Deanship of Graduate studies
Al-Quds University

Status of Communication among Health Care Providers at UNRWA Health Centers in Gaza Governorates

Rezeq Eid Abed Ramadan

MPH Thesis

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Prepared By:

Rezeq Eid Abed Ramadan

M.B., ch.B. Tanta Faculty of Medicine – Egypt

Supervisor: Dr. Yousef Aljeesh, Ph D

Assistant Professor- Islamic University

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Thesis Approval

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Prepared By: Rezeq Eid Abed Ramadan
Registration No: 20714199

Supervisor: Dr. Yousef Aljeesh

Master thesis submitted and accepted, date: 31/7/2010
The names and signatures of the examining committee members are as follow:

1-Head of Committee: Dr. Yousef Aljeesh signature……

2-Internal Examiner : Dr. Bassam Abu Hamad signature……

3-External Examiner : Dr. Ayyoub El Alem signature……

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Dedication

To the sprit of my parents, who care me child…….

To my wife, who spent her time and effort to finish this valued…

To my sons and daughters who are supporting me all the time……..

To the hope for peace and freedom to Palestinians allover the globe……..

I dedicate this work

Rezeq Eid Abed Ramadan

Declaration

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

Signed:…….

Dr. Rezeq Eid Abed Ramadan

Date: oct. 2010

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Abstract

Communication is very important issue in any health care setting. This study aims to explore the status of communication among healthcare providers who are working at the United Nations Relief and Work Agency for Palestinian Refugees in Gaza governorates. A descriptive analytical design was used. The study population is comprised of all health care providers who were working in the main five health centers; one health center from each governorate. Self-administered questionnaire was distributed to all the study population. The response rate was 95.5% . The SPSS package was used in the analysis of the collected data.

Findings revealed that the most commonly used communication among the UNRWA health teams was verbal communication (67%). Also the findings showed that the most commonly preferred tool of communication among the UNRWA health teams were (face to face-spoken (84.1%), telephone (6.4%), written messages (2.8%), email (2.1%) and intercom (1.4%). In addition, results showed that only 26.3% of healthcare providers had studied communication during their undergraduate program and 19.1% got training courses about communication. Through calculating all the points pertaining to knowledge about communication, 25.3% of health care providers had adequate knowledge about communication. Communication was vital for patients care from the perspectives of 89.5% of HCPs. Collectively, 87.3% of HCPs had positive perceptions about communication. Regarding practices relevant to communication, the elicited score was 62.8%. Participants' ranking of HCPs communication characters were as follows; mutual respect (72.1%), transparency (67.8%), equity (66.4%), political balance (63%), and positive competition (61.2%). Statistically significant variations were found in relation to profession, education, position and the country of graduation.

The study recommends improving communications among UNRWA health care providers through provision of training programme on communication skills , and enhancement of communication infrastructure.

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List of Abbreviations

B.Sc.	Bachelor Degree
CARE	Clarify Articulate Request Encourage
CIA	Crime Investigation Association (Central Intelligence Agency)
CFHP	Chief Field Health Programme
EMRO	Eastern Mediterranean Regional Office
EPI	Expanded Program of Immunizations
EWAR	Early Warning and Response
IDF	Israel Defense Foresees
GDP	Gross Domestic Product
GF	Gaza Field
GGs	Gaza Governorates
GNP	Gross National Product
GTP	Graduate Training Programme
GS	Gaza Strip
HC	Health Center
HCPs	Health Care Providers
IMR	Infant Mortality Rat
JCP	Job Creation Programme
KPE	Knowledge, Perception and Experience
LCD	Liquid crystal display
MDGs	Millennium Developmental Goals
MoH	Ministry of Health
MPH	Master of Public Health
NHA	National Health Authority
NVC	Non Verbal Communication
NGOs	Non Governmental Organizations
SWOT	Strength Weakness Opportunities Threats
OPt	occupied Palestinian territories
PCBS	Palestinian Central Bureau of Statistics
PHC	Primary Health Care
PLO	Palestine Liberation Organization
PMs	Para Medical staff

PMS	Police Medical Services
Q #	Question Number
SD	Slandered Deviation
SMS	Short messages Services
SMO	Senior Medical Officer
SSN	Senior Staff Nurse
SPSS	Statistical Package for Social Science
SWOT	Strength, Weakness, Opportunities and Threats
UNRWA	United Nations Relief and Works Agency
VC	Verbal Communication
US$	United States Dollars
WHO	World Health Organization
WB	West Bank

Chapter One

Introduction

1. Introduction

Clear communication is an essential ingredient for success in a rapidly changing health care climate since health care providers are working together in groups. Health care providers, to be effective, need high levels of participation, cooperation, and collaboration which cannot be achieved without proper communication. Improper communication might be the primary cause for error or wrong treatment and fatal mistakes. The study of communication status among health care providers (HCPs) at UNRWA health centers aims to give a description about the providers' knowledge, perception, experience, skills, and the process of their communications. The technology today affects the communication in terms of channels used, tools, and speed of transmission. Barriers to communication will be an interesting point to study; to describe the causes, to suggest solutions, and methods to improve communication. The Latin root of the word communicate is communicare, which means to make common or to share. Communication, therefore, is the transmission of information and meaning from one party to another with shared symbols (Bateman and Snell, 2004). Efforts to improve health care safety and quality are dependent on effective teamwork communications and collaboration during work in normal and emergency situations. The strategies to reduce medical errors have focused on the communication process among HCPs. Implementation of health programme, needs good communication between HCPs. Each care provider has his own level of knowledge, perception, and experience when all of them communicate to manage and administer patient care. However, the level of collaboration among the care providers today still appears to be inconsistent and often nonexistent. Communication among health care providers is getting increasingly important today due to higher levels of patient problems and fragmentation of care across multiple care providers. As more HCPs become involved in the care of a patient, coordination of their activities becomes more difficult but more essential. For that

effective communication is vital and essential for patient quality of care. In emergency, communication between health care providers becomes more an essential and vital issue. Verbal and non-verbal communication skills are needed to convey clear messages. Communication is the lifeblood of every organization (Nelson and Economy, 2005).

Today, more than ever before, communication plays a major role in how managers get important things done in a timely and high quality ways. If they can communicate effectively, they can overcome many challenges. (Durham et al. 2005). An effective communication occurs when the intended meaning of the source and the perceived meaning of the receiver are virtually the same (Schermerhorn et al. 2002). Efficient communication occurs at minimum cost in terms of resources expended. Time, for example, is an important resource (Alamry and Al Ghalby, 2007). Communication fosters motivation by clarifying to the employees what they have to do, how they are doing, and what can be done to improve performance if it supports formation of specific goals, feedback on progress toward the goal, and reinforcement of desired behavior, all stimulate motivation and required communication (Hareem, 2004). Communication also affects the willingness of health workers to provide suggestion where, probably, the most frequently cited source of interpersonal conflict is poor communication. HCPs relationship and effective communication are critical areas; we are in need to highlight it through this study.

The purpose of this study was to highlight the different types of communications, and to describe the status of communication among HCPs at the UNRWA health centers and to suggest actions for the improvement of methods and tools used to achieve effective and efficient communication. Lastly, scarcity of similar studies on this topic in Gaza field of health operations has made it valuable, interesting and important one.

1.1 Justification of the study

Communication of health care providers during work is a corner stone for the fruitful health products that might appear as excellent health services. Everywhere in management, you find that communication lies behind the success or failure of projects. Communication during work is not costly if done perfectly according to patients needs at the suitable time, on the other hand, time is costly in terms of patient health and time decision making and patient's life e.g., during emergency; failure of communication in terms of wrong understanding of the message may cost us the patient's life or the deterioration of his health. Interactions and communication between health care providers could be a motivating cause or reason for his/ her satisfaction, good performance and turnover in the organization. Today the winds of change are everywhere especially in the presence of rapid progress in communication methods, tools and technology. For that it was essential and one of the top needs for UNRWA health program to assess communication between health care providers, in term of points of strength, weakness, opportunities and threats (SWOT) to give recommendations based on evidence. Lastly, no similar study was found in the literature discussing this problem at UNRWA health program at Gaza Field (GF) with its current situations.

1.2 Overall aim of the study

The aim of this study was to understand the status of communication between health care providers who are working at the United Nation Relief, and Work Agency (UNRWA) for Palestine Refugees, at Gaza Governorates (GGs).

1.3 Objectives of the study

1. To identify health care providers' (HCPs) knowledge, perception, and experience regarding work related communications.
2. To identify the relationship between socio-demographic characters of communication, and the differences in communication characteristics at personal and organizational levels.
3. To explore the challenges and barriers facing communications between HCPs.
4. To identify the features and main communication chanels used by UNRWA HCPs.
5. To conclude recommendations to improve the communication among HCPs.

1.5 Research Questions

1. What are the HCPs knowledge, perceptions, and experiences regarding work related aspects of communications?
2. What are the relationship between socio-demographic characters of communication, and the differences in communication characteristics at personal and organizational levels?
3. What are the communication challenges and barriers that face HCPs and their ranking?
4. What are the communication features with ranking and the main communication chanel used by UNRWA HCPs?
5. What are the recommendations to improve status of communications among HCPs?

1.5 Feasibility and Cost

This study has been conducted at UNRWA health centers in the five governorates of Gaza strip (GS) as a requirement for the degree of MPH at the School of Public Health, Al-Quds

University. Discussions and exchange of ideas with responsible persons from the School of Public Health, UNRWA Health Department, and different specialties, made the implementation of this study more feasible. This study was self-funded; the researcher was responsible for all needed costs. It has been supervised by School of Public Health and UNRWA Health Department who provided the researcher with the necessary support such as access to study population, and ethical approval to conduct the study.

1.6 Context of the Study

The researcher provided some helpful background information about health care sector in order to put some perspective to health care system in general and UNRWA in specific at G F. The service delivery of primary health care has been affected by many factors such as demographic, socio-economic, political conditions, health status of Palestinian refugees and communication process. The current study was conducted at GGs in Palestine to describe the status of communication among HCPs, as a vital issue needed to provide the quality of care to patients.

1.7 Demographic Overview

Palestine with a total surface area of approximately 27,000 km^2 has its importance as it is located in the South West of Asia. It is being bordered on the west by the Mediterranean Sea, on the east by Syria and Jordan, on the north by Lebanon and on the south by Sinai desert and the Gulf of Aqaba (Annex 1, MOH, 2006). However, after the first world war in 1917, the British mandate illegally promised to give Palestine to the Jews to establish what they call a national home according to Belfour Declaration. As a result of that, struggle has

started with the Jews since then. After Al Nakbaa in 1948, Palestine has been separated geographically into two parts, the West Bank and Gaza Strip where the Palestinians has been displaced from their lands to be as refugees in the camps, and the state of Israel has been illegally created over about 80% of historical Palestine.

