people should be involved in decisions related to setting places and specialties of health care services while 29% of them said that it is not necessary to involve public in decision making (Litva *et al.* 2002). This reflects that clients could not be interested in being involved in activities like that because they do not realize its importance from the first place or they do not figure the impacts of their participation. In addition, involvement of clients is a new approach that requires time to be fully implemented internationally and/or national wise. This could be presented as a weakness area within the PHC services. Further strengthening of the relationship of clinics and the community is required in order to develop a client-centered PHC services.

4.1.2.3.2 Involvement in implementation of health interventions

The second domain for involvement in health care is clients' participation in implementing health interventions, mainly providing them with the required information that allows for

sharing responsibility between health provider and the clients. Half of the clients (Table 4.14) said that they preferred being involved in deciding their treatment plans.

Table (4.14): Distribution of clients' responses regarding involvement in their treatment plans.

	Variables	Responses				
		Yes	To some extent	No	Not Applicable	Total
1	**Preference for involvement in deciding treatment plans**					
	No.	125	45	78	24	272
	%	50.4%	18.1%	31.5%	-	100
2	**Being involved in deciding the best treatment plan**					
	No.	70	30	99	74	273
	%	35.2%	15.1%	49.7%	-	100
3	**Being involved in taking appropriate decisions for changing client's dietary habits**					
	No.	95	15	78	85	273
	%	50.5%	8.0%	41.5%	-	100
4	**Being involved in taking appropriate decisions related to time of medication use**					
	No.	114	8	66	85	273
	%	60.6%	4.3%	35.1%	-	100
5	**Being involved in setting next client's appointment date**					
	No.	63	26	69	115	273
	%	39.9%	16.5%	43.7%	-	100
6	**Total score***	Mean: 1.18±0.764				
*Calculation of score: yes = 2, to some extent = 1, no = zero, not applicable = not counted						

The researcher asked the clients an open ended question to discuss their opinions about the importance of their involvement in deciding their treatment plans. Clients said that they are responsible for their health and their children's health, they are the masters in their houses and they are responsible for giving the medications at the required time. Some of them said that their participation would assure the success of treatment. In addition, mothers said that they know their children more than the provider, thus they should be aware about the exact condition of their child in order to handle the situation through shared decision making with health care provider. Furthermore, some clients said that they like to discuss more with health care providers in order to be convinced in the treatment plan.

In contrast, some clients (31.5 %) did not prefer being involved. They said that the physician is well-educated and s/he knows more about their health conditions. In addition, they pointed to the doctor responsibility for deciding and clients' responsibility is demonstrating compliance with what the doctor says (Table 4.14).

Regarding involvement in deciding the treatment plan, 49.7% of the clients did not participate in deciding their treatment plan while 35.2% were involved and 15.1% were involved to some extent respectively. In Abu-Mourad *et al.* study (2007), almost 46% of the clients were satisfied with being involved in decisions related to their medical care plans (Abu Mourad *et al.* 2007). Ten years ago, Abu Dayya (2000) study figured that 71.2% of the clients in the GG did not participate in deciding their treatment plans. This might reflect a window of improvement in clients' participation in deciding their treatment plans. The researcher thinks that the increase in the awareness level among the population might have improved their willingness for more cooperation. In addition, it could be claimed that health care providers deal with more aware clients than the past. El Haj (2008) study highlighted the importance of increasing patients' awareness about their rights. In addition, the author recommends enhancing the processes of informing patients about their health conditions in order to assure changing their behaviours positively to enhance their own health status (El Haj, 2008).

Regarding involvement in changing dietary habits, 50% of the clients said that they were involved in this process with health care provider, 41.5% of the clients were not involved. Regarding involvment in deciding suitable times for medications use, 60% of the clients though that they were involved in this process while 35% did not think that they were involved. Regarding taking decsions for setting the next appointment time, 43.7 % of the clients were not asked, they were just informed. On the other hand, 39.9 % of the clients said that they were asked before setting the new appointment with the health care provider.

This reflect a weakness area in the involvment of clients in health care. Further improvements are required to enhance the client-provider cooperation to develop the most suitable treatment methods for enhancing communities health status.

4.1.2.3. 3 Involvement in evaluation of health care services

Evaluation of health care services by clients is very important to assure clients involvement in the health care system improvement. This action would enhance clients' participation and shared responsibility between them and health care providers in order to improve health and well being. The following table (4.15) illustrates the questions related to this domain of involvement. Most of the clients (90.9%) said that they were never asked about their opinion in the PHC services. However, 50.7 % of them think that the clinic staff would consider their feedback if they will be asked. On the other hand, 28.8% of the clients didn't think that the PHC clinics would solicit their opinions about the services.

Table (4.15): Distribution of clients' responses regarding their involvement in evaluating PHC services

	Domains	Options			
		Yes	No	Don't Know	Total
1	**Client was ever asked about his/her opinion in PHC services during the last 6 months**				
	No.	22	249	1	272
	%	8%	90.9%	0.4%	100%
2	**Client thinks that health facility solicits his/her feedback/opinion about the health care services**				
	No.	139	56	79	274
	%	50.7%	20.8%	28.8%	100%
3	**It is importance to considering clients feedback about PHC services**				
	No.	211	10	52	273
	%	77.3%	3.7%	19%	100%

Regarding their preference of being involved in evaluating PHC services, 77.3 % of the clients though that it is important to ask them about their opinions in the services while 19% of them didn't know if it is important to ask clients about their opinions or not. Four out of the ten randomly selected clinics (40%) have a suggestion box for the clients (Annex 11). Three out of them said that they consider the suggestions the clients put in those boxes. The researcher and data collectors observed three suggestion boxes in three clinics only. This might indicate low consideration for clients' perceptions.

In general terms, this domain "involvement" is considered a weakness area in the PHC system. This important domain reflecting client-centered care practice requires further efforts to understand its concepts by the health care providers in the first place followed by raising clients' awareness about their rights in being involved in the planning, evaluation and implementation of health care plans for themselves and their families.

4.1.3 Clients suggestions for improving PHC services

In response to an open ended question, the important things that would improve provision of services from clients' perspectives could be summarized into;

1. **Drugs availability**

Many clients complained from the drug management cycle where most clients come during the first few days after receiving the monthly drug stock. Shortly after that, drug shortages start to appear. The case worsens up in the last days before receiving the following monthly stock. This fact drives clients to increase their visits during the first days of the month (around the timing of receiving monthly stock for the clinic according to the clinic area). One client said "*This month I came late to the clinic so I did not find my drugs for diabetes*".

2. **Client/ clinic staff interaction**

Clients raised the importance of increasing the cooperation between clinic staff and clients in order to improve health care services delivery. Clients raised the importance of good communication and respect of clients to the clinic staff and vice versa.

3. **Human resources discipline**

Clients said that more supervision on all the clinics employees' performance should be done. Some of them complained from the administrative employees in particular. A client said "*What is the point of the availability of the physician if the admin employee is not working well*".

4. **Infrastructure**

Clients (especially in small clinics) preferred receiving services from larger clinics with better physical conditions, more equipment and expanded health care services. Clients also

complained from the windows with metal bars they should stand at when they receive their medicines. They said that this prevents them from asking more about the drugs and they feel that it makes a barrier for good communication with pharmacists. One client said "*I feel that the pharmacist is far away and I cannot ask him/her what I want*"

5. Health services delivery

- Working shifts: Some clients said that they need some clinics to open in the afternoon shifts; This was mainly stated by clients who were employees in other organizations. One client said "*Both me and my husband are employees; one of us should take a day off if one of our children get sick. I hope if the ministry can open one or two clinics in the afternoon shifts*"
- Privacy: Increasing patient privacy was one of the clients' concerns.
- Choice: Clients complained that they are referred to physician room number rather than a physician by name. This made them feel isolated and insecure until they explore who is waiting them in the examination room.

The aforementioned descriptive figures presented the strengths and weaknesses of the PHC services in general regardless of the characteristics variables of the clinics or the clients themselves. The following paragraphs compare between selected areas mentioned in the descriptive analysis and different characteristics of clients and PHC clinics. The provided comparisons illustrate possible differences in perceptions and it allows for better understanding of the descriptive analysis.

4.2 Inferential analysis

The following part compares between PHC clinics and clients characteristics variables with five main sub-domains that reflect the clients-centeredness of the PHC services which are; choice, respect, communication, planning and implementation. The comparison is based on the overall score for each factor.

4.2.1 Part A: PHC clinics characteristics variables

4.2.1.1 Clinic level

There were differences in clients' perspectives between big and small clinics in all the elicited scores. Clients' perspectives in small clinics were more positive than their counterparts in large clinics in regards to all the sub-domains of choice, respect, and communication in the health services delivery domain. Also, the same higher perspectives appeared within sub-domains of planning and implementation in the involvement domain (Table 4.16).

Table (4.16): Differences in perceptions of selected client-centeredness domains according to PHC clinic level

Dependent variables (Domains)	In-dependent variable (Clinic level)	N	Mean	SD	t	Sig.
A. Health care services delivery						
Choice	Level 2/3	57	0.576	0.431	2.46	0.015*
	Level 4	213	0.425	0.406		
Respect	Level 2/3	58	0.713	0.161	1.12	0.263
	Level 4	216	0.676	0.236		
Communication	Level 2/3	58	1.900	0.256	3.11	0.002*
	Level 4	216	1.726	0.404		
B. Involvement						
Planning	Level 2/3	50	1.174	0.676	2.08	0.029*
	Level 4	181	0.953	0.613		
Implementation	Level 2/3	52	1.234	0.749	1.35	0.183
	Level 4	199	1.075	0.766		

The statistical t-test was used to compare between the differences in the scores of the different sub-domains among level2/3 and level 4 clinics. The difference in choice score reached a statistically significant level (P value 0.02). This difference is justified due to the fact that small clinics staff are usually known by most of the clients. The differences in communication scores were also statistically significant (p value 0.02). This could be explained by the fact that clients who usually visit the small clinics are familiar with the clinic's staff. There are statistically significant differences in the elicited planning scores between big and small clinics (P value 0.029). This difference might be explained by the fact that three out of the five small

clinics have a representative committee for the clients who regularly reach the PHC clinic while all big clinics do not have a similar activity (Annex 11). However, one clinic only conducts regular meetings with the clients. This reflects that participation of clients in planning is not a common practice within the PHC system.

4.2.1.2 Clinic area

Different scores within all the compared sub-domains scores were noticed in each governorate which reflects differences in clients perspectives within the GG. The highest score of choice was in the Mid Zone PHC clinics while the lowest score was in the North governorate PHC clinics. Likewise, the highest respect score was in Mid zone PHC clinics and the lowest was in the North PHC clinics. The highest communication score was in Gaza PHC clinics while the lowest score was in the North PHC clinics. Rafah PHC clinics scored the highest both in the planning and implementation. This might be reflected to the fact that one of the PHC clinics in Rafah conducts regular meetings with the clinic clients. This might have had its positive effects on clients' involvement in planning and implementation of health interventions.

The researcher used One-way ANOVA test to compare the differences between the mean scores for the selected sub-domains between the five governorates. Post Hoc test (Scheffe) showed differences between the scores and the differences were statistically significant in all the scores between the five governorates (P value below 0.05).

Table (4.17): Differences in perceptions of selected client-centeredness domains according to PHC clinic area.

Dependent variables (Domains)	In-dependent variable (Clinic Area)	N	Mean	SD	F	Sig.
A. Health care services delivery						
Choice	North	60	0.1	0.3	23.82	0.00*
	Gaza	63	0.4	0.4		
	Mid Zone	28	0.8	0.3		
	Khanunis	52	0.6	0.4		
	Rafah	67	0.6	0.4		
Respect	North	60	0.52	0.27	15.58	0.00*
	Gaza	66	0.69	0.15		
	Mid Zone	28	0.84	0.09		
	Khanunis	53	0.72	0.18		
	Rafah	67	0.74	0.23		
Communication	North	60	1.55	0.46	7.926	0.00*
	Gaza	66	1.90	0.24		
	Mid Zone	28	1.84	0.23		
	Khanunis	53	1.77	0.43		
	Rafah	67	1.79	0.37		
B. Involvement						
Planning	North	33	0.17	0.40	44.51	0.00*
	Gaza	66	0.88	0.42		
	Mid Zone	26	1.43	0.56		
	Khanunis	47	0.96	0.52		
	Rafah	59	1.45	0.50		
Implementation	North	59	0.22	0.37	70.26	0.00*
	Gaza	57	0.96	0.67		
	Mid Zone	27	1.63	0.31		
	Khanunis	43	1.34	0.69		
	Rafah	65	1.67	0.44		

4.2.1.3 Presence of community representative committees

Clients in the clinics that have a representative committee (three clinics out of the ten clinics have a representative committee for their clients) for its clients had more positive perspectives about the health care services in comparison with clinics that do not have a committee. This is

well reflected through the fact that the scores for the sub domains of choice, respect, communication, planning and implementation in the clinics having a representative committee were much higher than clinics without representative committees.

The statistical t-test was used to compare between the differences in the scores of the different sub-domains among clinics which have representative bodies for the clients and other clinics which do not. The differences reached high statistically significant levels for all the factors (P value 0.001). These results reflect that the presence of representative committees for the PHC beneficiaries increase their overall perceptions about the PHC services in general. Thus, it will have its positive effects on clients' adherence with treatment plans.

Table (4.18): Differences in perceptions of selected client-centeredness domains according to PHC clinic interaction with community

Dependent variables (Domains)	In-dependent variable (Clinic has a representative committee for clients)	N	Mean	SD	t	Sig.
A. Health care services delivery						
Choice	Yes	31	0.75	0.343	4.88	0.001*
	No	239	0.42	0.409		
Respect	Yes	31	1.95	0.187	5.02	0.001*
	No	243	1.73	0.396		
Communication	Yes	31	0.79	0.073	6.48	0.001*
	No	243	0.66	0.231		
B. Involvement						
Planning	Yes	26	1.61	0.456	5.58	0.001*
	No	205	0.92	0.610		
Implementation	Yes	28	1.74	0.347	8.65	0.001*
	No	223	1.02	0.764		

To sum up, it seemed that clinic location, clinic level and clinic cooperation with the community have their effects on clients perceptions. The differences between clients' perceptions within the clinics characteristics variables regarding the selected client-centered care sub-domains reached statistically significant levels. This might imply the importance of

considering the characteristics of the clinics that enhances clients perceptions about the centeredness of the services provided through those clinics.

The second part of the inferential analysis will examine the effects of clients' characteristics variables on the clients' perceptions about the selected domains.

4.2.2 Part B: Clients' characteristics variables

4.2.2.1 Client's sex

Both male and female perspectives were not that much different, though, female group had higher scores in respect, communication and implementation (Table 4.19). Generally speaking, females usually scored higher satisfaction levels than males as they might have lower expectations (El Haj, 2008; Hamad, 2009). It is worth noting that male group had higher scores in both choice and planning scores. This might indicate better influence of males on choosing the health care provider they want. In addition, it might reflect an extent of better willingness of men to participate in health planning activities due to cultural aspects.

Table (4.19): Differences in perceptions of selected client-centeredness domains according to client's sex

Dependent variables (Domains)	In-dependent variable (Clinic level)	N	Mean	SD	t	Sig.
A. Health care services delivery						
Choice	Male	91	.462	.4368	0.13	0.894
	Female	179	.454	.4059		
Respect	Male	92	.6592	.24508	1.31	0.191
	Female	182	.6966	.21077		
Communication	Male	92	1.6984	.41194	1.93	0.055
	Female	182	1.7967	.36586		
B. Involvement						
Planning	Male	76	1.0221	.61471	0.353	0.724
	Female	155	.9908	.64359		
Implementation	Male	89	1.0790	.79049	0.448	0.655
	Female	162	1.1243	.75151		

t test was used to compare the scores of males and females regarding the selected client-centeredness domains. The differences of the scores of the five domains between males and females did not reach any statistically significant levels.

4.2.2.2 Client's attained education level

Generally, clients with higher education levels usually have lower satisfaction levels as they have higher expectations (Hamad, 2009). However, in this study clients with higher education level scored higher scores in the following domains; choice, respect, implementation and communication (Table 4.20). This might reflect that more educated people will have a better chance to know their rights and ask for them. For example, they will be able to choose the health care provider who will examine them more than others. In addition, they might be treated with more respect or attention due to their higher tendency to complain.

Table (4.20): Differences in perceptions of selected client-centeredness domains according to client's attained education level

Dependent variables (Domains)	In-dependent variable (Education level)	N	Mean	SD	F	Sig.
A. Health care services delivery						
Choice	Less than secondary	54	0.3	0.4	7.63	.001*
	Secondary	127	0.4	0.4		
	Higher than secondary	85	0.6	0.4		
Respect	Less than secondary	55	0.61	0.24	11.71	.001*
	Secondary	129	0.65	0.22		
	Higher than secondary	86	0.77	0.18		
Communication	Less than secondary	55	1.72	0.38	1.3	.273
	Secondary	129	1.74	0.42		
	Higher than secondary	86	1.81	0.33		
B. Involvement						
Planning	Less than secondary	41	0.77	0.63	5.04	.007*
	Secondary	82	1.12	0.66		
	Higher than secondary	105	0.95	0.56		
Implementation	Less than secondary	52	0.65	0.69	15.4	.001*
	Secondary	116	1.12	0.81		
	Higher than secondary	80	1.36	0.60		

Regarding the score of the implementation sub-domain, people with higher education level will be more persistent to ask for possible choices and alternatives while people with lower education level will consider health care provider opinion as there will be more asymmetrical information between them. The elicited score of planning dimension was higher among people with secondary and higher than secondary education than people with less than secondary education. This might reflects that clients with higher education levels are more aware about the importance of participation in planning activities or more aware about the existence of such activities

After using One-way ANOVA and Post Hoc test (Scheffe) test, statistically significant differences are observed between different education levels in choice (P value 0.001), respect (P value 0.00), planning (P value 0.007) and implementation scores (P value 0.001).

4.2.2.3 Client's Age

Clients with different ages had different perspectives about respect, planning and implementation sub-domains. The general scores of the domains varied among the different age groups where clients aging 20 years or less had higher score in the respect sub-domain than clients with higher age. In contrast, they scored the least in the planning sub-domain. There were no differences in the scores of choice and communication sub-domains among different age groups. It was noticed that clients with higher age seems to score higher in the involvement domain while they seemed to score lower with health care delivery domain. Yet, the differences of the scores of the five domains between age groups did not reach any statistically significant levels.

To sum up, various clients' characteristics variables have their effects on clients' perceptions about the selected client-centered care domains. Neither clients sex nor clients' age have significant effects on clients' perceptions. Clients attained education levels have positive impacts on clients perceptions about the extent of clients involvement in the implementation and planning.

Table (4.21): Differences in perceptions of selected client-centeredness domains according to client's age

Dependent variables (Domains)	In-dependent variable (age groups)	N	Mean	SD	F	Sig.
A. Health care services delivery						
Choice	20 and less	39	0.5	0.4	0.326	0.807
	21-30	111	0.5	0.4		
	31-50	20	0.5	0.4		
	51 and more	94	0.4	0.4		
Respect	20 and less	22	0.74	0.74	0.696	0.555
	21-30	112	0.68	0.69		
	31-50	94	0.66	0.67		
	51 and more	40	0.69	0.69		
Communication	20 and less	22	1.92	0.19	1.517	0.210
	21-30	112	1.77	0.22		
	31-50	94	1.73	0.23		
	51 and more	40	1.74	0.24		
B. Involvement score						
Planning	20 and less	17	0.82	0.18	0.555	0.645
	21-30	98	1.03	0.42		
	31-50	78	1.00	0.39		
	51 and more	34	1.03	0.36		
Implementation	20 and less	19	1.06	0.38	0.903	0.440
	21-30	99	1.20	0.65		
	31-50	88	1.02	0.62		
	51 and more	39	1.11	0.72		

Chapter (5)

Conclusion and Recommendations

5.1 Conclusion

Client-centred care enhances clients' accessibility to the care that suits them. It is the care that assures proper health care services delivery; that creates a space for the clients to be partners in the caring process rather than being only receivers of care services. This study tried to explore the extent at which the governmental PHC services are client-centered. The researcher assessed several domains with sub-domains in order to reach this objective.

The first client-centeredness domain was the appropriate accessibility to health care services. The results reflected good physical accessibility to the governmental PHC facilities where most of the respondents perceived the distance between their houses and the clinics as reasonable or the clinic was nearby their houses. As the physical accessibility is not only related to the ability to reach the clinic, but also to receive the desired services when required with the adequate quality. Most of the respondents were satisfied with the way of reception in the clinic. Another dimension of the physical accessibility is the availability of services. This study showed that some of the respondents reported being returned back home from the health care facility without getting the services they came to receive. The main reason was the unavailability of medications or lack of some medications that were prescribed to the clients.

Regarding the financial accessibility, most of the respondents are covered with a governmental health insurance, yet, this figure does not necessarily reflect the entire reality as those people who do not have any health insurance might not reach the PHC clinic in the first place. Further studies on vulnerable groups such as elderly and patients with chronic diseases should be carried on in order to reflect a clearer image about those vulnerable groups. Regarding technical and information accessibility, results showed good accessibility where most of the clients were satisfied with the health care provider who delivered the health care service for them and most of them felt that they have received all the information they wanted. Yet, there is a space for further improvement in this domain.

Most of the respondents received their prescribed medications with some shortages in certain drugs (regardless of the actually required medications). However, further improvement is

required in the way of dispensing medications to the clients. Instructions related to drug use were not written on most of the dispensed medications and clients usually received verbal drug use instructions. Most of the clinics usually face drug shortages in the last days before the new drug order reach the PHC facility.

Clients showed general acceptability for the time they have spent waiting for the health care services. Also, most of the clients were satisfied with the time they have spent with the health care provider. This figure might be a result of previous low expectations rather than actual satisfaction where several reports pointed to the limited time spent with health care providers within the governmental health care facilities. A weakness point in the caring system is the fact that most of the respondents were not able to choose the health care provider they want. Also, only slightly more than the half of the clients was asked for their approval before conducting medical examinations and other procedures. These figures as well as the previous studies point to the fact that clients are not fully aware about their rights.

Most of the clients were satisfied with their communication with the health care providers. They felt that they have asked about all the concerns they have and they felt that the health care providers were paying attention to them. Yet, some of the respondents complained from the communication with administrative staff. This shows that enhancing communication skills should be for all clinics staff who interact directly with the clients. Most of the clients felt that they were treated with respect. And most of them felt that their confidentiality was assured. However, some respondents complained form the presence of two physicians and their patients in the same room. The quality of basic amenities in the clinic was good and most of the clients were satisfied with them. However, some respondents said that there are no clean cups beside the drinking water tanks.

Generally speaking, there were positive perceptions about the health care services delivery in relation to the domains identified by the researcher. Yet, further improvements could be achieved especially in maintaining clients' confidentiality and privacy as well as improving communication between all the PHC clinics staff and the clients.

Involvement of clients in planning for health care services, deciding their treatment plans and evaluating the attained health care services is one of the most important domains that reflect the clients-centeredness of the health care services. This study figured that most of the clinics did not have representative committees for the clients and most of the clients did not participate in any planning activities for improving health care services delivery. Most of the clinics neither have suggestion boxes for the clients nor do they consider the suggestions the clients might raise. Regarding clients' involvement in deciding their treatment plans (clients autonomy according to responsiveness definition), almost half of the respondents said that they did not participate in deciding their treatment plans. On the other hand, most of the clients said that they prefer to be involved in deciding their treatment plans. Some clients did not want to participate because they consider treatment as the main responsibility of the health care providers not themselves. Regarding participation of clients in evaluating the PHC services, most of the clients were not asked before about their opinion in the health care services. On the other hand, most of the clients said that it is important to consider people's opinions in the health care services in order to provide better services.

In general terms, the domain of involvement of clients in planning, implementation and participation in health care services showed a weakness area in the health system. Yet, this might reflect low clients-centered services in regard to involving clients in the health care delivery. It is recommended to increase clients' involvement in the caring process to let them share the responsibility and think that their opinions are valued. This would enhance the relationships between the clients and the PHC services. Thus, it would have its positive impacts on clients' health.

Capturing clients' preferences and expectations is not an easy exercise. The researcher tried to figure out the factors that clients perceive as a reflection for good quality of care and the first factor that reflects good quality of PHC services was the availability of medications. In addition, when the researcher asked the clients about their suggestions for improving health care services, the first suggestion for most of the clients were the availability of medications all along the month and this reflects that clients' concerns are mostly about the availability of medications. It is well-known that the caring process is not only about a prescription and a

drug, but it is also about all the efforts that should be carried out in cooperation between health care systems and communities in order to improve people health and wellbeing. The respondents' answers reflected the general image about the relationship between the PHC clinics and the health care system. The relationship between the PHC and the community should be re-shaped not only regarding the providers' practices but also within community minds. The second factor that represents good quality of care was the respect from health care providers. This factor scored higher a percentage than being cured or relieved which came as the third factor. These results indicate that the clients showed high demand for a respectful interaction which reflects the importance of the humanitarian interaction in the caring process besides the technical side. Those results raise the importance of improving the interaction between the health care providers and the clients.