Gaza Strip (the focus area of our study) is a narrow piece of land lying on the cost of the Mediterranean Sea between Egypt and occupied Palestine, it is a 45 km long and ranges from 6-12 km wide, with an area of 378 square kilometers and an altitude of about 0-120 meter above sea level. Administratively it is divided into five governorates after the peace accord which has been signed between Palestinian Liberation Organization (PLO) and Israel, and a Palestinian National Health Authority (NHA) has been established. The five governorates are: Gaza North, Gaza, Mid-Zone, KhanYounis, and Rafah (MoH, 2006). According to (CIA World Fact–book), and (UNRWA Registration Statistical Bulletin 4th quarter 2008), the total population in Gaza was 1,500,202 inhabitants, and the registered Palestinian refugees were 1.073.820 (71.6%). The population density is about 4000 inhabitants /km2. This large number in the small area with the high density creates a worrying health, educational, and economic problems adding more pressure on the HCPs during service delivery and communications.

1.8 Refugees Camps in GS

There are eight camps accommodating the Palestinians who have been displaced from their lands in Jaffa, towns, villages, south of Jaffa, and the Beersheba areas in the Negev to Gaza Strip as a result of 1948 Nakbaa. Over two-thirds of the current estimated population of some 1.5 million in GS are registered refugees. The refugee camps in the GS have one of the highest population densities in the world. For example, over 82,000 refugees live in the Beach camp whose area is less than one square kilometer. This high population density is

reflected on the overcrowded health services, (Figures as of 31 December 2008, UNRWA web page). The camps are:

1- Jabalia Refugee Camp

It is the largest of the GS camps. It covers 1.4 km2 , located in the north of Gaza, close to a village by the same name (Jabalia). After Nakbaa, 35,000 refugees have settled in the camp in 1948, most of them came from villages in southern Palestine. Now, the camp houses a population of 195,249 refugees (Figures as of 31 December 2008, UNRWA web page). The camp houses about 18.19% of Gaza's total refugee population. Health services provided to Palestinian refugees through Jabalia health center which was built in the early sixties. It is the main health centre in the camp which is staffed by 96 health care workers assigned to a morning and afternoon shifts and to the nearby Fakhora sub-center. It provides services for general, non communicable disease, dental, maternal-child health, and family planning clinics, plus physiotherapy services, as well as a laboratory, pharmacy and X-ray. diagnostic services. In 2008, about 40,497 consultations were held each month. The HC had a telephone, land line, wireless call and receiving machine, mobile cellular phone and daily post for communication.

2- Beach Refugee Camp

It is one of the most crowded places of the Gaza Strip's refugee camps. The Beach camp is also locally known as "Shati". The camp, was established after Nakbaa in 1948, initially had accommodated 23,000 refugees from Al Ludda, Jaffa, Beersheba and other areas. It occupies 0.52 km2 of the costal strip north of Gaza town. The camp population is 172,436 (Figures as of 31 December 2008, UNRWA web page). The camp houses 16.07% of Gaza's total refugee population. Beach health centre was reconstructed in 1994.It is staffed by 33 health care workers assigned to a morning shift. It provides services in the general, non communicable disease, dental, maternal-child health, family planning clinics as well as

a laboratory and pharmacy. In Gaza governorate there are four UNRWA health centers named Remal HC, Gaza City HC, and Sabra HC, to provide services to refugees and those married non refugee living out side the official Beach camp.

3- Bureij Refugee Camp

Bureij now hosts the refugees who mostly displaced from towns east of the GS such as Falouja after the Nakbaa1948. UNRWA built the camp in the 1950s for 13,000 refugees who were housed in the British army barracks and tents at that time. The camp lies at the centre of the Gaza Strip east of the main Salah Ed-Din way and close to Neusirate camp. The camp population served is 42,042 (Figures as of 31 December 2008, UNRWA web page). The camp houses 3.92% of Gaza's total refugee population. Bureij HC is staffed by 37 health care workers assigned to a morning shift. It provides services in the outpatient general, non communicable disease, dental, maternal-child health clinics plus physiotherapy and family planning services as well as a laboratory and pharmacy. In 2008, an average of 16,286 consultations was held each month .The HC has a telephone land line, wireless call and receiving machine, mobile cellular phone and weekly post.

4-Maghazi Camp

It is located in the center of the Gaza Strip south of Bureij Camp. It was established in 1949 on a 0.6 km2 piece of land to shelter 9,000 people who had been displaced from villages in central and southern Palestine. The camp population served is 47,812 persons (Figures as of 31 December 2008, UNRWA web page). The camp houses 4.45 per cent of Gaza's total refugee population. Maghazi HC is staffed by 26 health care workers assigned to a morning shift only. It provides outpatient services in the general, non communicable disease, dental, maternal-child health, family planning clinics as well as a laboratory and pharmacy. In 2008, an average of 10,715 consultations was held each month .The HC has a

telephone land line, wireless call and receiving machine, mobile cellular phone and weekly post for communications.

5- Neusirate Refugee Camp

It is a crowded and busy camp, Neusirate is now home to more than 62,117 Refugees who have been displaced from the southern districts of Palestine such as Beersheba and the southern coast after the Nakbaa of 1948. The number of refugees was 16,000 at that time, they settled in a former British military prison and in tents. The camp took its name from a Bedouin tribe from the area and is located in the centre of the GS west of the Salah Eden highway running from Cairo to the north of Palestine. The camp population is 83,275 people (Figures as of 31 December 2008, UNRWA web page). The camp houses 7.76 % of Gaza's total refugee population. Neusirate health centre is the main health center of middle governorate. It was built in 1963, and was reconstructed in 2006. It is staffed by 68 health care workers assigned to a morning and afternoon shifts and provide Neusirate sub center by needed staff. It provides services for general, non communicable disease, dental, maternal-child health, and family planning clinics, plus radiology and physiotherapy services, as well as a laboratory and pharmacy. In 2008, an average of 30,237 consultations was held there each month. Neusirate sub center provides health services to the areas far away from the center of the camp The HC has a telephone land line, wireless call and receiving machine, mobile cellular phone and weekly post for communications.

6-Deir El-Balah Refugee Camp

It is the smallest of the Gaza Strip's eight refugee camps. It is located on the Mediterranean coast in the central part of the GS, west of the town by the same name. The name means "Monastery of the Dates," a reference to the abundant date palm grown in the area. After Nakbaa a total of 9,000 refugees have settled there. Most of the original refugees were

from villages in central and southern Palestine. The camp population served is 41,382 people (Figures as of 31 December 2008, UNRWA web page). The camp houses 3.86% of Gaza's total refugee population. Deir El-Balah HC was reconstructed in June 1993.It is staffed by 43 health care workers assigned to a morning shift only. It provides outpatient, dental, maternal and child health, family planning clinics as well as a laboratory and a pharmacy. In 2008, an average of 17,091 consultations was held each month .The HC had telephone, wireless call and receiving machine, mobile cellular phone and weekly post for communications.

7-Khanyounis Refugee Camp

It is located about two kilometers from the Mediterranean coast north of Rafah, west of KhanYounis town which was a major commercial centre and stopping-off point on the ancient trade route to Egypt. After Nakbaa a total of 35,000 refugees from Beersheba area moved to this camp. Today, the camp is a home to 181,570 refugees (Figures as of 31 December 2008, UNRWA web page). The camp houses 16.92 per cent of Gaza's total refugee population. Khan Younis HC was constructed in the early sixties. It provides services for general, non communicable disease, dental, maternal-child health, and family planning clinics, plus radiology and physiotherapy services, as well as a laboratory, pharmacy and X-ray. The HC had telephone, wireless call and receiving machine, mobile cellular phone and weekly post for communications.

In Khan Younis governorate there are four UNRWA health centers named Khan Younis HC, Ma'en HC, Japanese HC and Am El Nasser HC to provide services to refugees and those married non refugee living out side the official Khan Younis camp.

8- Rafah Refugee Camp

It is located in the south of Gaza, near the Egyptian border. The camp was established in 1949 to house 41,000 refugees. At that time, it was one of the largest and most densely

populated of the eight refugee camps of the GS. However, several thousands of people have moved from the camp to a housing project nearby (Tel Es-Sultan). Today the camp is almost indistinguishable from the adjacent city. The camp population is about 173,000 people (Figures as of 31 December 2008, UNRWA web page). Rafah houses about 16.12 per cent of Gaza total refugee population. Health services provided to Palestine refugee through Rafah health centre which was constructed in the early sixties. It is staffed by 88 health care workers assigned to morning shift. It provides services for general, non communicable disease, dental, maternal-child health, and family planning clinics, plus radiology and physiotherapy services, as well as a laboratory, pharmacy and X-ray. In 2008, an average of 40,884 consultations was held each month. Rafah HC had a telephone land line, wireless call and receiving machine, mobile cellular phone and weekly post for communications. In Rafah governorate there are three UNRWA health centers named Tel Es-Sultan HC, Shabora HC and Shoka HC, to provide services to refugees and those married non refugee living out side the official Rafah camp.

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1.9 Socioeconomic Conditions

The occupied Palestinian territory (OPt) is suffering the long-term effect of socio-economic hardship with progressive isolation of the GS and growing lack of continuity in the WB. In GS restrictions on the movement of people and goods in and out is affecting not only access to basic health services but also limiting commercial activities (Emergency Appeal, 2008). However in GS, the Israel still has the upper hand over the borders which force more constraints on it. Palestinian economy has been in a state of steady decline due to strict closure and violence; the last example of violence was demonstrated by the war on Gaza in 27 December 2008 named Operation Cast lead launched by the Israeli occupation army, which added more deterioration to the socio-economic conditions among Palestinian

refugees, where an increase in the number of people living under the poverty line of US$ 2.8 per capita daily expenditure. The increased need for health care among the refugee population is not only the result of a demographic increase, but a consequence of the swelling number of a highly vulnerable group of newly poor with no alternative health care providers after the internal conflict between Hamas and Fatah that resulted of separation GS from WB. Furthermore restriction of movement and complete closure of Gaza borders and points of entry and exit for people and goods even for humanitarian aids and assistance by the Israeli Forces made GS a typical commutative prison for more than one and a half million population. The long term effects of socio-economic hardship and the observed trend is toward a tightening of restriction with increased isolation of Gaza, and a growing lack of geographic continuity with the WB. Combinations of rapid population growth, increased demand for health services with increased levels of poverty and high percentage of unemployment made all the population as a vulnerable group. In GS there are a higher proportion of children under 15 years and the fertility rate is higher according to both UNRWA and national estimates.