The inferential analysis showed interesting results that reflected the effect of both clinics and clients' characteristics variables. The researcher compared the scores for selected sub-domains that reflects client-centered care (they were; choice, respect, communication, involvement in planning and involvement in implementation of health interventions) within those different characteristics'. Clients visited level2/3 clinics had better perspectives regarding their ability to choose their treating health care provider, their communication and interaction with health care providers and finally being involved in planning. This result reflects that the small clinics allow for better interaction between the health care providers and the clients, thus, it enhances general feelings of clients and confidence within the health care facilities. Interesting results showed highly significant differences in favour of the clinics that have representative committees for their beneficiaries than those who do not have such committees. This Result highlights the importance of having such active committees that will allow the clients to feel as partners in the caring process rather than being such receivers of care.

There were no significant differences between the perspectives of the clients regarding the selected sub-domains in relation with respondents' sex and age. In contrary, respondents with higher education levels scored higher in the sub-domains of choice, respect, planning and implementation. The differences in the scores reached statistically significant level except for the communication sub-domain. These results reflect that clients with higher education levels

have better chances to choose the health care provider; they have higher demands to participate in deciding their treatment plans; thus, health care providers might have different ways in interacting with them.

5.2 Recommendations

5.2.1 The Study Recommendations

1. For adopting a client-centred approach in care, efforts should start at the policy level. The caring system will not be client-centred unless all the efforts are intensified among all the stakeholders (policy makers, providers and beneficiaries') to raise the awareness and set policies and regulations that support this approach of care. This could be achieved through;

    - Engaging in a national dialogue about clients' centeredness of care to sensitize different partners and stakeholders and stimulate policy formulation in this regard.
    - Endorsing the client-centeredness approach as a part of the health system conceptualization of the primary health care model (creating system thinking about this concept).

2. Providing training to policy makers, health managers and health care providers in client centeredness concepts, approaches and modalities is essential.

3. Increasing clients' involvement in the process of designing health programs, treatment plans and the evaluation of health actions is a necessity that should be maintained constantly and systematically.

4. Establishing representative committees for communities at each PHC clinic as this might enhance the interactions and partnership between the clients and the clinics teams.

5. Enhancing interactions between the communities and the health care facilities meanwhile considering clients health rights. This could be achieved through;

   - Conduct campaigns that describe the patients' rights as well as their responsibilities.
   - Conduct training sessions for health care providers and administrative personnel within the clinics about the patients' rights and responsibilities.
   - Promoting the communication skills of health providers through training, supervision and monitoring.
   - Paying more attention to confidentiality and privacy within the PHC clinics' premises.

6. The constant availability of the essential drugs is very important to effectively implement the treatment plan of beneficiaries. All effort should be intensified to constantly guarantee the availability of the essential drugs.

7. Enhancing the appropriate prescribing practices is vital particularly drug labelling and counselling.

8. Enhancing an environment that is conducive to the responsiveness to clients needs and expectations such as;
   - Replacing the metal bars in front of PHC pharmacies windows with friendly space that allows for better communication and information exchange.
   - Provide clean cups for drinking water
   - Presence of a suggestions box in a visible place within the clinics

9. Regularly, monitoring clients' perspectives about the health care services through routine data collection and reporting. Clients' satisfaction questionnaires, exit interviews, soliciting regular feedback through meetings and interactions, ensuring the availability of suggestion boxes and responding to clients' perspectives are good practical tools for monitoring clients' perspectives.

5.2.2 Recommendations for further research

1. Conducting qualitative studies that explore in-depth the overviews of health care providers and the clients regarding the client-centered care.

2. It would be beneficial to carry out additional research studies to assess the factors that reflect good quality of health care services as well as clients' definition of the qualified health care providers.

3. Conducting additional research studies to assess the extent at which the governmental health care sector is suitable for the health care providers themselves and how it might affect on their application of the client-centered approach in their daily practice.

References

Abed, Y. (2007). *Joint Report on Health Sector Review* (HSR), Palestine: Health Sector Review.

Abu Dayya, A. (2000). *Palestinian Citizen Satisfaction about Health Care Services Provided by Ministry of Health and His Awareness about His Rights in Receiving Health Care Services*. Ministry of Health, Palestine, Quality Improvement Project.

Abu Mourad, T., Shashaa, S., Markaki, A., Alegakis, A., Lionis, C. and Philalithis, A. (2007). An evaluation of patients' opinions of primary care physicians: the use of EUROPEP in Gaza Strip-Palestine. *Journal of Medical System*, *31,* 497-503.

Abu Mourad, T., Radi, S., Shashaa, S., Lionis, C. and Philalithis, A. (2008). Palestinian primary health care in light of the national strategic health plan 1999-2003. *Journal of the Royal Institute of Public Health, 122,* 125-139.

Al Hindi, F. (2002). *Clients' Satisfaction with Radiology Services in Gaza. School of Public Health,* Al-Quds University, Palestine. (Unpublished master thesis).

Bauman, A., Frady, H. and Harris, P. (2003). Getting it right; why bother with patient-centered care?. *Medical Journal of Australia, 179*, 253-256.

Beckerleg, S., Lewando-Hundt, G., Eddama, M., el Alem, A., Shawa, R. and Abed, Y. (1999). Purchasing a quick fix from private pharmacies in the Gaza Strip. *Social Science and Medicine***,** *49*(11), 1489-1500.

Bergeson, S. and Dean, J. (2006). A systems approach to patient-centered care. *Journal of the American Medical Association, 296* (28), 2848-2851.

Berry, L., Seider, K., Wilder, S. (2003). Innovations in access to care: a patient centered approach. *Annals of Internal Medicine, 139*, 568-574.

Britten, N. (2003). Clinicians and patients roles in patient involvement. *Quality and Safety in Health Care, 12*, 87.

Burn, S., Grove, K. (2010). *The Practice of Nursing Research Conduct Critique and Utilization,* (2nd ed). W.B. Saunders Company.

Cameron, A., Ewen, M., Auton, M. and Abegunde, D. (2011). *The World Medicines Situation 2011; Medicines Prices, Availability and Affordability*. Geneva, Switzerland: World Health Organization.

Campbell, S. M., Roland, S. A. and Buetow, S. A. (2000). Defining quality of care. *Social Science and Medicine, 51*, 1611-1625.

COPE (2003). *Client Oriented Provider Efficient Handbook: A Process For Improving Quality In Health* (Revised ed.). USA: Engender Health's Quality Improvement Series.

Cheraghi-Sobi, S., Hole, A., Mead, N., McDonald, R., Wballey, D., Bower, P. and Roland, M. (2008). What patients want from primary care consultations: a discrete choice experiment to identify patients priorities. *Annals of Family Medicine, 6* (2), 107-115.

Davis, K., Schoenbam, S., Audet, A. (2005). A 2020 vision of patient centered primary care". *Journal of General Internal Medicine, 20*, 953-957.

Davies, E. and Cleary, P. (2005). Hearing the patient's voice? factors affecting the use of patient survey data in quality improvement. *Quality and Safety in Health Care, 14,* 428-432.

Declaration of Alma Ata (1978), 6-12 September . *International Conference on Primary Health Care,* Alma Ata: USSR.

Donabedian, A. (1988). The quality of care how can it be assessed. *Journal of the American Medical Association, 260* (12), 1743-48.

Ducinskiene, D., Vladickiene, J., Kalediene, R. and Haapala, I. (2006). Awareness and practice of patient's rights law in Lithuania. *BMC International Health and Human Rights, 6*, 10.

Edwards, A., Elwyn, G., Smith, C., Williams, S., Thornton, H. (2001). Consumers views of quality in the consultation and their relevance to shared decision-making approaches. *Health Expectations , 4,*151-161.

El-Afifi, M. (2008). *Workload Status in Primary Health Care Pharmacies-Gaza Governorates***.** School of Public Health, Al-Quds University, Palestine. (Unpublished master thesis).

El-Haj, M. (2008). *Perception of Hospitalized Patients about the Services Provided at the European Gaza Hoapital.* School of Public Health, Al-Quds University, Palestine. (Unpublished master thesis).

Elkhatib, Z. (2010). *Patients' Satisfaction with the Non-communicable Diseases Services Provided at UNRWA Health Centres in Gaza Governorates*. School of Public Health, Al-Quds University, Palestine. (Unpublished master thesis).

Elliott, R. (2009). Non-adherence to medicines: not solved but solvable. *Journal of Health Services Research and Policy. 14* (1), 58-61.

Elwyn, G., Edwards, A., Wensing, M., Hood, K., Atwell, C. and Grol, R. (2003). Shared decision making: developing the OPTION scale for measuring patient involvement. *Quality and Safety in Health Care*, 12, 93-99.

Fathhalla, M. (2004). *A Practical Guide for Health Researchers*. Cairo: Regional office for the Eastern Mediterranean, World Health Organization.

Fattouh, R. and Abu Hamad, B. (2010). "Impact of using essential drug list: analysis of drug use indicators in Gaza Strip". *Eastern Mediterranean Health Journal, 16* (8), 710-716.

Frampton, S. Guastello, S., Brady, C., Hale, M., Horowitz, S., Smith, S. and Stone, S. (2008). *Patient Centered Care-Improvement Guide*. United Kingdom: Picker institute and Planetree institute.

Gadallah, M., Zaki, B., Rady, M., Anwer, W. And Sallam, I. (2003). Patient satisfaction with primary health care services in two districts in lower and upper Egypt. *Eastern Mediterranean Health Journal, 9* (3), 422-430.

Giacaman R. Khatib R., Shabaneh L. (2009). Health status and health services in the occupied Palestinian territory. *Lancet, 373*, 837-849.

Graduate Institute of Development Studies (2005). *Palestinian Public Perceptions*, report 8, Palestine, Graduate Institute of Development Studies.

Haddad, S., Fournier, P., Machouf, N., Yatara, F. (1998). What does quality mean to lay people? community perceptions of primary health care services in Guinea. *Social Science and Medicine, 47*(3), pp. 381-349.

Hansen, P., Peters, D., Viswanathan, K., Dipankar, R., Mashkoor, A. and Burnham, G. (2008). Client perceptions of the quality of primary care services in Afghanistan. *International Journal for Quality in Health Care, 20 (*6), 384-391.

Hamad, B. (2009). Clients satisfaction about health services in Gaza: review of research findings" paper presented at: *Toward a Comprehensive Vision for Human Resources Development in the Palestinian Public Sector-First Conference*. April, 2009, Gaza, Palestine.

Hamad, B. (2011). *Research on Child Health Survival in Gaza. Palestine***:** Save the Children and Medical Aid for Palestinians.

Hanan (2005). *Hanan base line facility assessment for maternal and child health and nutrition services: First cohort, Hanan clinics in the West Bank and Gaza, Technical paper number 5.* Palestine: Hanan Project, USAID.

Health Sector review (2005). *Task force 3: Health Services Delivery*. Palestinian National Authority, Italian cooperation and Istituto Superioredi Sanità.

Hibbard, J. (2004**).** Moving toward a more patient-centered health care delivery system: measuring patients' engagement and activation should be made a routine part of quality assessment. *Health Affairs-Web exclusive*. 133-135. Reterived February 27, 2011, from Dartmouth-Hitchcock Medical Center: http://www.dhmc.org/dhmc-internet-upload/file_collection/Hibbard%20JH%20.pdf

Institute of Medicine (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century, Free executive summary*. USA: National Academy of Science. Reterived April 12, 2011, from The national academies press: http://www.nap.edu/catalog/10027.html

Johnson, F. (2008). Why not ask? measuring patients preferences for health care decision making-editorial. *Patient, 1,* 245-248.

Kerssens, J., Groenewegen, P., Sixma, H., Boerma, W. and Van der Eijk, I. (2004). Comparison of patient evaluations of health care quality in relation to WHO measures of achievement in12 European countries. *Bulletin of the World Health Organization, 82*, 106-114.

Kuzel, A., Woolf, S., Gilchrist, V., Engel, D. (2004). Patient reports of preventable problems and harms in primary health care. *Annals of Family Medicine, 2*, 333-340.

Levenstein, J., Mccracken, E., Mcwhinney, I., Stewart, M. and Brown, J. (1986). The patient-centred clinical method. 1. A model for the doctor-patient interaction in family medicine. *Family practice, 3* (1), 24-30.

Labhardt, N., Schiess, k., Manga, E., Langewitz, W. (2009). Provider–patient interaction in rural Cameroon-how it relates to the patient's understanding of diagnosis and prescribed drugs, the patient's concept of illness, and access to therapy. *Patient Education and Counseling, 76*, 196-201.

Laamanen, R., Ovretveit, J., Sundell, J., Rehn, N., Swominen, S., Brommels, M. (2006). Client perceptions of the performance of public and independent not for profit primary health care. *Scandinavian Journal of Public Health, 34*, 598-608.

Letaief, M., Ben Hmida, A., Mouloud, B., Essabbeh, B., Ben Aissa, R. and Gueddana, N.(2008). Implementing a quality improvement programme in a family planning centre in Monastir, Tunisia. *Eastern Mediterranean Health Journal, 14* (3), 615-627.

Laing, A., (2002). Meeting patient expectations: health care professionals and service re-engineering. *Health Services Management Research, 15*, 165-172.

Little, P., Everitt, H., Williamson, I., Warner, G., Moore, M., Gloud, C., Ferrier, K., Payne, S. (2001a). Preferences of patients for patient centered approach to consultation in primary health care. *BMJ, 322*, 1-7.

Little, P., Everitt, H., Williamson, I., Warner, G., Moore, M., Gould, C., Ferrier, K. and Payne, S. (2001b). Observational study of effect of patient-centeredness and positive approach on outcomes of general practice consultations. *BMJ, 323*, 908-911.

Litva, A., Coast, J., Donovan, J., Eyles, J., Shepherd, M., Tacchi, J., Abelson, J. and Morgan, K. (2002). The public is too subjective: public involvement at different levels of health-care decision making. *Social Science and Medicine, 54*, 1825-1837.

MARAM (2003). *MARAM Project Survey of Women and Child Health and Health Services in the West Bank and Gaza Strip*, Palestine, MARAM project, USAID.

Massoud, R., Askov, K., Reinke, J., Franco, L., Bornstein,T., Knebel, E., MacAulay, C. (2001). *A Modern Paradigm for Improving Healthcare Quality. QA Monograph Series 1*. USA: Quality Assurance Project U.S. Agency for International Development (USAID).

Mataria, A., Donaldson, C., Luchini. S. and Moatti, J. (2004). A stated preference approach to assessing health care-quality improvements in Palestine: from theoretical validity to policy implications. *Journal of Health Economics, 23*, 1285-1311.

Margolis, S., Al-Marzouqi, S., Revel, T. and Reed, R. (2003). Patient satisfaction with primary health care in the United Arab Emirates. *International Journal for Quality in Health Care, 15* (3), 241-249.

McKague, M. and Verhoef, M. (2003). Understandings of health and its determinants among clients and providers at urban community health center. *Quality Health Research, 13 (5),* 703-717.

McLaughlin, C. and Kaluzny, A. (2000). Building client centered systems of care: choosing a process direction for the next century. *Health Care Management Review, 25* (1), 73-82.

Mead, N., Bower, P. (2000). Patient-centeredness: a conceptual frame work and review of the empirical literature. *Social Science and Medicine, 51*, 1087-1110.

Mead, N., Bower, P. (2002). Patient-centred consultations and outcomes in primary care: a review of the literature. *Patient Education and Counselling, 48*, 51-61.

Michie, S., Miles, J. and Weinman, J. (2003). Patient-centredness in chronic illness: what is it and does it matter?. *Patient Education and Counselling, 51*, 197-206.

Moran, J., Bekker, H., Latchford, G. (2008). Every day use of patient centered, motivational techniques in routine consultants between doctors and patients with diabetes. *Patient Education and Counseling, 73*, 224-231.

Nanbakhsh, H., Salarilak, S., Islamloo, F. and Aglemand, S. (2008). Assessment of women's satisfaction with reproductive health services in Urmia University of Medical Sciences. *Eastern Mediterranean Health Journal, 14* (3), 605-614.

Obeidallah, W. Mahariq, M., Barzeq, A. and Zemli, M. (2000). *Drug Situation Analysis for the West Bank and Gaza Strip.* Palestine: Department of Essential Drugs and Medicines Policy, World Health Organization.

Palestine, Ministry of Health (2003). *Strategic National Health Plan for the Palestinian People 1999-2003.* Palestine, Ministry of Health.

Palestine, Ministry of Health (2005). *Heath Sector Review Report***.** Palestine, Ministry of Health.

Palestine, Ministry of Health (2006). *Health Status of the Palestinian Population Annual Report,* Palestine, Ministry of Health.

Palestinian Central Bureau of Statistics (2004). *Access to Health Services Survey – 2003, (Main Findings)*. Palestinian Central Bureau of Statistics, Ramallah-Palestine.

Palestinain Central Bureau of Statistics (2010). *Status of Palestinians living in the Occupied Palestinian territories.* Ramallah, Palestine.

Palestinian Non Governmental Organizations Network {PNGO}(2009), *Priorities and Needs of Health Sector in Gaza Governorates: Consequences of the Long Siege and the Last War on Gaza*, Work shop conclusions, February 2009, Gaza, Palestine.

Rao, K., Peters, D., Roche, B. (2006). Towards patient-centered health services in India—a scale to measure patient perceptions of quality. *International Journal for Quality in Health Care, 18* (6), 414–421.

Rameshan, P. and Singh, S. (2005). Quality of the health delivery system: a case on the customer orientation of primary health centere. *Journal of Health Management, 7*, 187.

Saha, S., Beach, M. and Cooper, L. (2008). Patient centeredness, cultural competence and health care quality. *Journal of National Institute of Health, 100* (11), 1275-1285.

Schoen, C., Osborn, R., Huynh, P., Doty, M., Davis, K., Zapert, K., Peugh, J. (2004). Primary Care And Health System Performance: Adults' Experiences In Five Countries Differing performance levels among countries highlight the potential for improvement and cross-national learning. *Health Affairs-Web exclusive, 4*, 487-503.

Stewart, M. (2001). Towards a global definition of patient centered care, the patient should be the judge of patient centered care. *BMJ, 322*, 444-445.

Tongue, J., Epps, H., Foresel, L. (2005). Communication skills for patient-centered care. research based, easily learning techniques for medical interviews that benefit orthopedic surgeons and their patients. *Journal of Bone and Joint Surgery, 87*, 652-658.

Wilkerson, L., Fung, C., May, W., Elliot, D. (2010). Assessing patient-centered care: one approach to health disparities education. *Journal of General Internal Medicine, 25* (l 2), 86-90.

Wolosin, R. J.(2005). The voice of the patient: a national representative study of satisfaction with family physicians. *Quality Management in Health Care, 14* (3), 155–164.

Valentine, N., Silva, A. and Murray, C. (2001). *Estimating Responsiveness level and distribution for 191 countries: Methods and Results.* GPE discussion paper series No. 22. Geneva. Retrieved March 19, 2011, from World Health Organization: http://www.who.int/responsiveness/papers/paper22.pdf

World Health Organization (1999). *Public health in action. Community Involvement in Health Development: A Review of the Concept and Practice, Chapter 1-Community Involvement in*

Health Care Development: an overview, Pare 9. Geneva, Switzerland: World Health Organization.

World Health Organization (2000). *The World Health Report, Health Systems: Performance Improvement*. Geneva, Switzerland, World Health Organization.

World Health Organization (2001b). *Background Paper for the Technical Consultations on Responsiveness Concepts and Measurement-13-14 September*. Geneva, Switzerland. World Health Organization

World Health Organization (2002). *25 Questions and Answers on Health and Human Rights.* Geneva, Switzerland, World Health Organization. Retrieved March 22, 2011, from WHO: http://whqlibdoc.who.int/hq/2002/9241545690.pdf

World Health Organization (2004a). *Quality Improvement in Primary Health Care: A Practical Guide.* Cairo, WHO Regional Office for the Eastern Mediterranean (EMRO).

World Health Organization, (2004b) *Management of Drugs at Health Centre Level, Training manual.* Brazzaville, WHO Regional Office for Africa.

World Health Organization (2006a). *Quality of Care: A Process for Making Strategic Choices in Health Systems*. France, WHO Library Cataloguing-in-Publication Data.

World Health Organization, (2006b). *Using indicators to measure country pharmaceutical situations Fact Book on WHO Level I and Level II monitoring indicators*. Geneva, Switzerland. World Health Organization.

World Health Organization, (2006c). *Mission Report Review of the pharmaceutical management and supply system in the West Bank and Gaza*. Retrieved April 20, 2011, from Eastern Mediterranean Regional Office:

http://www.emro.who.int/palestine/reports%5cmonitoring%5cwho_special_monitoring%5cdrugs_monito_sys%5cwho%20pharmaceutical%20management%20report%20(october%202006).pdf

World Health Organization (2007a). *Health Systems Observatory-Glossary for health System.* Eastren Mediterranian Regional Office (EMRO), Division of Health System and Services Development, Health Policy and Planning Unit. Reterieved April 30, 2011, from EMRO: http://gis.emro.who.int/HealthSystemObservatory/PDF/Instruments%20And%20Tools/Glossary.pdf

World Health Organization (2007b). *People-Centered Health Care: A Policy Framework.* Geneva, Switzerland, World Health Organization.

World Health Organization (2008). *The World Health Report, Primary Health Care Now More than Ever*. World Health Organization, Geneva.

World Health Organization (2009). *Health conditions in the Occupied Palestinian territory, including east Jerusalem and occupied Syrian Golan. Sixty second world health assemply*, Provisional agenda item. Retrieved March 19, 2011, from World Health Organization: http://apps.who.int/gb/ebwha/pdf_files/A62/A62_ID1-en.pdf

World Health Organization (2010). Referral of patients from the Gaza Strip, December 2010. Retrieved May 1, 2011 from Issuu: http://issuu.com/who-opt/docs/update_rad_december_2010

World Health Organization (2011). Background Note on Drug Shortages in Gaza. Retrieved April 28, 2011, from Issuu: http://issuu.com/who-opt/docs/backgroundnote-drugs

Zebiene, E., Razgauskas, E., Basys, V., Baubiniene, A., Grevicus, R., Padiaga, Z., Svab, I. (2004). Meeting patient's expectations in primary care consultations in Lithuania. *International Journal for Quality in Health Care, 16,* (1), 83-89.

Annexes

Annex 1: Gaza Governorate map with health care facilities locations

Annex 2: Sample distribution and data collection plan

58 PHC Clinics
300 individuals
2 Clinics per area

Area	North	Gaza	Mid. Zone	Khanunis	Rafah
Sample %	% 20	% 27	% 10	% 20	% 23
Level 2	5	5	12	8	1
Level 3	6	8	2	2	2
Level 4	1	2	1	2	1
Sample no.	60	80	30	60	70
Level 4	Shuhada Jabalia	Shuhada Remal	Shhada Deir el Balah	Shuhada Khanunis	Shuhada Rafah
Level 2/3	Beit Lahia old	El Salam	Hekr El Jame	Joret el Loot	Shabora
Data collection period and days	October	1st, 2nd, 3rd / 13th,14th,15th / 27th,28th,29th			
	November	1st, 2nd, 3rd / 13th,14th,15th / 27th,28th,29th			

Annex (3): Clients exit interviews Arabic and English questionnaires

اشعار عدم ممانعة

السيد/ة مراجع العيادة الصحية المحترم/ة

لقد تم اختيارك بصورة عشوائية للمشاركة في هذا البحث الذي اقوم به للحصول على درجة الماجستير في الصحة العامة من جامعة القدس-أبوديس. تهدف هذه الدراسة الى قياس مدى استجابة خدمات الرعاية الصحية الأولية لاحتياجات و توقعات المواطنين من خلال الاجابة على مجموعة من الاسئلة في هذه الاستبانة علما بأن

- مشاركتك في هذه الرسالة تطوعية، بحق لك القبول أو الرفض
- سيأخذ هذا الاستبيان 20 دقيقة من وقتك على الأقل.
- لا يوجد اجابات صحيحة او اخرى خاطئة.
- اراءك أ و اجاباتك لن تؤثر على الخدمات الصحية التي تتلقاها من هذه العيادة.
- السرية مكفولة و لا داعي للتعريف باسمك.