According to UNRWA 2008 calculations, dependency ratio, measured as the proportion of population below 15 and above 65 years of age, was almost 90% in the GS. This implies an economic burden on family unit and worsening poverty levels. (Annual report of the UNRWA Department of Health 2008. p.16)

1.10 Emergency in Gaza Strip

During the military operation named Operation Cast Lead, launched by the Israel aggression forces between the 27th of December 2008 and the 18th of January 2009, almost 1400 people were killed. Among those, 431 were children and 112 women. At least

5380 people were injured, including 1872 children and 800 women. Injuries were often multiple traumas with head injuries, thorax and abdominal wounds (Annual report of the UNRWA Department of Health 2008). According to the initial assessment of the situation conducted by the WHO "vital infrastructure was compromised or destroyed, resulting in a lack of shelter and energy sources, food insecurity and overcrowding. An estimated 100,000 people were newly displaced. Fifteen hospitals and 41 primary health care clinics in the Strip were damaged during the strike and 29 ambulances were damaged or destroyed. Twenty one out of 56 Ministry of Health and three out of 17 UNRWA PHC centers were closed during part or all of the period of the crisis. Access to health care was severely restricted and hampered by security constraints" (WHO, 2009). Fifty-two UNRWA instillations in GS were damaged by the Israeli army fire, including seven health centers and the UNRWA Field Office. As a result of the severe shelling on the 15th of January the warehouse and all stores were destroyed. Preliminary estimate indicated that the cost of repairs to damaged Agency instillations exceeds US$ 3 million, not including the cost supply replacement, of which a relevant proportion were drugs, that was estimated to require additional US$ 3.6 million. During the conflict, UNRWA provided temporary shelter to over 50.000 Palestinians who sought refuge in over 50 of the Agency's schools. Although the security constraints severely limited the movement of the staff, with only around 1000 of the Agency's 10 000 Palestinian staff in GS working through the crisis, UNRWA managed to continue health service delivery and to adjust to the health needs of displaced people and to the deterioration of the environmental health stander. The combination of worsening environmental health conditions overcrowding, loss of shelters and overburdened health facilities led to an increased risk of out breaks. In order to monitor more closely communicable disease in GS, UNRWA in collaboration with WHO established an epidemiological surveillance system of early warning and rapid response

(EWAR) based on the existing in place information and facilities. UNRWA started issuing every week the UNRWA epidemiological Bulletin for GS to the WHO and all the members of the Health Cluster for Gaza crisis.

http://www.un.org/unrwa/programmes/ health/index.html. Accessed on the 28/3/ 2009.

1.11 Health Care System in Palestine

The health care system is a mosaic of four subsystems: the governmental, non-governmental organizations (NGOs), the United Nation Relief and Work Agency health programme, and the private service delivery. The MoH is responsible for the significant portion of both primary health care (PHC) and secondary care and some tertiary care (MoH, 2005).

The MoH in Gaza employees represent more than two thirds (67%) of the health human resources; owns and manages about 75% of hospital beds, where 64% of births were delivered, and provides PHC services through 56 PHC centers, where 39 percent of physician consultations outside the private sector were taken place (MoH 2004). About 35% of the Expanded Program of Immunizations (EPI) are provided, and where 17 percent of family planning users receive this service (PCBS 2007).

1.12 Background of UNRWA

UNRWA was established by the UN General Assembly resolution 302 IV of 8 December 1949. The mandate of UNRWA has been renewed repeatedly by the General Assembly. UNRWA reports directly to the General Assembly to which the Commissioner-General submits an annual report. A general review of UNRWA program and activities is done on

an annual basis by the ten-member Advisory Commission, which includes representatives of the Agency's donors and host authorities. The Advisory Commission has a working relationship with the PLO. UNRWA has been the main comprehensive primary health care provider of the Palestine refugees for the 61 years and the largest humanitarian operation in the Near East. The mandate of the health programme is to protect, preserve and promote the health status of the Palestine refugees within the Agency's five areas of operations (Jordan, Lebanon, Syria, Gaza Strip and the West Bank) aiming to achieve the highest attainable level of health consistency with Millennium Developmental Goals (MDGs), the Convention on the Rights of the Child and polices and strategies of the WHO (UNRWA, 2008).

1.13 UNRWA Vision

The UNRWA vision is to achieve for every Palestine refugee the best possible standards of human development, including attaining of his/her full potential individually, and as a family and community member, and to be an active and productive participant in the socioeconomic and cultural life, and to feel assured that his or her rights are being defended, protected, and preserved (UNRWA, 2008).

1.14 NRWA Mission

The mission of the UNRWA is to provide education, health, relief and social services as well as access to microfinance and micro enterprise opportunities for Palestine refugees living in Jordan, Lebanon, the Syrian Arab Republic, the West Bank and the Gaza Strip. The primary beneficiaries of UNRWA services are Palestine refugees, particularly the

most vulnerable groups including children, women, the aged and the disabled. Certain non-refugees have been provided with services under exceptional circumstances as mandated by the General Assembly .

1.15Organizational Structure

The Department of Health at Headquarter in Amman, Jordan, comprises the Director of Health and his Deputy, who are seconded from WHO to UNRWA on a non-reimbursable loan basis. The Director of Health reports to the UNRWA Commissioner-General on administrative and policy matters and to WHO/EMRO regional Director on technical matters. The Headquarter team also comprises two Division Chiefs, in charge of disease Prevention and Control and Health Protection and Promotion sub-programs, a Health Policy and Planning Officer, a Senior Pharmacist, a Head Laboratory and Medical Diagnostics, a Maternal and Child Health Officer and a Statistician. In 2008, a Media and Communication Officer and an Epidemiologist and Public Health Specialist were integrated in the team. In each of the five fields of the Agency's area of operations, the Health Department is headed by Chief Field Health Programme (CFHP), who reports directly to the Field Director on administrative issues and to the Director of Health on technical matters. The Chief Field Health Programme is assisted by a Deputy Chief, a Field Disease Control Officer, a Field Family Health Officer, a Field Nursing Officer, a Field Sanitary Engineer, a Field Pharmacist, a Field Laboratory Services Officer and a Senior Dental Surgeon. In addition, the Chief of the Environmental Health Programme in the Gaza Strip receives policy guidelines from Director of Health on the strategic orientation of the Programme.

1.16 Function of the Health Programme

Functions of UNRWA Health programs are to protect, preserve and promote the health of Palestinian refugees to meet their basic health needs through programme implementation and service delivery of the following objective programs:

1.Health Protection & Promotion: Including expanded maternal and child health care and family planning, school health, mental health, nutritional surveillance and food safety.

2.Curative Medical Care Services: Outpatient medical care, oral health services pharmaceutical, laboratory, medical diagnostic and radiology .

3.Disease prevention and control: Integrated control of communicable, non-communicable disease and management of health information system.

4.Environmental health: Project design, surveying, and environmental sanitation.

5.Emergency preparedness and response to crisis that impact on the refugee.

6.Research unit: Coordination of Agency operational research and technical support to Field in their research projects. The research unit also publishes relevant research conducted by the programme in international medical journals increasing the visibility of the Agency (UNRWA, 2008).

1.17 Human Resources in UNRWA Health Services, Gaza Strip

During 2008, a total of 1268 professional, administrative, support and other staff provided comprehensive health services to registered Palestine refugees in G.S. where 850 staff members provide medical care services and 418 staff members providing environmental health services (UNRWA, 2008). On 9/9/2009 the total number of working staff delivering health services to health centers including health department in Gaza field are 803 staff

members as medical health care providers, para medical and non medical labor category. The medical and para medical health care providers accounts 502 medical staff members supported by a team of specialists in ophthalmology diabetes, gynecology and obstetrics, cardiology, chest and pediatrics; they are assigned to cover all UNRWA health centers according to a planned schedule of visits (Gaza Field Health Department, 2009).

1.18 UNRWA Health Centers, Gaza Strip

There are twenty UNRWA health centers distributed all over the five governorates of GS according to population density as follows: Three HCs in the north (Beth anon HC, Jabalia HC and Al Fakhora Sub Center). Four HCs in Gaza Governorate (Beach HC, Remal HC, Gaza Town HC, and Sabra HC). Five HCs in the middle governorate (Buraje HC, Magaze HC, Neusirate HC, Neusirate Sub center and Deir El Balah HC). Four HCs in Khan Younis governorate (Khan Younis HC, Japanese HC, Ma'en HC and Am El Nasser sub center). Four HCs in Rafah governorate (Rafah HC, Shabora HC, Al Shoka HC , and Tel El Sultan HC). The HCs of Jabalia, Remal, Neusirate, Khan Younis, and Rafah are provided as the main HCs. Those main HCs are working in two shifts morning and afternoon and /or attached to most of them the nearby sub centers, also they provide all health services. HCPs for operational purposes were divided into three groups: 1) Physicians group includes the following post titles: Senior Medical Officers, Medical Officers, and Dental Surgeons. 2) Nurses group includes the following post titles: Senior Staff Nurses, Staff Nurses, Practical Nurses and Mid Wives. 3) Para Medical group includes the following post titles: Laboratory Technicians, Physiotherapists, Physiotherapy Assistants, Assistant Pharmacists, X- Ray Technicians and Dental hygienists. Activities and services were provided to Palestine refugees and those married from non refugee, by the HCPs. The

primary comprehensive health services cover and includes the following areas: Preconception care, family planning, perinatal care services as ante-natal care, surveillance and management of sexually transmitted diseases, intra- natal and post natal care. Infant and child health care services as growth monitoring, management of infants and children in the well baby and new born clinic in addition to sick baby clinic dealing common diseases of infancy and problems of growth retardation, anemia and immunization with referral facilities to secondary levels to the contracted hospitals. Out patient care services includes patient consultation, diagnosis, laboratory investigation, x- ray examination, provision of drugs from local health center pharmacy according to essential drug with reimbursement system for special not included and requested by specialist and if needed referral to contracted hospitals accordingly. UNRWA HCs provide also Oral health services, physiotherapy and Community mental health services as counseling and group interventions especially for victims of violence and war. Now over aged student services as those needs special care these services provided in collaboration with school health programme in an initiative step with excellent expected result according to observed level of care and facilities with quality of work. Control of non communicable diseases including hypertension and diabetes mellitus, cardiac asthmatic, psychic and other chronic patients as cancer and rheumatoid patient and suffering from debilitating diseases. Community out reach health education programme carried by each health center to promote healthy life-style, early detection of diabetes and hypertension and effective case management of patients suffering from diabetes and or hypertension with special stress on remote areas, isolated pockets, dangerous conflict areas and vulnerable groups and those exposed to violence as target for home visits and mobile teams.