شكرا لتعاونك

فائق الاحترام و التقدير

الباحثة

هدى حيدر عثمان

كلية الصحة العامة

جامعة القدس/ابوديس

1) الرقم التسلسلي :		2) اليوم		3) التاريخ ...../...../.....	
4) اسم جامع البيانات	.....		5) اسم العيادة.....		
6) منطقة العيادة	1. الشمال	2. غزة	3. الوسطى	4. خانيونس	5. رفح

I. Access to health care services الوصول الى خدمات الرعاية الصحية					
a. General Information and Physical Access معلومات عامة و سهولة الوصول الى العيادة					
1	**ما هو سبب زيارتك للعيادة اليوم** **غير منطوق؟**	1. زيارة لنفسي	2. لأحد أطفالي	3. لي و لطفلي	4. غير ذلك.....
		1. رعاية حوامل 2. تطعيم 3. احضار دواء 4. زيارة أخصائي	5. علاج 6. رعاية ما بعد الولادة 7. تغيير جرح /حرق 8. متابعة	9. طب أسنان 10. تنظيم اسرة 11. تبخيرة 12. غير ذلك	
2	**من قدم لك الرعاية الصحية اليوم؟** **غير منطوق**	1. طبيب عام 2. طب عائلة 3. طبيب اخصائي	4. صيدلي 5. قابلة قانونية 6. ممرض	7. مساعد صيدلي 8. لا أعرف 9. غير ذلك.....	
3	**هل عرف مقدم الخدمة الصحية بنفسه**		1. نعم	2 . لا	
4	**هل هذه زيارتك الأولى لهذه العيادة**		1. نعم	2. لا	
5	**كيف وصلت الى العيادة**	1.مشيا على الأقدام	2. مواصلات عامة	3. سيارة خاصة	4. غير ذلك
6	**كم تكلفك مواصلات الذهاب الى و العودة من العيادة**		.....شيكل		لا ينطبق
7	**ما هو رأيك في المسافة بين مكان سكنك و مكان العيادة**		1. العيادة قريبة من مكان سكني	2. المسافة مناسبة بين مكان سكني و العيادة	3. العيادة بعيدة عن مكان سكني
8	**لماذا اخترت التوجه الى هذه العيادة بالتحديد (بغض النظر عن توجيه التأمين الحكومي)** **غير منطوق** **يحتمل ذكر اكثر من اجابة**	1. أقرب عيادة الى المنزل		7. نصيحة احد الاقارب	
		2. أرخص من مكان اخر-تأمين حكومي		8. بناءا على نصيحة مقدم رعاية صحية اخر	
		3. اعرف احد العاملين في العيادة		9. جودة للخدمات الصحية في هذه العيادة	
		4. طريقة الاستقبال الحسنة		10. وجود طبيب متخصص	
		5. توفر الادوية		11. غير ذلك.....	
		6. توفر خدمات متكاملة/عيادة كبيرة		.....	
9	**هل انت راض عن طريقة استقبالك في العيادة ؟**		1. نعم	2. لا	
10	أرجو التوضيح				
b. Financial Access الوصول الى الخدمات الصحية من الناحية المادية					
11	**هل لديك تأمين صحي حكومي ؟**	1. نعم	2. لا **توجه الى سؤال 13**		
12	**حالة التأمين**	1. مدفوع	2. غير مدفوع		

13	هل دفعت مقابل أي خدمة صحية تلقيتها اليوم	1. نعم	2. لا توجه الى سؤال 16	
14	دفعت مقابل ماذا ؟		المبلغ المدفوع	
15	هل تمثل هذا المبلغ عبئا ماليا عليك؟	1. نعم بصورة كبيرة	2. الى حد ما	3. لا

c. Access to Medication الوصول الى الأدوية

16	هل تم وصف أي وصفة دوائية لك اليوم	1. نعم	2. لا توجه الى السؤال 24		
17	كم عدد الأدوية التي تم وصفها لك	1. واحد 2. اثنان	3. ثلاثة 4. أربعة	5.خمسة فأكثر 6.لا أعرف	
18	كم عدد الأدوية التي وجدتها في صيدلية العيادة	1.واحد 2.اثنان	3. ثلاثة 4. أربعة	5. خمسة فأكثر 6. لا أعرف	
20	هل سألك الطبيب عن ادوية اخرى تتناولها حاليا قبل وصف الدواء لك اليوم؟	1. نعم	2. لا	3. لا أعرف	
21	هل تلقيت معلومات كافية عن طرق استخدام /مواعيد استخدام الأدوية	1. نعم	2. لا	3. لا أعرف	

22	هل من الممكن ان ارى الأدوية التي تم صرفها لك		في غلاف على حده	اسم الدواء	الجرعة	الاستخدام
	نعم √	الدواء الأول				
		الدواء الثاني				
		الدواء الثالث				
	لا X	الدواء الرابع				
		الدواء الخامس				
23	الى من تتوجه بالسؤال عن ادويتك في حال لم تتلقى المعلومات الكافية عنها من العيادة ؟ غير منطوق	1.اعود لسؤال الطبيب 2.اعود لسؤال الصيدلي 3.اعود لسؤال الممرض 4 اتوجه بالسؤال لصيدلية خارج العيادة	5. أسأل اقاربي او أصدقائي 6. لا أسأل أحد 7. أقرأ النشرة الدوائية 8 غير ذلك		
24	هل وجدت كل الادوية التي تم وصفها لك في زيارتك السابقة لهذه العيادة/عيادة حكومية اخرى	1. نعم	2. لا	3 لا ينطبق	
25	اذا لم تجد الادوية التي تم وصفها لك في العيادة، من أين تحضرها عادة ؟ غير منطوق يحتمل ذكر أكثر من اجابة	1. عيادة حكومية اخرى 2. عيادة وكالة 3. عيادة غير حكومية 4. جمعية خيرية	5. اشتريها من صيدلية 6. انتظر حتى وصول الدواء الى العيادة 7. لا احضر الدواء 8. غير ذلك		

d. Technical and information Access. الوصول الى مقدم رعاية صحية مؤهل و الوصول الى المعلومات

	خلال زيارتك للعيادة اليوم				
26	تلقيت الرعاية بواسطة مقدم رعاية صحية مؤهل	1. نعم	2 الى حد ما	3. لا	4. لا ينطبق
27	سألت كل الاسئلة التي تريد	1. نعم	2 الى حد ما	3. لا	4. لا ينطبق
28	تم تزويدك بكل المعلومات التي تحتاجها بالنسبة لحالتك/مشكلتك	1. نعم	2. الى حد ما	3. لا	4. لا ينطبق
29	تم تزويدك بهذه المعلومات بطريقة واضحة و مفهومة بالنسبة لك	1. نعم	2. الى حد ما	3.لا	4. لا ينطبق

30	كان مقدم الرعاية الصحية حريصا على ان تستوعب كل المعلومات التي قدمها لك	1.نعم	2.الى حد ما	3.لا	4.لا ينطبق
31	هل تم اعطائك معلومات صحية (تثقيف صحي) خلال زيارتك؟	1. نعم	2. لا توجه الى سؤال 33		
32	هل كانت المعلومات متعلقة بحالتك/ سبب زيارتك؟	1. نعم	2. لا		
33	هل استلمت أي منشورات صحية ؟	1. نعم	2. لا توجه الى سؤال 35		
34	هل كانت المنشورات متعلقة بحالتك / سبب زيارتك؟	1. نعم	2. لا		
35	هل استفدت من المعلومات الصحية التي قدمت لك ؟	1. نعم	2. الى حد ما	3. لا	4. لا ينطبق
36	ما هو مصدر المعلومات الصحية الرئيسي لديك بشكل عام؟ غير منطوق يحتمل ذكر اكثر من اجابة	1. طبيب الرعاية الأولية 2. تمريض الرعاية الأولية 3. صيدلي الرعاية الأولية 4. الصيدليات العامة 5. طبيب خاص	6. وسائل الاعلام 7. احد اقاربي من مقدمي الرعاية الصحية 8. الأسرة أو الأصدقاء 9. الانترنت 10. غير ذلك		

II. Health Care Services Delivery تقديم خدمات الرعاية الصحية

a. Time عامل الوقت

37	كم انتظرت من الوقت لتلقي الخدمة الصحية	من الساعة ..... الى ..... مدة الانتظار بالدقائق		
38	هل انت راض عن وقت الانتظار هذا؟	1. نعم توجه الى سؤال 40	2. الى حد ما	3. لا
39	اذا لم تكن راض عن وقت انتظارك، هل توجهت بالشكوى لاحد ما؟؟			
		1. نعم لمن؟		
		2. لا لماذا؟		
40	هل امضيت وقتا كافيا مع مقدم الرعاية الصحية من وجهة نظرك؟	1. نعم	2.الى حد ما	3. لا

b. Choice عامل الاختيار

41	هل سمح لك باختيار مقدم الرعاية الصحية الذي تريد/اذا توفر اكثر من واحد	1. نعم	2. لا	3. لا ينطبق
42	هل اخذت موافقتك قبل البدء بالفحص الطبي	1. نعم	2. لا	3. لا ينطبق
43	هل اخذت موافقتك قبل القيام باي اجراي طبي اخر	1. نعم	2. لا	3. لا ينطبق

c. Communication عامل التواصل

44	هل تحدثت بسهولة مع مقدم الخدمة الصحية؟	1. نعم	2. الى حد ما	3. لا	4. لا ينطبق
45	هل استمع لك مقدم الخدمة الصحية باتصات؟	1. نعم	2. الى حد ما	3. لا	4. لا ينطبق
46	هل كان مقدم الخدمة الصحية منشغلا بأمر اخر أثناء محادثتك؟؟	1. نعم	2. لا		3. لا ينطبق
47	هل أنت راض عن طريقة تعامل و تحدث مقدم الرعاية الصحية معك؟	1. نعم	2. الى حد ما		3. لا

d. Referral and consistency of care عامل تناسق الخدمة الصحية

48	هل تتابع امورك الصحية عند طبيب محدد في هذه العيادة	1. نعم توجه الى سؤال 50	2. لا
49	هل تتابع طبيب محدد في مكان اخر	1. نعم	2. لا

50	هل تم تحويلك الى مركز صحي اخر اليوم؟	1. نعم	2. لا توجه الى سؤال 55	
51	هل وضح لك الى أين يجب أن تذهب؟	1. نعم	1. لا	
52	هل وضح لك متى يجب ان تتوجه؟	1. نعم	2. لا	
53	هل تم تخييرك ما بين اماكن التحويل المحتملة	1. نعم	2. لا	3. لا ينطبق
54	هل واجهتك صعوبات خلال اجراءات التحويل	1. نعم	2. لا	3. لا ينطبق

e. Respect (Include dignity and confidentiality) عامل الاحترام

55	هل تم احترام خصوصيتك خلال الفحص الطبي؟	1. نعم	2. لا	3. لا ينطبق
56	من كان يتواجد في غرفة الطبيب خلال حديثك معه عن حالتك/مشكلتك	1. ..... 2. ..... 3.	4. ..... 5. ..... 6.	
57	هل طلب منك مقدم الخدمة الصحية الجلوس قبل تقديم الخدمة الصحية لك؟	1. نعم	2. لا	3. لا ينطبق
58	هل عاملك مقدم الخدمة الصحية باحترام ؟	1. نعم	2. لا	3. لا أعرف
59	هل شعرت باي تمييز في المعاملة ما بينك و بين الاخرين ؟	1. نعم	2. لا	3. لا أعرف
60	كيف ذلك ؟			
61	هل تعتقد ان مقدم الرعاية الصحية سيحافظ على خصوصية/سرية حالتك؟	1. نعم	2. لا	3. لا أعرف

III. Involvement in Planning, Implementation and Evaluation المشاركة في التخطيط، التنفيذ و التقييم

a. Planning التخطيط

62	هل سمعت عن وجود لجنة ممثلة للمجتمع المحلي للعيادة الصحية في منطقة سكنك؟	1. نعم	2. لا	3. لا أعرف
63	تقدم العيادة شرح/توضيح عن ماهية الخدمات التي تقدمها للمواطنين؟	1. نعم	2. الى حد ما 3.لا	4. لا أعرف
64	مقدمي الرعاية الصحية في هذه العيادة على علم و دراية بالمشاكل الصحية الموجودة في المنطقة التي تسكن بها؟	1. نعم	2. الى حد ما 3. لا	4. لا أعرف
65	يشارك المجتمع المحلي في منطقة العيادة في تحديد الاحتياجات الصحية	1. نعم	2. الى حدما 3.لا	4. لا أعرف
66	هناك شراكة بين العيادة و المجتمع المحلي المحيط بها للنهوض بالوضع الصحي ؟	1. نعم	2. الى حدما 3.لا	4. لا أعرف
67	من المهم اشراك المجتمع في عمليات التخطيط الصحي و تحديد الاحتياجات الصحية لكل منطقة	1. نعم	2. الى حدما 3. لا	4. لا أعرف

b. Implementation (Autonomy) التطبيق

	خلال زيارتك، هل تم اشراكك في التالي :				
68	تحديد خطتك العلاجية	1. نعم	2. الى حد ما	3. لا	4. لا ينطبق
69	تحديد اوقات تناول دواءك	1. نعم	2. الى حد ما	3. لا	4. لا ينطبق
70	تحديد وقت المراجعة/الموعد القادم	1. نعم	2. الى حد ما	3. لا	4. لا ينطبق

71	تغير عاداتك الغذائية	1. نعم	2. الى حد ما	3. لا	4. لا ينطبق
72	هل تفضل أن يتم اشراكك في تحديد خطتك العلاجية؟ و لماذا؟	1. نعم	2. الى حد ما	3.لا	4. لا ينطبق
	لماذا؟				

c. Evaluation of PHC services التقييم

73	هل تم سؤالك عن رأيك في جودة الخدمة العلاجية التي تلقيتها من عيادة حكومية خلال الست شهور الماضية؟	1. نعم	2. لا	3. لا أعرف
74	باعتقادك، هل يقدر مقدمو الرعاية الصحية رأيك ووجهة نظرك عن الخدمات الصحية ؟	1. نعم	2. لا	3. لا أعرف
75	برأيك ، هل من المهم سؤال المواطنين عن رأيهم في الخدمات الصحية المقدمة لهم خلال العيادات الحكومية ؟	1. نعم	2. لا	3. لا أعرف

VI. Perceptions التصورات

76	هل الخدمات الصحية المقدمة خلال هذه العيادة متلائمة مع احتياجات المجتمع الصحية؟	1. نعم	2. الى حد ما	3. لا
77	هل تمت تلبية احتياجاتك ؟	1. نعم	2. الى حد ما	3. لا
78	هل افتقدت وجود خدمة صحية معينة في هذه العيادة	1. نعم	2. لا **توجه الى سؤال 80**	
79	ما هي الخدمات التي لم تتوفر في العيادة؟			
80	هل عدت الى منزلك من أي عيادة حكومية دون الحصول على الخدمة الصحية التي كنت تريد خلال الستة شهور الماضية؟	1. نعم	2. لا **توجه الى سؤال 82**	
81	لماذا؟ غير منطوق يحتمل ذكر أكثر من اجابة	1. وقت انتظار طويل 2. عدم توفر الدواء 3. عيادة مزدحمة 4. عيادة قديمة	5. لم استطع الدفع مقابل تلقي الخدمات/الأدوية 6. لا يوجد مقدم رعاية صحية مؤهل 7. غير ذلك	

82 ما هو رأيك بالنسبة للعناصر التالية في هذه العيادة الحكومية

توفر مياه صالحة للشرب	☐ جيدة	☐ متوسطة	☐ سيئة	☐ غير متوفرة	☐ لا أعرف
توفر كراسي مريحة في اماكن الانتظار	☐ جيدة	☐ متوسطة	☐ سيئة	☐ غير متوفرة	☐ لا أعرف
بيئة العيادة: نظافة العيادة	☐ جيدة	☐ متوسطة	☐ سيئة	☐ لا أعرف	
بيئة العيادة: نظافة دورات المياه	☐ جيدة	☐ متوسطة	☐ سيئة	☐ لا أعرف	
بيئة العيادة: الاضاءة في العيادة	☐ جيدة	☐ متوسطة	☐ سيئة	☐ لا أعرف	
بيئة العيادة: التهوية في العيادة	☐ جيدة	☐ متوسطة	☐ سيئة	☐ لا أعرف	

83 برأيك، ما هي اهم ثلاثة اشياء ستساهم في تقديم خدمات صحية أفضل في هذه العيادة؟
1. .....
2. .....
3. .....

5

84	**ما هو العامل الاساسي الذي يدل على جودة الخدمات الصحية في عيادات الرعاية الأولية الحكومية من وجهة نظرك؟** **غير منطوق** يحتمل ذكر أكثر من اجابة	1. التواصل الجيد مع مقدمي الخدمة لصحية 2. الحصول على معلومات كافية 3. توفر الأدوية بصورة دائمة		4. ان يتم علاجك 5. تعامل الطاقم الصحي باحترام 6. شكل و نظافة العيادة الخارجي 7. غير ذلك .....
85	**ما هو رأيك في جودة الخدمة الصحية التي تلقيتها اليوم؟**	1. ممتازة 2. جيدة	3. مقبولة 4. سيئة	5. سيئة جدا 6. لا أعرف

الخصائص الديمغرافية						
مستوى التعليم	1. لا يقرأ ولا يكتب	2. ابتدائي	3. اعدادي	4. ثانوي	5. جامعي	6. دراسات عليا
العمر	.....	**الجنس**			1. ذكر	2. انثى
الوضع المهني	1. يعمل	2. لا يعمل	**العمل الحالي /المهنة**		.....	
متوسط الدخل الشهري..... شيكل		عدد الأفراد المعتمدين على الدخل ..... فرد				
الحالة الاجتماعية	1. متزوج	2. اعزب	3. مطلق		4. أرمل	
المواطنة	1. مواطن	2. لاجئ				
مكان السكن	1. الشمال	2. غزة	3. الوسطى		4. خانيونس	5. رفح
	مخيم		حي		قرية	

English questionnaire

Participation Consent

Dear Client,

You have been randomly selected to participate in this research study conducted by myself as a part of the requirements for the Masters Degree in Public Health at Al-Quds University.

The study is titled "Clients Centeredness of the Governmental Primary Health Care Services: Gaza Governorates". It has been designed to reflect clients' opinions about the degree of centeredness of the governmental PHC services towards them. It is anticipated that the results of this study will help to increase the degree of responsiveness of the PHC services to the beneficiaries' needs and perspectives.

- Your participation in this study is totally optional, you have the right to accept or refuse sharing your opinions.
- You will be interviewed and asked some questions. This might take almost 30 minutes out of your time.
- There are no right and/or wrong answers; just give your perspectives
- Your answers will be confidential; the provided responses refer to your opinions and personal experience with PHC services.
- The responses you will provide will not affect the services you receive from the clinic

Thank you for your patience and cooperation.

The Researcher

Huda Haidar Anan
School of Public Health

Clients Centeredness of the Governmental Primary Health Care Services: Gaza Governorates

Clients' Exit Interview

Day:	Date: ..../...../.....	Serial No.	Clinic name:…….....

Clinic Area	☐ North	☐ Gaza	☐ Mid-Zone	☐ Khanunis	☐ Rafah

I. Accessibility to health care services			
a. General Information and physical access			
	What is your reason/s for visiting this clinic today **Non prompted**	☐ For myself ☐ Both myself and child	☐ For my child ☐ Others
		☐ Chronic disease ☐ Ante-natal care ☐ Immunization ☐ Drug prescription ☐ Curative care for myself ☐ Curative care for my child ☐ Dental Care ☐ Family planning	☐ Lab/Diagnostic test ☐ Post natal care ☐ Emergency ☐ Follow up ☐ Dressing change ☐ Injection ☐ Other..... .....
	Who provided you with the services today?	☐ GP ☐ Family doctor ☐ Specialist ☐ Nurse	☐ Paramedical ☐ Midwife ☐ Pharmacist ☐ Other
	Did the health care provider introduce himself to you?	☐ Yes	☐ No
	Is this your first visit for this clinic?	☐ Yes	☐ No
	How did you arrive to the clinic today?	☐ Walking	☐ Private car
		☐ Public transportation	☐ Others
	How do you perceive the distance to reach the PHC center?	☐ Clinic is near my house	☐ Distance is Reasonable ☐ Clinic is far from my house
	How much did it cost you to reach the clinic	..... NIS	
	Why did you choose to come to this	Nearest facility to your house	
		Obligatory/ according to health insurance	

1

	facility in particular? **<u>Non prompted</u>**	You know someone from the clinic staff
		Way of reception
		Availability of drugs
		Availability of a specialist
		Good reputation
		Affordable cost of services
		Other health care providers recommendations
		Relatives or friends recommendations
		Good quality of services
		Other .....

	Did you like the way of reception in this clinic?	☐ Yes	☐ No
	Would you explain?		
	What do you think about the quality of the care you received today?	☐ Excellent ☐ Good ☐ Neither good nor bad	☐ Bad ☐ Very bad ☐ Difficult to judge

b. Financial Access

	Type of health insurance	☐ None	☐ Governmental ☐ valid ☐ not valid	☐ Others	
	Were you asked to pay for services you received today? if no go to Q.11			☐ Yes	☐ No
	Paid for what			**How much**	
☐	Co-Payment for medication				
☐	Diagnostic test				
☐	Others.....				
	Does this money make a financial burden on you?	☐ Yes	☐ To some extent	☐ No	
	What do you think about this transportation payment	☐ Reasonable	☐ Expensive		

c. Technical & Information Access

During your visit to the PHC clinic today

a.	**You have been seen by a qualified health care provider who could understand your situation?**	☐ Yes	☐ No	☐ NA
b.	**You were able to ask all the questions in your mind about your health condition?**	☐ Yes	☐ No	☐ NA
c.	**you were given all the required information regarding your health condition?**	☐ Yes	☐ No	☐ NA
d.	**The health provider explained the information related to your condition in a clear way to you?**	☐ Yes	☐ No	☐ NA

2

	The health care provider was concerned that you really understand the information he shared with you.	☐ Yes	☐ No	☐ NA
	Did you receive any health education materials today	☐ Yes	☐ No	☐ NA
	If yes, Was it related to you reason for visit/condition?	☐ Yes	☐ No	☐ NA
	What is your main source of health related information in general? **Non prompted**	☐ PHC physician ☐ PHC nurse ☐ PHC pharmacist ☐ Community pharmacies	☐ Media ☐ Relative health provider ☐ Family and friends ☐ Other…… ……	

d. Access to medication

	Has the doctor prescribed any medication to you today?			☐ Yes	☐ No
	How many drugs were prescribed for you today	☐ One ☐ Two	☐ Three ☐ Four	☐ Five ☐ Six	☐ Don't know
	How many drugs did you dispense/find from the clinic pharmacy?	☐ One ☐ Two		☐ Three ☐ Four	☐ Five ☐ Six
	Do you think that you got all the information you want about the medication?			☐ Yes	☐ No
	Were you asked about other medications you are taking before prescribing this drug to you?			☐ Yes	☐ No

	Could you please let me see the drug package?	**Each drug packed alone**		☐ Yes	☐ No
	Data collector to check the drug labels (written by the pharmacist/pharmacist assistant) please tick × if the drug name, dose and frequency are written on the label	Label Status	Drug Name	Dose	Frequency
		Drug 1 Drug 2			
		Drug 3			
		Drug 4			

	Were all the prescribed drugs available in the clinic in your last visit to the clinic?	☐ Yes	☐ No	☐ NA
	If you didn't receive the required information about the prescribed medication from the PHC, Where do you usually get the information from??	☐ Return to PHC clinic physician ☐ Return to PHC pharmacist ☐ Ask in a Community pharmacy ☐ Ask Family and friends	☐ Ask PHC nurse ☐ Don't ask ☐ Others ..... …… ……	
	If you didn't find the drug/s in the clinic, Where do you usually get your prescribed medication from?	☐ Another Gov. PHC clinic ☐ UNRWA clinic ☐ NGO clinics ☐ Charitable associations ☐ Community pharmacies	☐ Don't get any medication ☐ Others …… …… ……	

II. Health care services delivery

a. Time

	How long did you wait from your arrival until receiving health care service	From ……. To …… …….. Minutes		
	Are you satisfied with this waiting time?	☐ Not satisfied	☐ Satisfied	☐ NA
	If you were not satisfied, did you complain about it?			
	☐ **Yes**	**To whom?**		
	☐ **No**	**Why?**		
	Do you think that you've spent enough time with the health provider?	☐ Yes	☐ No	☐ NA
	Explain please?	....		
b. Choice				
	Were you allowed (given the opportunity) to choose your health provider if there is more than one in the clinic?	☐ Yes	☐ No	☐ NA
	Were you asked before the medical examination	☐ Yes	☐ No	☐ NA
	Were you asked before conducting any medical procedure for you (your consent was taken before conducting any medical examination, sample taking, lab test….etc)	☐ Yes	☐ No	☐ NA
c. Communication				
	Did you have the chance to say all what you want to your health care provider?	☐ Yes	☐ No	☐ NA
	Did you communicate freely with the health care provider?	☐ Yes	☐ No	☐ NA
	Did you like the provider attitude during your conversation with him/her?	☐ Yes	☐ No	☐ NA
	Did the health care provider listen carefully to you?	☐ Yes	☐ No	☐ NA
d. Referral and consistency of care				
	Do you have specific health provider who follows up your/your family condition in <u>this clinic</u>?		☐ Yes	☐ No
	<u>If No.</u> Do you have specific health provider who follows up your/your family condition in another clinic?		☐ Yes	☐ No
	Were you referred to another health facility today?		☐ Yes	☐ No
	Did the health provider describe where you should go?		☐ Yes	☐ No
	Did the health provider describe when you should go?		☐ Yes	☐ No
	Do you know where you should go?		☐ Yes	☐ No