Chapter Two

Literature Review

2. Literature Review

This chapter reviews the literature about health care providers' communication, types, methods, barriers, skills, factors affecting delivery of effective communication. It starts with different definitions of communication, healthcare providers operational definition, model of communication, perception of communication, barriers, meaning of clear communication, effective communication and skills, interpersonal relation, building confidence, meeting challenges and overcoming barriers, presentation skills, and organizational communication.

2.1 Preface

Effective and efficient communication between health care providers is vital for patient safety and providing quality care. Effective communication amongst health care providers is crucial for ensuring that patients receive safe high quality- care.

However, during health care settings, a number of barriers hampers effective communication. HCPs discussions about patients are often carried out in a busy work environment in which health providers are dealing with many patients and numerous tasks. Instructions are transmitted by the phone, rather than face to face. In emergency, information has to be presented quickly. In the attempt to present concise and clear information, it can be misunderstood if the message is not clear or if barriers or noise are present. This chapter on the literature review will try to explain these points.

2.2 Definitions of communication

- " The process by which we assign and convey a meaning in an attempt to create shared understanding" www.k12.wa.us/CuriculumInstuct/communications/default.aspx. Access on 26.9.2009.
- "The interchange of information between at least two persons". (Lippincott & Raven 1996).
- "The process in which two parties exchange information and share meaning". (Gregory M, 2007)**.**
- "The process of sharing information with other individuals."(Samuel S.Certo, 2003).
- "The imparting or interchange of thoughts, opinion, or information by speech, writing, or signs". Non Verbal communication (NVC) is usually understood as "process of communication through sending and receiving wordless messages". (Wikipedia free encyclopedia). Access on 23/6/2009.
- "A process whereby information is enclosed in a package and is discrete and imparted by sender to a receiver via a channel/medium. The receiver then decodes the message and gives the sender a feedback". (Wikipedia free encyclopedia).
- Effective communication occurs "when the intended meaning of the source and the perceived meaning of the receiver are virtually the same" (Schermerhorn et al. 2002).
- Efficient communication "occurs at minimum cost in terms of resources".

- Definition of health care providers (HCPs): defined as "Any individual, institution, or agency that provides health services to health care consumers. (Mosby's, Medical Dictionary, 2009).

2.3 Operational definition

The researcher used this definition , **communication** is the process of sending or receiving messages in an interactive way to impart or interchange information's, opinions, thoughts or instructions verbally, nonverbally or written during work; what ever the channel or media used

2.4 Functions of Communications

Communication serves four major functions within a group or organization: control, motivation, emotional expression, and information making. Communication act to control member behavior in several ways. The organization have the authority hierarchies and formal guidelines that employees are required to follow as in technical instructions for HCPs, and job descriptions, or to comply with the agency's policies. But informal communication control behavior when work group tend to harass a member how to produce too much, and makes the rest of the group look bad, they informally communicating with, and controlling, the member's behavior (Abedalbaqi, 2003). Communication foster motivation by clarifying to employees what to do, how will they are doing and what can be done to improve performance. Achieving specific goals are self motivators (Hareem, 2004). For many employees, their workplace is the primary source for social interaction and feeling of satisfaction, therefore it provides a release for emotional

expression of feeling for fulfillment of social needs (Robbins, 1997). Finally it gives the employees a chance of information making (Robbins, 2003).

2.5 The Nature of Communication

As communication is the transmission of information and meaning from one party to another through the use of shared symbols (Bateman and Snel, 2004) ideas and thoughts of others can be shared and the benefits also shared, understood and generalized. Effective communication would exist when a thought or idea was transmitted, so mental picture perceived by the receiver was exactly the same as that envisioned by the sender (Robbins, 1997).

2.6 Types of Communication Based on Communication Channels

Based on the channels used for communicating, the process of communication can be broadly classified as verbal communication and non-verbal communication.

Verbal Communication (VC): Verbal communication is further divided into written and oral communication. The oral communication refers to the spoken words in the communication process. Oral communication can either be face-to-face communication or a conversation over the phone or on the voice chat over the Internet. Spoken conversations or dialogs are influenced by voice modulation, pitch, volume and even the speed and clarity of speaking. The other type of verbal communication is written communication. Written communication can be either via snail mail, or email. The effectiveness of written communication depends on the style of writing, vocabulary used, grammar, clarity and the precision of language.

Nonverbal Communication (NVC): It includes the overall body language of the person who is speaking, which will include the body posture, the hand gestures, and overall body movements. The facial expressions also play a major role while communicating since the expressions on a person's face say a lot about his/her mood. On the other hand gestures like a handshake, a smile or a hug can independently convey emotions. Non verbal communication can also be in the form of pictorial representations, signboards, or even photographs, sketches and paintings.

2.7 Components of the communication process are

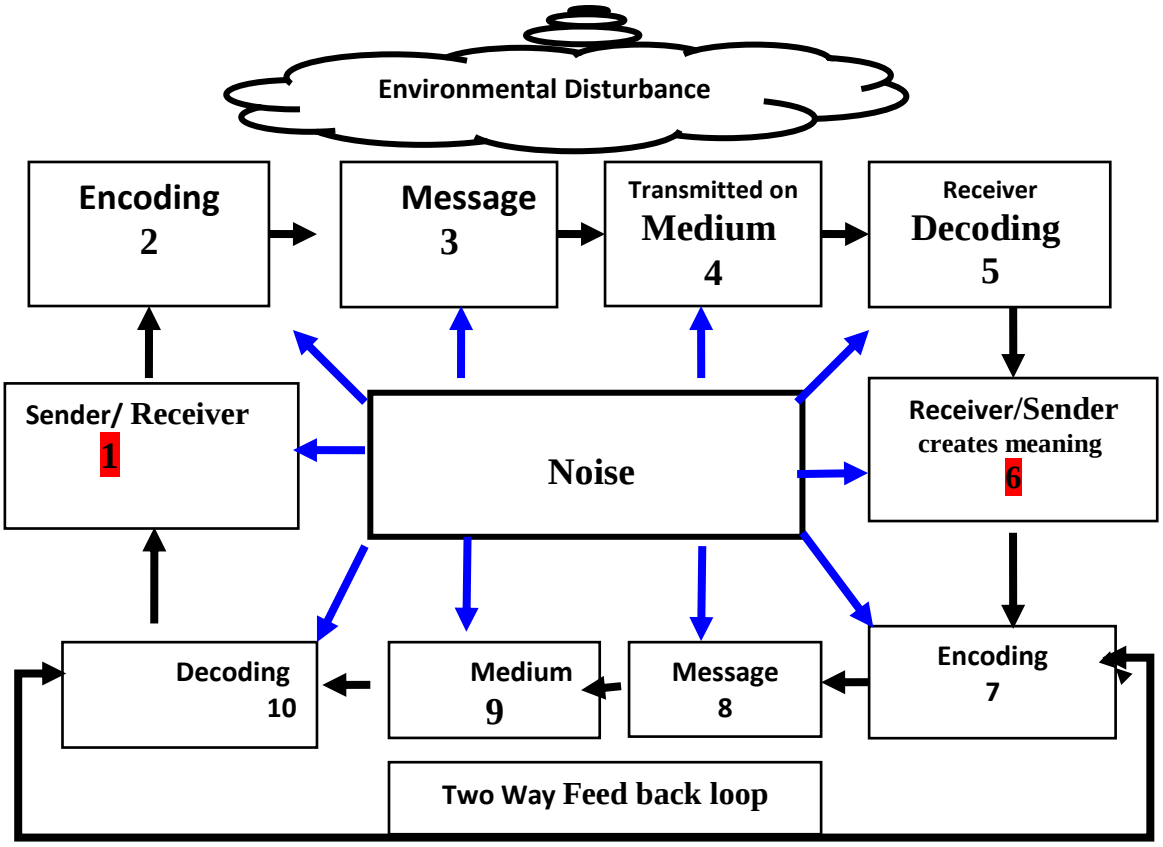

Figure (2.1) shows communication as being a two-way process

Consisting of consecutively linked elements from 1 to 10 affected by noise as surrounding work. Also could be one if no feedback.

1. **Sender (source):** The sender is an individual, group, or organization that desire to communicate with particular receiver.
2. **Encoding:** Communication begins when a sender encodes an idea or thought. Encoding is changing or translating mental thoughts into a code or language that could be under stood by others.
3. **The message:** The output of encoding is a message. Sometimes message may contain a hidden agenda or trigger emotional reaction. Also the messages needs to match the medium (channel) conveying it.
4. **Medium or Channel:** Simply medium and channel had the same meaning, potential media include face to face conversation, telephone calls, written memos or letters, photographs or drawing, meetings, bulletin boards, computer output, and charts or graphs. All media have advantages and disadvantages. Media selection is the key component of communication effectiveness
5. **Decoding**: Decoding is the receiver's version of encoding. Decoding consist of translating verbal, oral, or visual aspects of messages into form that can be understood.
6. **Receiver:** May be individuals, groups, or organizations. The receiver creates the meaning of a message in his /her own mind. Sometimes receiver's interpretation of the message differs from that intended by the sender (source).So miscommunications and unintentional communications are expected. (Robert Kreitner, Angelo Kinicki. 1992)
7. **Feedback:** Feedback is the receiver's response or answer on the message. At this point in the process the receiver becomes a sender. The feedback is used to give the sender an idea to what extent his message is understood by the receiver.

8. **Noise:** Noise represents anything that interferes with transmission and understanding of the message. Communication accuracy can be improved by reducing noise and communication productivity increased by reducing the physical barriers.

2.8 Perceptual Model of Communication

Traditional model of communication process has been described as pipeline in which information and meaning are transferred from person to person**.**

Recently the critique being based on, unrealistic assumptions; because assumption that if communication transfers intended meaning from person to person (Gregory, et al, 1988) is true, miscommunication would not exist and there is no need to worry about misunderstanding.

Perceptual model of communication provide communication as a process in which receivers create meaning in their own.

2.9 Clear communication

It is an essential ingredient for success in rapidly changing health care climate (Riley J B, 2008); group members must know each other; a sense of group identity must be present; and there must be a sense of group efficacy, a belief that the group can and will perform better than individuals working on their own (Druskat, 2001; Gundry and La Mantia, 2001; Rosenthal, 2001). Group development stages are forming, storming, norming, and performing (Tuckman, 1965; Stuart and Laraia, 2005). Individuals must work together with a sense of belonging, yet each must still retain a sense of self identity. Group communication needs a high level of participation, corporation and collaboration.