	If no, What will you do??			
	Was your opinion considered when the health provider decided where you should be referred?	☐ Yes	☐ No	
e. Respect (Include dignity, autonomy and confidentiality)				
	Was your Privacy assured during your physical examination?	☐ Yes	☐ No	☐ NA
	Who were in the room during your physical examination	....		
	Did the health care provider offer you a sit before discussing your condition?	☐ Yes	☐ No	☐ NA
	Did the health care provider treat you with respect?	☐ Yes	☐ No	☐ DN
	Did you feel any kind of difference between you and anyone else from the clinic visitors	☐ Yes	☐ No	☐ DN
	If yes, how.....			
	Do you think that the health care providers keep the confidentiality of your condition?	☐ Yes	☐ No	☐ DN
II. Involvement				
a. Planning				
	Have you heard about any representative committee that represent clients opinions to the clinic?	☐ Yes	☐ To some extent	☐ No ☐ DN
	Does the facility present any information about its activities to the people in the area?	☐ Yes	☐ To some extent	☐ No ☐ DN
	Do you think that health care providers are oriented towards the most current health problems in your area?	☐ Yes	☐ To some extent	☐ No ☐ DN
	Do you know about any previous involvement of community in planning for health services?	☐ Yes	☐ To some extent	☐ No ☐ DN
	Do you think it is important to involve people in planning for health care services?	☐ Yes	☐ To some extent	☐ No ☐ DN
	Do you think there is an obvious partnership between the clinic and the community to improve health status?	☐ Yes	☐ To some extent	☐ No ☐ DN
b. Implementation (Autonomy)				
	Were you encouraged to be involved in the decisions related to			
	Ddeciding the suitable treatment plan	☐ Yes	☐ To some extent	☐ No ☐ NA
	Changes in your dietary habits	☐ Yes	☐ To some extent	☐ No ☐ NA
	Medication timing	☐ Yes	☐ To some extent	☐ No ☐ NA

5

	Follow up/ next appointment date	☐ Yes	☐ To some extent	☐ No	☐ NA
	Setting your treatment plan	☐ Yes	☐ To some extent	☐ No	☐ NA
	Do you prefer being involved in deciding your treatment plan?	☐ Yes	☐ To some extent	☐ No	☐ NA
	Please explain				

c. Evaluation of PHC services

	Were you asked about your opinion about the health care services you receive from the gov. clinics during the last 6 months?	☐Yes	☐ No	
	Does the facility solicit your feedback/opinion about the health care services?	☐Yes	☐ No	☐DN
	Do you think it is important to ask for people's opinions in Gov. PHC services?	☐Yes	☐ No	☐DN

I. Perceptions

	Are the health care services suitable to population needs	☐ Yes	☐ To some extent	☐ No
	Your needs have been met	☐ Yes	☐ To some extent	☐ No
	Did you miss a specific services in the clinic during this visit	☐ Yes	☐ No	
	What was it? ……..			

What do you think about the following basic amenities in PHC clinics

	Drinking water		☐ Good	☐ Fair	☐ Bad	☐ Not available	☐ DN
	Availability of chairs in waiting area (comfortable place to sit)		☐ Good	☐ Fair	☐ Bad	☐ Not available	☐ DN
	Cleanliness of toilets		☐ Good	☐ Fair	☐ Bad	☐ DN	
	Clinic environment	**Cleanliness**	☐ Good	☐ Bad	☐ Bad	☐ DN	
		Lighting	☐ Good	☐ Bad	☐ Bad	☐ DN	
		Ventilation	☐ Good	☐ Bad	☐ Bad	☐ DN	

	What are the most important three things that could be done to improve the way of providing the services in this clinic?		
	Have you returned back home from a governmental PHC clinic without receiving the health care service you came for during the last six months? If no go to Q. 76	☐ Yes	☐ No
	Why did you return back without receiving the required health care service?	☐ Long waiting time ☐ Lack of medication ☐ Crowded clinic ☐ No qualified health provider	☐ Lack of proper communication with health provider ☐ Couldn't afford to pay the required fees

	Non prompted	☐ Poor facility structure ☐ Inappropriate reception	☐ no specific reason ☐ Others.....
	What is the most important factor that indicate good quality of health care services from your point of view **Non prompted**	☐ Availability of drugs ☐ Being cured ☐ Respectful interaction with health care providers ☐ Physical structure of the facility	☐ Good communication with health providers ☐ Gaining enough information ☐ Affordable services ☐ Other.....
	What do you think about the services you received today	☐ Excellent ☐ Good	☐ Acceptable
		☐ Bad ☐ Very bad	☐ Don't know

II. Demographic characters						
Education	☐ Illiterate	☐ Primary	☐ Preparatory	☐ Secondary	☐ University	☐ Higher edu.
Age	**Sex**	☐ Male	☐ Female			
Currently Working	☐ Yes	☐ No	**If working, current job**			
Average monthly income.....			**No. of dependents**			
Marital status	☐ Married	☐ Single	☐ Divorced	☐ Others		
Citizenship status		☐ Refugee	☐ Non-refugee			
Place of living	☐ North	☐ Gaza	☐ Mid-Zone	☐ Khanunis	☐ Rafah	
	☐ Refugee Camp		☐ Non camp			

Annex 4 : PHC clinics general information questionnaire

Primary Health Care Clinic Information

اسم العيادة	.....			سنة الانشاء	.....					
المستوى	1. الثاني	2. الثالث	3. الرابع	المحافظة	الشمال	غزة	الوسطى	خانيونس	رفح	
المتوسط الشهري للمترددين على العيادة:				تاريخ استلام طلبية الدواء الشهرية						
الخدمات الصحية المقدمة خلال العيادة	1. رعاية حوامل 2. تنظيم أسرة 3. تثقيف صحي 4. مختبر 5. طب أسنان	6. تطعيم . 7. رعاية ما بعد الولادة 8. تغذية 9. زيارات منزلية 10. أمراض مزمنة	11 . خدمات علاجية 12. تغير جروح / حقن 13. اخرى..... 14. ..... 15.							

عدد العاملين في العيادة	المهنة	دائم	بطالة	متطوع
	طبيب عام			
	طبيب متخصص			
	ممرض			
	صيدلي			
	مساعد صيدلي			
	فني مختبر			
	اداري			
	عمال			

اسئلة لمدير العيادة (المدير الاداري أو المدير الطبي)				
يوجد صندوق لشكاوى و اقتراحات المواطنين	1. نعم	2. لا	3. لا اعرف	
يتم اخذ شكاوى و اقتراحات المواطنين بعين الاعتبار	1. نعم	2. لا	3. لا اعرف	
هناك فئة مستهدفة محددة لهذه العيادة	1. نعم	2. لا	3. لا اعرف	
تتضمن فئات مهمشة محددة	1. نعم	2. لا	3. لا اعرف	4. لا ينطبق
تقوم العيادة بعمل تحديد احتياجات دوري لهذه الفئة المستهدفة	1. نعم	2. لا	3. لا اعرف	4. لا ينطبق
هناك لجنة ممثلة لسكان المنطقة المحيطة بالعيادة	1. نعم	2. لا	3. لا اعرف	
يتم التواصل بصورة دورية بين العيادة و اللجنة الممثلة للمواطنين	1. نعم	2. لا	3. لا اعرف	4. لا ينطبق
اذا كانت الاجابة "نعم"، متى كان اخر اجتماع؟				

جامع البيانات ليجيب عن التالي		
يوجد لوحة ارشادية توضح اماكن و أوقات الخدمات في مكان واضح في العيادة	1. نعم	2. لا
يوجد صندوق لشكاوى و اقتراحات المواطنين في مكان واضح في العيادة	1. نعم	2. لا

Primary Health Care facility information (Interview with Admin manager of the clinic**)**

Name (Health facility).....			**Main services provided by the clinic:**
Year of establishment:			☐ Antenatal care ☐ Postnatal care ☐ Family planning ☐ Child immunizations/well baby ☐ Health education ☐ Non-Communicable diseases ☐ Curative services ☐ Women immunization ☐ Nutrition services ☐ Home visits ☐ Daily care (dressing and injections) ☐ Dental Care ☐ Lab tests ☐ Others..... .....
Level	☐ IV	☐ III	☐ II
Governorate			
Address …….....			
Trends of beneficiaries during the last 6 months			
Trend	Possible Reason		
☐ The same			
☐ Decreasing			
☐ Increasing			

No. of facility staff	**Full time**	**Job creation**	**Volunteers**
General Doctors			
Specialists doctors			
Pharmacists			
Pharmacist assistants			
Nurses			
Para medicals			
Administrative			
Others …….....			

Is there a suggestions box for the clients in the facility?	☐ Yes	☐ No	☐ DN
If yes, Do you consider people suggestions derived from that suggestion box?	☐ Yes	☐ No	☐ DN
Is there a sign board that shows the clinic services and timing?	☐ Yes	☐ No	☐ DN
The clinic has a clearly defined beneficiary group	☐ Yes	☐ No	☐ DN
The clinic's beneficiary group includes Vulnerable population in particular	☐ Yes	☐ No	☐ DN
The clinic involves representatives of its beneficiary group(s) as key partners	☐ Yes	☐ No	☐ DN
The clinic conducts regular assessments of the needs of its beneficiary groups and the findings are used for planning purposes	☐ Yes	☐ No	☐ DN
The beneficiary group is regularly involved in the planning processes	☐ Yes	☐ No	☐ DN

Annex 5: Official letter from Al Quds University to the Ministry of Health

Al-Quds University
Jerusalem
School of Public Health
2010/4/10

جامعة القدس
القدس
كلية الصحة العامة

الأخ/د. ناصر أبو شعبان المحترم
مدير عام تنمية القوى البشرية-وزارة الصحة
تحية طيبة وبعد،،،

الموضوع: مساعدة الطالبة هدى حيدر غنان

تقوم الطالبة المذكورة أعلاه بإجراء بحث بعنوان:

"Client's Centeredness of the Governmental Primary Health Care services-Gaza Governorates "

كمتطلب للحصول على درجة الماجستير في الصحة العامة-مسار إدارة صحية و عليه نرجو التكرم للإيعاز لمن تروه مناسب لتسهيل مهمة الطالبة في جميع البيانات اللازمة من مراكز الرعاية الأولية التابعة لوزارة الصحة.
علماً بأن المعلومات ستكون متوفرة لدى الباحثة و الجامعة فقط.

و قبلوا فائق التحية و الاحترام،،،

د. بسام أبو حمد
منسق عام برامج الصحة العامة

نسخة
- الملف

Jerusalem Branch/Telefax 02-2479923
Gaza Branch/telefax 08-2884422-2884411
Sphealth@admin.alquds.edu

Annex 6: Helsinki committee approval letter

(7)

Palestinian National Authority
Ministry of Health
Helsinki Committee

السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

التاريخ7/6/2010

Name:

الاسم: هدى حيدر عنان

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

Client's Centeredness of the Governmental primary Health Care services- Gaza Governorates.

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

In its meeting on June 2010

and decided the Following:-

To approve the above mention research study.

و ذلك في جلستها المنعقدة لشهر 6 2010

و قد قررت ما يلي:-

الموافقة على البحث المذكور عاليه.

Signature
توقيع

Member
عضو

Member
عضو

Chairperson

Conditions:-

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

Annex 7: Ministry of Health approval letter

السلطة الوطنية الفلسطينية
وزارة الصحـــــــة
الإدارة العامة للرعاية الأولية

Palestinian National Authority
Ministry Of Health
General Administration of P.H.C

الرقم :

التاريخ: 2010/7/28

السادة / مدراء صحة المناطق المحترمين

السلام عليكم ورحمة الله وبركاته .....

الموضوع:تسهيل مهمة باحث

نفيدكم علماً بأن الطالبة / هدى حيدر عنان والتي تعمل في منظمة الصحة العالمية ملتحقة ببرنامج ماجستير الصحة العامة وبصدد عمل بحث بعنوان

Client s Centeredness of the Governmental Primary Health Care Services

حيث ستقوم الباحثة بتعبئة استبانه من متلقي الخدمات الصحية في مراكز الرعاية وإجراء مقابلة شخصية مع مدراء يعملون في مجال الرعاية الأولية وأخذ آرائهم بخصوص خدمات الرعاية الصحية .

للتكرم بتسهيل مهمتها في إجراء البحث بما لا يتعارض مع مصلحة العمل وضمن ضوابط وأخلاقيات البحث العلمي دون تحمل الوزارة أي أعباء .

واقبلوا التحية .....