2.10 Meaning of Interpersonal Communication

Communication involves the reciprocal process in which messages are sent and received between two or more people (Riley J B, 2008). The focus is on the communication exchange among HCPs. Communication can either facilitate the development of work related action relationship or create a barrier. In general there are two parts to face-to face communication; the verbal expression of the sender's thoughts and feelings, and the nonverbal expression.

2.11 Factors affecting the exchange of messages between HCPs

According to Riley the following factors affect communication.

1. Environmental factors: formality, warmth, privacy, familiarity, freedom or constraint, physical distance between people, climate, mood, architecture, arrangement of furniture.
2. Territory and personal space: crowding, seating, arrangement, roles, status, position, physical characteristics (size, height).
3. Physical appearance and dress: body shape, race, body smell, hair, gender, body movements, posture, age.
4. Nonverbal cues: facial expressions, eye movements, vocal cues.
5. Interpersonal factors: developmental stage, language mastery, difference in perception, difference in decision-making process, difference in values, self concept (Riley, 2008).

2.12 Important Functions of Interpersonal Communication

1. Communication is the vehicle for establishing work relationship.

2. Communication is the mean by which people influence the behavior of others and thus it is critical to the successful outcome of HCPs interventions.
3. Communication is the relationship itself, because without it, work activities and relationship is impossible. (Riley, 2008) (Stuart GW, Laraia, 2005)

2.13 The meaning of Assertive Communication

Assertiveness is the key to successful relationship between HCPs. It is the ability to express your thoughts, your ideas, and your feeling without undue anxiety and without expense to others. Assertiveness means being clear about what you need and respectful in your language and behavior. Assertive communication is lifelong learning skill that require time and practice. Be willing to accept the fact that you will make mistake. Be patient. It is a matter of choice. It is important to feel confident that you can speak up for yourself, yet it is not necessary or even wise to speak your mind in every situation (Riley, 2008). Remember assertiveness helps you give or receive immediate feedback about behavior that might have serious consequence if ignored (Grover, 2005)

2.14 Communication Skills

2.14.1 Definition of Communication Skills: According to the various dictionaries

- Communication skills are the ability to use language (receptive) and express (expressive) information.
- Communication skills are the set of skills that enables a person to convey information so that it is received and understood. Communication skills refer to the repertoire of behaviors that serve to convey information for the individual.

2.14.2 Commonly Known Types of Communications Skills

1. Intra-personal communication skills: This implies individual reflection, contemplation and meditation. One example of this is transcendental mediation.
2. Inter-personal communication skills: This is direct, face-to-face communication that occurs between two persons. It is essentially a dialogue or a conversation between two or more people. It is personal, direct, as well as intimate and permits maximum interaction through words and gestures

Interpersonal communications may be:-

a. Focused Interactions skills: This primarily results from an actual encounter between two persons. This implies that the two persons involved are completely aware of the communication happening between them.

b. Unfocused interactions skills: This occurs when one simply observes or listens to persons with whom one is not conversing. This usually occurs for example, at stations and bus stops, as well as on the street, and observing some one work.

c. Non verbal communication skills : This includes aspects such as body language, gestures, facial expressions, eye contact, etc., which also become a part of the communicating process

d. Mass communication **skills**: This is generally identified with tools of modern mass media, which includes: books, the press, cinema, television, etc. It is a means of conveying messages to an entire population. It is an ever-continuing process that is going on all the time. It is as important to human life as is day-to-day existence.

http://www.communicationskills.co.in/types-of-communication-skills.htm. Access on 29/12/2009.

2.14.3 Importance of Communication Skills:

Identification is one of the key ingredients of effective communication. In fact, unless your listeners can identify with what you are saying and with the way you are saying it, they are not likely to receive and understand your message." The words above are the underlying factor that explains the importance of communication skills. In fact, Good communication is as stimulating as black coffee, and just as hard to sleep after. In the end the communicator will be confronted with the old problem, of what to say and how to say it. The colossal misunderstanding of our times is the assumption that insight will work with people who are unmotivated to change. People can only hear you when they are moving toward you, and they are not likely to when your words are pursuing them. Even the choicest words lose their power when they are used to overpower. Attitudes are the real figures of speech. http://www.communicationskills.co.in/importance-of-communication-skills.htm Access on 29/12/2009

2.14.4 Listening styles and skills

Listening is the process of actively decoding and interpreting verbal messages.

Listening Styles are:

- Result-Style**:** They are interested in hearing the bottom line or result of communication message first.
- Reason-Style: They must be convinced about linking point of view before accepting it.

- Process- Style: Listener likes to discuss issues in detail.

Listening skills: Those are some skills to be good and effective listener:

1. Ask questions. 2. Use technique of reflection. 3. Be interested in the other person. 4. Avoid interruption e.g. Do not continually interrupt the speaker, Close the door, stop receiving calls, do not look out the window or papers on the disk. 5. Respect the speaker by giving him or her you full attention (Maher, 2000). 6. Remember that not all communication is verbal. Facial expression and gestures reveal feeling too. (Dessler, 2004).

2.14.5 Ten Commandments for Good Listening

1.Stop talking; you cannot listen if you are talking. " Give every man thin ear, but few the voice".

2.Put the talker at ease. Help the talker feel free to talk; this is often called establishing a permissive environment.

3.Show the talker that you want to listen. Look and act interested listen to understand rather than to oppose.

4.Remove distractions. Do not doodle, or shuffle papers. Will it will be quieter if you shut the door?

5.Empathize with the talker. Try to put your self in the talker's place so that you can see his or her point of view.

6.Be patient. Allow plenty of time. Do not interrupt the talker. Do not start for the door to walk away.

7.Hold your temper. An angry person gets the wrong meaning of the worlds.

8.Go easy on argument and criticism. This puts the talker on the defensive. He or she may clam up or get angry. Do not argue: even if you win, you lose.

9.Ask questions. This encourages the talker and show you are listening.

10.Stop talking. This is the first and the last commandment. Nature gives us two ears but only one tongue. (Samuel S. Cero , 2003)

2.14.6 Examples of Communication Skills: While speaking fluently is an important aspect of communicating, yet it is not the only requirement. One should be able to listen effectively, speak fluently and clearly, write well and read in the language/s they are familiar with. Apart from these basic aspects of communications, one needs to keep in mind the non-verbal aspects too, in order to be considered adept in communication skills. The fact is that one needs to constantly work towards developing effective communication skills. And primarily they need to overcome the barriers to effective communication. This is in fact the first and foremost primary step to became a good communicator.

2.14.7 How to improve communication skill? One should be:

1. Aware of the communication process**:** One should be aware of every aspect of the present communication, the purpose, objective and needs. One needs to be aware of what is occurring within the self; and what the others feeling; aware of all that is occurring between the communicators and aware of all that is happening around.

2. Digging deeper: One should be able to dig below the surface and derive and understands each communicator's primary needs from the conversation taking place.

3. Clarity of thought: One needs to be clear and focused on the subject at hand and not beat around the bush and be ambiguous.

4. Listening: One should hone the skills of listening with understanding.

5. Assert respectfully: It is important that one develops speaking up assertively. http://www.communicationskills.co.in/verbal-communication-skills.htm**.** Access on 29/12/2009.

2.14.8 Good Communication Skills

1. Maintain eye contact with the audience**:** This is vital as it keeps all those present involved in the conversation. It keeps them interested and alert, during conversation.

2. Body awareness: One needs to be aware of all that their body is conveying to them, as well as others. For instance, if there is anxiety rising during the course of a conversation then one feels thirsty and there may be a slight body tremor. At that point one needs to pause and let someone else speak. A few deep breaths and some water works as the magic portion at this point.

3. Gestures and expressions**:** One needs to be aware of how to effectively use hand gestures and the way they need to posture their body to convey their messages effectively. Sometimes it may happen that they verbally convey something, but their gestures and facial expressions have another story to tell.

4. Convey one's thoughts**:** It is important for one to courageously convey what they think. This is because when things are left unsaid, then what is being spoken is not as convincing as it should be. Then a lack of confidence develops.

5. Practice effective communication skills: One should practice speaking and listening skills as often as possible. In order to practice effective speaking skills one can read passages from a book aloud, in front of a mirror, or simply performs a free speech in front of the mirror. And where listening is concerned, one can try transcribing from the radio or television.

http://www.communicationskills.co.in/good-communication-skills.htm

Accessed on 29/12/2009

2.15 Communication among Health Care Providers

Effective communication between HCPs leads to understanding, achieving the objectives of health Programme, it raises the awareness about health risks, and used to be a motivation for the staff members during work, the following points g summaries some of these benefits and results:

1) HCPs communication also can increase demand for appropriate health services. It can make available information to assist in making complex choices, such as selecting health plans. HCPs communication can be used to influence the public agenda, advocate for policies and programs, promote positive changes in the socioeconomic and physical environments, improve the delivery of public health and health care services, and encourage social norms that benefit health and quality of life.

2) The practice of health communication has contributed to health promotion and disease prevention in several areas. One is the improvement of interpersonal and group interactions in clinical situations (for example, provider-patient, provider-provider, and among members of a health care team). Collaborative relationships are enhanced when all HCPs

are capable of good communication. Another area is the dissemination of health messages through public education campaigns that seek to change the social climate to encourage healthy behaviors, create awareness, change attitudes, and motivate individuals to adopt recommended behaviors.

2.15 Nonverbal communications Nonverbal communication is "Any message, sent or received independent of written or spoken ward. According to Robert Kreitner, sources of nonverbal communication include the following:

1. Physical features: as body type – overweight, muscular, under weight, skin color, clothes, and physical handicaps.

2. Body movement and gestures: as leaning forward, backward, pointing give additional information. Defensive communication as by Folding arms, crossing hands and crossing one's leg .It is important to remember that" There isn't a reliable dictionary for gestures and its meaning depends on the context, the actor, the culture and others. Inaccurate interpretation of, body movement can create additional" noise" in the communication process.

3. Touch: Touching is powerful nonverbal communication; in many cultures, it means warmth, attraction, and friend ness. People tend to touch those they like.

4. Facial Expressions: Smiling for instance typically represents warmth, happiness, or friendship; although puckered lips during conversation they might convey confusion.

5. Eye Contact: Eye contact is strong nonverbal cue that serves four functions in communication. First, eye contact regulates the flow of communication by signaling the

beginning and end of conversation. Second, gazing facilitates and monitors feedback because it reflects interest and attention. Third, eye contact conveys emotion. Fourth, gazing relates to the type of relationship between communicators.