مدير عام الرعاية الأولية
بوزارة الصحة
الدكتور / فؤاد عبد الحليم العيسوي

وزارة الصحة
الإدارة العامة للرعاية الأولية
الرقم: ٥٠٥
التاريخ: ٢٠١٠/٧/٣١

Annex (8) : Differences between GG areas in the factors that indicate good quality of services

Factor that indicate good quality of services						
	North	Gaza	Mid	Khanunis	Rafah	Total
1. Good communication with health care provider						
Yes	11	13	8	32	15	79
No	48	53	18	21	50	190
Total	59	66	26	53	65	269
2. **Gaining enough information about my condition**						
Yes	4	6	10	30	25	75
No	55	60	16	23	40	194
Total	59	66	26	53	65	269
3. **Availability of medication**						
Yes	46	23	17	34	61	181
No	13	43	9	19	4	88
Total	59	66	26	53	65	269
4. **Being cured**						
Yes	26	10	10	30	17	93
No	33	56	16	23	48	176
Total	59	66	26	53	65	269
5. **Respect from health care providers**						
Yes	51	28	6	20	20	125
No	8	38	20	33	45	144
Total	59	66	26	53	65	269
6. **Good Facility building/structure**						
Yes	5	13	1	14	9	42
No	54	53	25	39	56	227
Total	59	66	26	53	65	269

Annex (9): Average waiting time according to type of health care service

No.	Health care service	Waiting time by minutes			
		Average	Standard Deviation	Maximum	Minimum
1	Dental Care	62.1	47.4	180	15
2	Family Planning	50.0	36.1	120	10
3	Vaccination	36.1	21.2	90	0
4	Specialized physician	35.9	18.1	60	5
5	Ante Natal Care	35.8	22.7	120	5
6	Follow up	32.7	25.6	100	5
7	General physician	28.2	22.1	120	0
8	Post Natal Care	25.0	8.7	30	15
9	Dressing change or injection	21.7	15.4	50	5
10	Nebulizer	21.7	17.6	40	5

Annex (10): Quality of basic amenities in Level2/3 and level 4 clinics

#	Variable	Total		Level 2 or 3		Level 4	
		No.	%	No.	%	No.	%
1	Availability of drinking water						
	Good	123	44.9%	26	44.8%	97	44.9%
	Moderate	57	20.8%	10	17.2%	47	21.8%
	bad	9	3.3%	2	3.4%	7	3.2%
	Not Available	23	8.4%	7	12.1%	16	7.4%
	Do not Know	62	22.6%	13	22.4%	49	22.7%
	Total	274	100.0%	58	100.0%	216	100%
2	Availability of chairs in waiting area (comfortable place to sit)						
	Good	141	51.5%	36	62.1%	105	48.6%
	Moderate	101	36.9%	16	27.6%	85	39.4%
	bad	13	4.7%	3	5.2%	10	4.6%
	Not Available	15	5.5%	1	1.7%	14	6.5%
	DN	4	1.5%	2	3.4%	2	0.9%
	Total	274	100.0%	58	100.0%	216	100.0%
3	Cleanliness of toilets						
	Good	181	66.1%	48	82.8%	133	61.6%
	Moderate	88	32.1%	7	12.1%	81	37.5%
	bad	0	0.0%	0	0.0%	0	0.0%
	DN	5	1.8%	3	5.2%	2	0.9%
	Total	274	100.0%	58	100.0%	216	100.0%
4	Clinic environment/cleanliness						
	Good	112	41.0%	29	50.0%	83	38.6%
	Moderate	67	24.5%	5	8.6%	62	28.8%
	bad	34	12.5%	4	6.9%	30	14.0%
	DN	60	22.0%	20	34.5%	40	18.6%
	Total	273	100.0%	58	100.0%	215	100.0%
5	Clinic environment/Lightening						
	Good	203	74.1%	45	77.6%	158	73.1%
	Moderate	65	23.7%	9	15.5%	56	25.9%
	bad	4	1.5%	2	3.4%	2	0.9%
	DN	2	0.7%	2	3.4%	0	0.0%
	Total	274	100.0%	58	100.0%	216	100.0%
6	Clinic environment/ventilation						
	Good	190	69.3%	45	77.6%	145	67.1%
	Moderate	70	25.5%	10	17.2%	60	27.8%
	bad	8	2.9%	1	1.7%	7	3.2%
	DN	6	2.2%	2	3.4%	4	1.9%
	Total	274	100.0%	58	100.0%	216	100.0%

Annex 11: PHC clinics general information

Variables		Level2/3	Level 4	Total	
		No.	No.	No.	%
1	**There is a suggestions box for the clients in the facility**				
	No	4	2	6	60%
	Yes	1	3	4	40%
	Total	5	5	10	100%
2	**Clients suggestions derived from the suggestion box are considered**				
	Not applicable	4	2	6	60%
	No	1	0	1	10%
	Yes	0	3	3	30%
	Total	5	5	10	100%
3	**The clinic has a clearly defined beneficiary group**				
	Do not know	0	0	0	0%
	No	3	3	6	60%
	Yes	2	2	4	40%
	Total	5	5	10	100%
4	**The clinic's beneficiary group includes vulnerable population in particular**				
	Not applicable	3	3	6	60%
	Do not know	1	0	1	10%
	No	1	2	3	30%
	Yes	0	0	0	0%
	Total	5	5	10	100%
5	**There is a representative committee for beneficiaries of this clinic**				
	Do not know	**0**	**1**	**1**	**10%**
	No	2	4	6	60%
	Yes	3	0	3	30%
	Total	**5**	5	10	100%
6	**The clinic conducts regular meetings with this representative committee**				
	Not applicable	1	1	2	20%
	Do not know	0	1	1	10%
	No	3	3	6	60%
	Yes	1	0	1	10%
	Total	5	5	10	100%
7	**There is a sign board that shows the clinic services and timing**				
	No	2	1	3	30%
	Yes	3	4	7	70%
	Total	5	5	10	100%
8	**There is an observed suggestion box in the clinic**				
	No	4	3	7	70%
	Yes	1	2	3	30%
	Total	5	5	10	100%

تمحور خدمات الرعاية الصحية حول المستفيدين من مراكز الرعاية الصحية الأولية الحكومية في محافظات غزة

إعداد : هدى حيدر عنان

إشراف: د. بسام أبو حمد

ملخص:

مقدمة

تعتبر خدمات الرعاية الصحية الأولية العمود الفقري للعديد من أنظمة الرعاية الصحية حول العالم، و التي من المفترض أن تستجيب لاحتياجات و توقعات المستفيدين. يعتبر توجه "تمحور الخدمات حول المستفيدين أو متلقي الخدمة الصحية" من التوجهات الحديثة المتبعة عالميا لتحسين إمكانية الوصول إلى الخدمات الصحية المختلفة و زيادة مشاركة المجتمعات المحلية في عمليات تخطيط و تنفيذ و تقييم الخدمات الصحية. أن عملية المشاركة تلك تضمن كذلك تقديم خدمات صحية ذات جودة عالية ملبية لتطلعات المستفيدين.

أهداف الدراسة

ركزت هذه الدراسة على التحقق من مدى تطبيق توجه "تمحور الخدمات حول المستفيدين من مراكز الرعاية الصحية الأولية في قطاع غزة" من خلال معرفة آراء المستفيدين حول المحاور التالية

1. سهولة الوصول إلى الخدمات الصحية (الوصول المادي، المالي، المعلومات و الأدوية الرئيسية).
2. طريقة تقديم الخدمات (وقت الانتظار، المشاركة في اختيار الطبيب المعالج، الاحترام و التعامل، طرق التواصل و الحوار مع مقدم الخدمة الصحية و كذلك آراء المستفيدين عن بيئة العيادة و المرافق الحيوية المتوفرة لديها) .
3. مدى مشاركة المواطنين في اتخاذ القرارات فيما يتعلق بالخدمات الصحية المقدمة (تخطيط ، تنفيذ و تقييم)
4. العوامل الدالة على جودة الخدمات الصحية من وجهة نظر المستفيدين.

منهجية الدراسة

الدراسة كمية مقطعية حيث قامت باستطلاع آراء المترددين على العيادات الحكومية من خلال استبيانات تمت تعبئتها من قبل الباحثة و اثنين من جامعي البيانات المحترفين خلال شهري أكتوبر و نوفمبر من العام 2010 من خلال عمل مقابلات أجريت مع 300 مستفيد\ة لعشرة مراكز رعاية صحية أولية في محافظات غزة (تم اختيار العينة بصورة عشوائية) و قد كانت نسبة الاستجابة 91%. و قد تم أيضا جمع معلومات

محددة عن مراكز الرعاية الصحية الأولية نفسها من خلال استبانه أخرى تمت تعبئتها من خلال عمل مقابلات مع المدراء الإداريين لتلك المراكز.
قامت الباحثة بإتباع كافة الخطوات اللازمة لضمان مصداقية و دقة النتائج و قامت الباحثة بإجراء اختبار كرونباخ ألفا الذي يقيس مدى انسجام النتائج واظهر درجة انسجام عالية (نتيجة الاختبار 0.9). كما التزمت الباحثة بالمعايير الأخلاقية البحثية كالحصول على موافقة لجنة هلسنكي و المشاركة الطوعية.

أهم النتائج

- الوصول إلى الخدمات الصحية

- أبدى المستجيبون/ات وجهة نظر ايجابية لمحور الوصول إلى الخدمات الصحية بشكل عام. وقد أظهرت النتائج أيضا بعض القصور في توفر الأدوية وعمليات صرفها و كذلك كتابة الإرشادات اللازمة عن استخدام الأدوية على المغلفات.

- تقديم الخدمات الصحية

- اظهر المستفيدون مستوى جيد من الرضي على محور تقديم الخدمات الصحية من حيث الرضي عن وقت الانتظار لحين تلقي الخدمات و زمن المشورة و كذلك طريقة التحاور و النقاش مع مقدم الخدمة الصحية.
- كان هناك بعض جوانب الضعف في احترام خصوصية المستفيدين و كذلك إمكانية اختيار مقدم الخدمة المفضل للمستفيدين.

- المشاركة

- أظهرت النتائج قلة مشاركة المستفيدين في عمليات التخطيط لتحسين الخدمات.
- قلة مشاركة متلقي الخدمات الصحية في تحديد خططهم العلاجية مع مقدم الرعاية الصحية.
- عدم مشاركة متلقي الرعاية في تقييم خدمات الرعاية الصحية بشكل عام.
- أظهرت النتائج أن معظم العيادات الصحية لا تقوم بعقد اجتماعات دورية مع المستفيدين لاستيضاح آرائهم عن الخدمات الصحية و مناقشة المشاكل التي تواجههم. و القليل من المراكز الحكومية كان لديها مثل هذه الاجتماعات.

- العوامل الدالة على جودة الخدمات الصحية

- كان العامل الرئيسي الذي يدل على جودة الخدمات الصحية بالنسبة للمستفيدين من الخدمات هو توفر الأدوية (67%) مما يدل على طبيعة العلاقة ما بين المستفيدين و مراكز الرعاية الصحية

كمصدر لتلقى الأدوية بشكل رئيس وقد تكون هذه النتيجة انعكاسا للظروف الراهنة التي تتميز بنقص حاد للأدوية.

- التعامل الجيد أيضا من قبل الطواقم العاملة في المراكز الصحية بشكل عام هو العامل الثاني الذي يدل على جودة الخدمات الصحية (تم ذكره من قبل 46% من المستجيبين) مما يدلل على أهمية تحسين التعامل و التحاور مع المستفيدين من الخدمات من قبل جميع العاملين في العيادات الحكومية.

- العامل الثالث هو الشفاء من المرض حيث تم ذكره من قبل 34 % من المستجيبين.

أهم التوصيات

توصى هذه الدراسة بضرورة مشاركة متلقي الخدمات الصحية في تحديد خططهم العلاجية بالإضافة إلى إشراكهم في التخطيط لتقديم خدمات انسب و أفضل للمواطنين و كذلك المشاركة في تقييم الخدمات الصحية لما له من أثر كبير على تحسين رضى المواطنين عن الخدمات. و تقترح الباحثة أيضا التالي:

1. تبني سياسات وطنية خاصة بتمحور الخدمات حول المستفيدين.
2. نشر ثقافة تمحور الخدمات الصحية حول المستفيدين كثقافة مؤسساتية من خلال برامج محددة و متابعة تطبيقها.
3. تنظيم تدريب لصناع القرار و مزودي الخدمات حول توجه أو ثقافة تمحور الخدمات حول المستفيدين.
4. زيادة وعي المواطنين حول حقوقهم في تلقى الخدمات الصحية الملائمة لهم.
5. إنشاء لجان ممثلة عن المواطنين تقوم باجتماعات دورية مع إدارات العيادات المختلفة لمناقشة المشاكل التي يواجهونها أو دراسة اقتراحاتهم لتحسين تقديم الخدمات الصحية خلال تلك المراكز.
6. ضرورة توفير الأدوية الأساسية لجميع المترددين على العيادات ت مع ضمان الاستهلاك الرشيد لأدوية و كتابة طرق استخدام الدواء على أغلفة الدواء الخارجية.