6. Interpersonal Distance Zones**:** These zones are:

- Intimate distance, the zone for love making 18 inches.
- Personal distance for interaction with friends 4 feet.
- Social distance for social interaction 4 -12 feet.
- Public distance for formal interaction 12-25 feet. (Kreitner R. 1991).

7. Positive nonverbal actions that help to communicate include the following:

(1) Maintaining eye contact. (2) Occasional nodding the head in agreement. (3) Smiling and showing animation. (4) Leaning toward the speaker. (5) Speaking at a moderate rate, in a quiet, assuring tone. (Kreitner R. 1991).

2.17 Principles of Effective Communication

1. **Principle one**: Information giving is not communication. Communication requires that participant share a mutual interaction, with the receiver providing feedback to the sender.
2. **Principle two**: The sender is responsible for clarity.
3. **Principle three**: Use simple and exact language. In both written and spoken communication, wards used precisely and in simplest terms possible are more likely to be understood.

4. **Principle four**: Feedback be encouraged. The best way to be sure a message has been accurately interpreted is to obtain feedback; lack of it is a common reason for misunderstanding.
5. **Principle five**: The sender must have credibility, personal and professional. Remember the rule "Say what you mean and mean what you say".
6. **Principle six**: Acknowledgment of others is essential.
7. **Principle seven:** Direct channels of communication are best (Kreitner R. 1991).

2-18 Ten commandments for effective communication

1. Seek to clarify your ideas before communicating: - The more systematically you analyze the problem to be communicated, the clearer it become.
2. Examine the purpose of each communication: Before each communication, ask yourself what really want to accomplish with your message, identify your most important goal and do not try to accomplish too much with each communication. The sharper the focus of your message the greater its chance of success.
3. Consider the total physical and human setting whenever you communicate.
4. Consult with others, with appropriate one, when planning to communicate.
5. Be mindful of the overtones while communicate rather than merely the basic content of your message.
6. Take the opportunity, to convey something of help or value to the receiver.
7. Follow up your communication.
8. Communicate for tomorrow as well as today.
9. Be sure that your actions support your communications.
10. Seek not only to be understood, but also to understand.(Samuel S. Certo , 2003).

2.19 Speaking and Presenting Skills

The following are some tips for effective presentation that can be practiced by HCPs:

1) Understand, exactly what it is you want to accomplish.

2) Do not write a speech.

3) Write your introduction.

4) Practice, practice, a practice. The old saying really is true: Practice makes perfect. .(Samuel S. Certo , 2003).

2.20 Writing skills

Here are some of the best ways to improve HCPs writing skills.

Think before you write. Ask yourself in the pre-writing phase; what my readers know? What do they need to know? What decisions will be based on this information? Am I writing to increase knowledge? Am I trying to urge action? Know what motivate your readers (Dicker and Hein, 1999). Organize your ideas before you start to write by sketching out an outline of major points,

*Make it short. Get the point quickly.

*Make your points clearly, or simply.

*Take the reader into consideration.

*Take some time to revise your draft.

*Go through your entire letter, memo or report.

*Delete all unnecessary words, sentence paragraphs and use specific word.

2.21 Running effective Meeting between HCPs

The following important areas should be tested:

1. Preparing lunch the meeting: every one has opportunity to provide their input
2. Managing the meeting
3. Issuing Minutes. (Dicker and Hein, 1999).

2.22 Organizational Communication

No organization exists solely in isolation with one member who has no contact with anyone or anything. The exchange of ideas and information is fundamental for all organizations. This exchange may take place internally between different sectors or departments, or externally with other organizations.

Organizational communication is the specific process through which information moves and is exchanged through an organization; it is the interpersonal communication within organization.

Organizational communication directly relates to the goals, functions, and structure of human organizations. Information flows through both formal and informal structure and it flows downward, upward, and laterally (Schermerhorn, 2002).

2.22.1 Formal communication: The formal communication in an organization sets out the command structure and interrelation between the departments within it. A company organization chart will usually outline the chain of command and responsibility and hence indicate the likely information flow within that organization. Flow of communication can move upward, downward, horizontally or diagonally and often are prearranged and necessary for performing some tasks.

2.22.2 Informal communication: The informal communication tends to co-exist alongside the formal structures that are established by management. In this way individuals informal networks and information is communicated as people chat during tea breaks, and as they pass in corridors. Such informal networks arise due to social needs and to, fill the information gaps left by the formal communication (Hareem, 2004). In other word it is organizational communication that does not follows the lines of organization chart. Informal organizational communication network generally exist because organizational members have a desire for information that is not furnished through formal organizational communication. One familiar information channel is the grapevine or network of friendship and acquaintances through which rumors and other unofficial information are passed from person to person (Bateman and Snell 2004).

2.22.2.1 Grapevine: The term grapevine originated from the Civil War practice of stringing battlefield telegraph lines between trees.

Today grapevine represents the unofficial communication system of the informal organization. Information traveling along the grapevine supplements official or formal channels of communication. Although the grapevine can be source of inaccurate rumors, it functions positively as an early warning signal of organizational changes.

Grip vine has three characteristics: First, it is not controlled by management. Second, it is perceived by most employees as being more believable and reliable than formal communication and issued by management. Third, it is largely used to serve self-interests of those people within it. The grapevines have the advantage of being able to transmit information quickly and efficiently. In addition, grapevine helps fulfill the needs of people involved in them. Being a part of grapevine can provide a sense of social satisfaction and

security when important things are going on. The primary disadvantage of grapevine occurs when they transmit incorrect or untimely information. (Kreitner R, Knicki A. 1991).

Grapevine Pattern**:** The most frequent pattern is not a single strand (each tells one other) or gossip chain (one tell all), but the cluster pattern (some tell selected others; most typical). People constantly pass along grapevine information to others are called liaison individual or "gossips". Effective managers monitor the pulse of work groups by regularly communicating with known liaisons. Research about grapevine provided the following insights:

(1) It is faster than formal channels.

(2) It is about 75% accurate.

(3) People rely on it when they are insecure, threatened, or facing organizational changes.

(4) Employee uses the grapevine to acquire the majority of their on-the- information. (Katherine I. Miller 1988).

The key managerial recommendation is to monitor and influence the grapevine rather than to control it. Keith Davis, who has studied the grapevine for 30 years, offers this advice:

No administrator in his right mind would try to abolish the management grapevine**.** It is as permanent as humanity is; nevertheless, many administrators have abolished the grapevine from their own mind. They think and act without adequate weight to it. This is a mistake. The grapevine is a factor to be reckoned with in the affairs of management. The administrators should analyze it and should consciously influence it (David M, Herold and Charles K, 1985)**.**

2.22.2.2 Rumors : Rumors have at least three purposes:

1. To structure and reduce anxiety.
2. To make sense of limited or fragmented information.
3. To serve as vehicle to organize group members.

Rumors can be very dysfunction to both people and organization (Schermerhorn, 2002).

2.23 Communication Barriers

Unfortunately, most of the stages in the process model have the potential to create distortion and therefore the sender's intended message does not always get across to the receiver. In the encoding stage, words can be misused. In the transmission stage, a memo gets lost on a cluttered desk, or words spoken with ambiguous inflection. Decoding problem arise when receiver does not listen carefully or read too quickly and overlooks a key point. In addition, of course, receivers can misinterpret the conclusion from unclear memo, or listener takes a general statement by boss too personally. More generally, it is important to understand the following sources of noise that are common to most interpersonal exchanges addressed as barriers to effective communication.

Barriers to effective communication

Barriers to communication are personal and environmental characteristics that interfere with accurate transmission or reception of the message. They are (1) natural tendency to evaluate or judge a sender message and (2) not listening with understanding. Awareness of this barrier is first steps to improve inter personal communication. The second step is to have both parties to the communication be able to come to understand each other's point of view by good listening. In other way**,** barrier can be summarized as follow:

1-Physical, 2-Cultural, 3-Perceptional, 4-Motivational, 5-Experiential, 6-Emotional, 7-Linguistic, 8-Non-verbal, 9-Competition, 10-Purpose as barrier, 11-Gestures as barrier, 12-Different forms or reasons for verbal interaction.

http://www.google.com/search?q=communication+barriers&hl=ar&hl=&start=10&sa=N Access in 8/7/2009.

2.24 Electronic Communication

2.24.1 Modes of communications:

1.Traditional communication: Face to face interaction, Telephony, Letters, Memos, Fax.

2.Modern Technology Communication: recently pagers, facsimile machine, and meeting - video conferencing, electronic meeting, E- mail, cellular phones, voice messaging and palm-sized communicator, Private network, Chatting Room, Internet based inter organization, Human resource program, Oracle Financial System, Interact. Electronic communication have revolutionized both the ability to access other people and to reach them instantaneously. We have moved from the world of the telephone, mail, photocopying, and face-to-face meeting into one of the voice mail, facsimile transmission, computer- mediating conferencing, and use of internet and intranets. HCPs can use computers not only to gather and distribute data but also to talk with others electronically.

2.24.2 Advantages of electronic meeting

1.Usually less costly than face-to-face meeting. There is no travel, accommodation, or meeting room costs involved.

2.Less disruptive. Members can participate from the comfort of their offices or homes.

3.Tend to be more efficient, focused, and businesslike than face to face meeting.

4.Are ideal for simple decision that needs to be made between face to face meetings, a face -to-face meeting becomes something to look forward, since it is more substantive issues (Mina, 2002).

2.24.3 Disadvantages of Electronic Meeting

It is difficult to respond to facial expressions. It is difficult to detect emotional reactions to the discussion and respond to it with a supportive statement, without seeing the individual who may need this support. It is easily to tune out in a virtual meeting, without anyone knowing that you are doing it. Virtual meeting do not engage people on a human or social level to the extent that face-to-face meeting do. It is more challenging to maintained privacy and confidentiality e.g. an e mail exchange. Therefore, people may be less comfortable discussing sensitive issues (Mina, 2002).

2.25 Boundaries of basic communication competence among HCPs

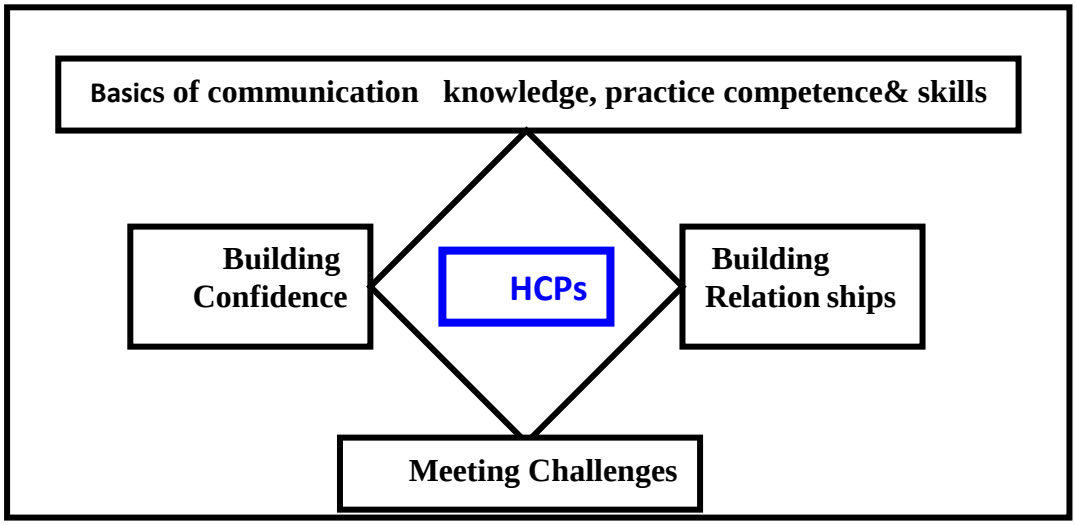

Figure (2.2) shows boundaries of basic communication competence among HCPs

2.25.1 HCPs as a Group Working Together

Researches demonstrate that three condition must be met for effective group development: group members must trust one as; group identity must be present; and sense of group efficacy present, a belief that group can and will perform well, that the group as a whole perform better than individuals working on their own (Druskat, 2001; Gundry and La Mantia, 2001; Rosenthal, 2001. Four stages occur in the development of team. According to Tuckman, 1996; Stuart and Laraia, 2005), the stages are: forming, storming, Norming, and performing.

2.25.2 Building Relationships among HCPs

Warmth ,respect, honest, understanding others feelings, specificity, to be stream line during interview, expressing your opinion, humor, and spirituality are the most important points in building relationships among HCPs as a team, which is essential to get effective communication needed to provide the service.

1) Warmth: benefits of warmth among HCPs during work

"Speak with me in a warm and caring voice" (Lee-Hsieh et al 2004, p.26)

Warmth is the glue in the bonding between people and the magnetism that draws us to closure intimacy with others. It is a special ingredient, even a catalyst, in our human relationships. The expression of warmth makes us feel welcomed, relaxed, and joyful. Exchange of warmth with HCPs during work makes the work place more pleasant environment, warmth enhance closeness, which has social and work related benefits. Extending our warmth to our colleagues makes us more approachable. Increased communication among colleagues ensures that important messages about work related policies and procedures are transmitted. According to Levine and Adelman (1982), a study conducted in the United States had found that 93% of the messages are transmitted by tone of voice and facial expression, and only 7% by words. We may turn to the nonverbal expression of emotion and attitude more than verbal. Expression of warmth is predominantly nonverbal; it is wise to head these finding (Riley, 2008).

2) Respect: The benefits of respect among HCPs are reflected on their productivity

According to Riley, respect is the foundation of helping interventions (Egan, 2006). When we show respect to our colleagues, we are sending them messages, " I value you. You are important to me". Receiving respect makes people feel important, cared for, and worth, while in contrast, when people do not receive respect, they feel hurt and ignored. When people sense that they are not being treated with respect, they feel angry and rejected. Experience shows that positive correlation exists between respect, warmth, and successful treatment outcome in psychotherapy. A lack of respect of colleagues has contributed to

morale and productivity problems, and may contribute to high level of stress associated with emotional outbursts and violence.

3) Genuineness = your natural self = realness = to be real is to be your self

Carl Roger (1980), a pioneer in the study of communication, used the two synonyms realness and congruence which he clams is the basis for best communication. A fundamental feature of genuineness, in Roger's view, is the presentation of ones true thoughts and feelings, both verbally and nonverbally, to another person. It is not only the words you say or how to say them, but also your facial expression and body posture that make genuineness. Being genuine is that you send the other person the real picture of you, not a distorted one that differs from how you think or feel. This is reflected on the messages conveyed among HCPs.

4) Empathy

Is the act of communicating to our fellow human being that we understand something about their world (Dunne, 2005). As a health care provider, your practice reflects your understanding as human behavior. Synonym for empathy is communicated understanding. Empathy includes the ability to reflect accurately and specifically in words colleagues are experiencing, drawing on the non verbal behavior of warmth and genuineness. The goal of verbal empathy is to offer a verbal reflection that is accurate, without exaggeration or minimizing what they are being told. It is showing that you understand the other person’s point of view.

5) Self-Disclosure in personal and professional relationships

To disclose means to "unclose" or to open up. To self –disclose then, means to open up our selves to others. Self-disclosure is another interpersonal communication behavior that HCP can use to show to his colleagues that he understands them. It can facilitate movement toward a common goal (Grover, 2005).

6) Specificity: Recognizing when specificity is useful

Being specific is being detailed and clear in the content. Being specific is important when HCPs are doing such things: Explaining your thoughts and feeling or reflecting others thoughts and feeling, when asking questions, giving information or feedback, or evaluating. Being specific or concrete usually benefits communication in three ways (Arnold and Boggs, 1997; Stuart and Laraia, 2006: 1). The process of communication is more satisfying when we are "on the same wave length" as those whom we are communicating. 2) Communicators achieve clearer comprehension of their own thoughts and full understanding of other's thoughts. 3) The foundation for problem solving is complete and accurate, which enhance the success of further communication in our relationships with client and colleague.

7) Humor

Humor is an important part of human behavior and everyday life, the ability to see the amusing side of the situation rather than being serious all the time, an exceptional way of perceiving life, and a perspective that free us from conformity and puts us in touch with our authentic spontaneous self (Kiplinger, 1987; Astedt-Kurki and Isola, 2001). Humor among staff facilitates work environment (Astedt – Kurki and Isola, 2001). Humor does the following (Green, 1994): 1) Invite interaction, 2) Puts others at ease, 3) Wines affection

and 4) Helps us cope with stress and fear. Lastly negative humor can build barriers among HCPs, but Positive humor can build bridges among them.

8) Spirituality

Definition: spirituality comes from the Latin word meaning" breath of life" (Brillhart, 2005, p.31). We cannot neglect the spiritual role of HCPs especially the nurses as there is often no body better placed or better qualified to provide spiritual care than the nurses (Kemp, 2001).

2.25.3 Building Confidence

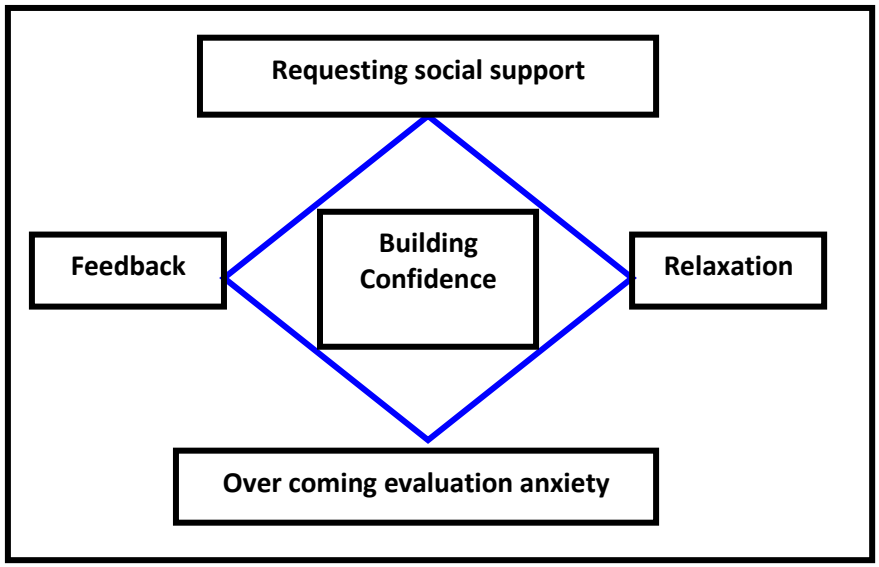

Figure 2.3: Components of Building Confidence

1) Requesting Social Support for HCPs

Social support for HCPs at UNRWA health centers is essential and needed. Researches on relationships between social support and health have shown important implications for

nursing practice today. The literature review reveals positive relationship existing between the presence of social support and health and coping with illness (Komblith et al, 2001; Adams et al, 2002). Research also shows that social support affects the ability to cope with stress, crises, or serious illness; the experiencing of containment or depression and loneliness; and the functioning of immune system (Hall, 2002). Mayor Rudolph Giuliani's public display of grief strengthened people's resolve to rebuild and restore confidence in New York after bombing of the World Trade Center on September 11, 2001(Dutton et al 2002).

2) Overcoming Evaluation Anxiety

Evaluation anxiety occurs when we are upset about having our performance judged and are intimidated by the evaluation process. We can not directly control other's responses to our work, and we overvalue the responses of others. This creates a kind of anxiety that interferes with performing at our best (University Illinois, 2006).Learning to relax and decrease unpleasant symptoms helps diminish their negative impacts on HCPs communication during work.

3) Feedback

Is defined as the "transmission of evaluation or corrective information to an action, event or process" (Merriam-Webster's Collegiate Dictionary, 2005-2006).

Feedback is important because it helps us to view our behavior from another perspective.

Feedback is something positive – a gift for the other person, could be a stress reliever? Cultivate positive people in your life by giving specific praise about colleagues, especially in front of people important to them (Anderson, 2002).

Continuous quality improvement depends on regular feedback for excellence (Porter-O'Grady, 1994), after receiving our feedback; colleagues may wish to make change.

The following points are important for feedback: 1) Gain permission from your colleague to give feedback so the individual will be more open to your input (Ambrose and Moscinski, 2002), 2) Be specific, 3) Convey your perspective, 4) Invite comments from the receiver, 5) Check how your feedback is being received (Riley J, 2008)

4)Relaxation

Worry can trigger tension in your muscles, resulting in soreness, headaches, or digestive upsets. In turn, bodily tension is an aggravating signal to your mind that you are not at peace and that something is "eating away at you". In contrast, relaxation is "a state of consciousness characterized by feeling of peace and release from tension, anxiety and fear" (Ryman and Rankin-Box, 2001) that contributes to your general sense of well-being (Spenser and Jacobs, 2003). HCPs among UNRWA health centers are exposed to daily stress factors that affect their communication during work. Occupational stress is a major health issue leading to anxiety, short term and long term physical problems, and counterproductive behavior at work (Spector, 2002). Lastly we must know that there is no quick-fix to manage stress, because stress is the result of "an interaction between the negative environment, unhealthful life style, and self defeating attitude and beliefs" (Micozzi, 2006).

2.25.4 Meeting Challenges

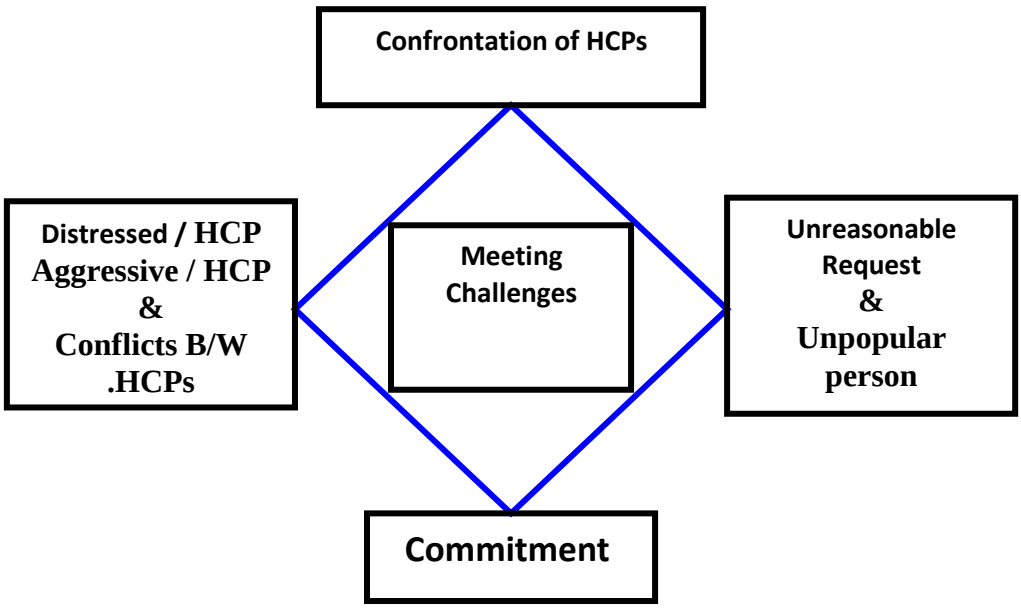

Figure 2.4: Challenges Facing HCPs Communications during Work

1-Confrontation skills are "being able to identify and to respond – communicate – provide –feedback regarding these discrepancies in another person's behavior in such a manner that the other person can grow" (Tindal, 1994).

Patterson, Greeny, McMillan, and Switzler (2005) say that to confront is to hold someone accountable, to offer an opportunity to solve problems and build relationships. Confrontation among HCPs in some situation is needed and useful, the question how and when? When it make others aware of their destructiveness or lack of productivity during work as example, and how by making suggestion about how they could behave in a more constructive and productive way. What is called CARE model or approach adapted by Bower and Bower, (1991), can be summarized as follows: C=Clarify the behavior that is problematic, A=Articulate why their behavior is a problem, R=Request change in your colleague behavior, E=Encourage your colleague to change by emphasizing on the positive

consequences of change or the negative implications of failing to change. This model is useful in situations might happen during work (Riley J, 2008).

2-Refusing unreasonable request

HCPs during their interaction imposed to situations they must say "No" to some requests from their colleague or others. Creel (2006) is a professional organizer, create a list of 20 ways to say NO as it is sometimes your rights to refuse in assertive way. Saying no to unreasonable request is a way of saying Yes to your self, because as" you are saying Yes to your values; yes to your style of doing things, yes to your way of perceiving situation, and yes to your ways of judging and deciding. It is freeing to remove your energy from unreasonable requests and invest in your vision and goals"(Riley 2008). Here are some suggestions to say "no" effectively under the heading "Do" and "Don'ts".

Do: State your refusal very near the beginning of your reply so that your requester hears a clear, direct answer right way. Indicate concisely the reason for saying no if it strengthen your refusal. Communicate your understanding so that the requester feels you comprehend your state even if you cant solve it. Suggest an alternative source of help if it seems appropriate. Think about your response, then speak in a forthright, calm, polite manner. Maintain a matter - of – fact, consistent way refusing in the face of an aggressive requester.

Don't: Begin your refusal with a list of lengthily excuses against which an aggressive requester. Stammer, pause, him and how hesitate, or burst out your refusal; this will reveal that you are unsure of your response. Lose eye contact for lengthy periods, shift uncomfortably, or convey other non verbal discomfort that reveals your discomfort. Raise your voice or give other bodily clues of being enraged. It is your right to refuse, and you do not need to become hostile to protect this matter.(Riley J, 2002 Work Shop).

Sometimes it is difficult to find just the right words to express your refusal.

Berent and Evan(1992) offer some phrases that might be helpful: **"No!"** to be used as follow: "No, thank you, I don't care to.., I've never done that and don't want to start".

"I can't do that.." . " I make it a habit never to…". I make it a habit always to…" As a matter of principle, I……" Peter Drucker, a well leadership expert, at age 95 reflecting on lessons learned, advises that leaders are purpose driven, can establish a mission, and can say no to requests that do not support their mission (Karlgarrd, 2004).

Sometimes the magic of little words help as skills in communication in confrontations as the use of word **"and"** instead of **"but"** ,when offering criticism or differing opinion between HCPs (Berent and Evans , 1992) as to say:" I appreciate the intensity of your feeling this and I think …..". I can understand your reason, and I think my reason …"

Or to say:" That's an interesting idea; and here another way to think." That's a compromise.

3-Communicating with a distressed colleague

Kaufman and Wetmore (1994) suggest four common events that can causes stress: loss of control, change, sense of threat, and unrealized expectations. Remember that it is not the situation itself the cause of problem but the reaction to it. Ideally we need to keep calm enough to be able to understand the reason for another person's distress, to remain nonjudgmental so that we can convey appropriate compassion for situation at hand, and to be clearheaded enough to act responsibly on behalf of other person. The question is how to improve your communication skills with a distressed colleague? The answer is for each situation, you have to go through the following steps: Step 1: Assessment of the data per

situation. Step 2: To put your communication strategy and desired outcomes. Step 3: To implement and evaluate your communication strategy.

4-Aggressive colleague or client

Aggressiveness is an unpleasant attitude; HCPs sometimes are facing aggressiveness during work. It reefers' to: rejecting, hostile, abusive, and manipulative behavior. Aggressive behavior may be the result of anger, an emotion that arise in response to feeling of powerless or out of control as result of over crowdedness of work place, needs to work more and more, technology stress; so HCPs become more irritable and angry ; which can lead to breakdown in communication and aggression. (Hegle, 2001c; Hollinsworth et al, 2005): First remember before you deal with aggression or anger to breathe deeply and remain calm. Try to separate the problem from the person and avoid taking the behavior personally. Pay attention to people's personal space and don’t move in too close, and chose the words carefully to demonstrate respect for other person (Hegle, 2001b).

Remember that assertive communication is crucial to dealing effectively with conflict. (Antai-Otong, 2001).

Here selected points to follow from experiences of Jakubowski and Lange (1978) to be considered in dealing with aggressive one.

- Get the source of the problem.
- Increase your aggressor awareness of abusive behavior and its negative effect.
- Limit the aggressive behavior.

5-Communication with unpopular person

As we are HCPs communicating with each others, sometimes we label some one as popular; I mean normal person, and we like to work with him, or we prefer to communicate with him, the opposite will be if the label was unpopular. To get effective communication; the strategy is to change such negative attitude toward the unpopular person, and to treat all colleagues fairly with respect to their dignity, because non caring behavior or neglect leads to ineffective communication, and failure to achieve the goals.

6-Conflict Situation Involving health care providers

Conflict can be a source of personal and organizational stress by the nature of work (Vivar, 2006). Conflict can occupy 30% of a manager time (Marick and Albert, 2002). Conflict resolution can build interdependence and professional collaboration and help team members to better address the big picture issues (Smith et al, 2001). Cushine (1988) identifies four categories of conflict intensifying in degree of difficulty from first to last: facts, methods goals, and values. **Facts:** Conflicts about facts are differences about data. This disagreement can be resolved by terminating debate and seeking information from reliable source. **Methods**: Conflicts about methods are differences about how something is done. A conflict about method occurs when there is no absolute slandered shared by all parties affected by issue. Resolving conflicts of this kind includes acknowledging that more than one way exists to accomplish the same goal or task. A mean to minimize this type of conflict is to establish criteria for method selection. **Goals**: Goals conflicts are differences about desired outcomes. Discussion often reveals that parties share common concern. If they are able to identify a common goal, this redefinition opens up new opportunities for problem solving. **Values** Differences in belief system are the most complex type of conflict, and a high level of motivation is required from involved parties

to understand each other beliefs. If the parties can avoid divisiveness or allocating other point of viewpoints to rigid categories of "right" or "wrong" and find combatable goals, they are on their way to conflict management (Cushine, 1988). Several forms of conflict are seen (Kinder, 1981).

1. Interpersonal conflict occurs between two individuals or among members of a group

2. Intergroup conflict occurs among established groups. Intergroup conflict is the struggle between groups. Health Care Providers are of different background, with variety of professional outlook, also with different socializations, with different personal view based on sex, age, cultural origin, socioeconomic situation and life experience; that situation made form them suitable field for conflict. Many times team members have different or opposing ideological view.

7-Conflict resolution approaches

Harrington-Mackin (1994) advises dealing with conflict in a timely way and suggests that most people find it difficult to openly discuss and work through conflict. The best solution is win-win conflict management strategy cover each of the following steps (Flanagan, 1995): 1-View the problem in term needs (what is required) instead of solution (what should done) to facilitate a mutual problem solving approach; detach yourself from biases and stay focused on actual data. 2- Consider the problem as mutual one to be solved requiring the active involvement of all affected. 3-Describe the conflict as specifically as possible, using undistorted data. 4-Identify the differences between concerned parties before attempting to resolve the conflict. 5- See the conflict from another point of view. 6-Use brainstorming to arrive at possible solution instead of adopting the first or most

convenient idea. 7-Select the solution that best meets both parties' needs and consider all possible consequences. 8- Reach an agreement about how the conflict is to end and not to recur. 9- Plan who will do what and where and when it will be done. 10-After the plan has been implemented, evaluate the problem-solving process and review how the solution turned out. (Riley, J. 2008)

2.25.5 Continuing the commitment

Commitment is necessary to move on your chosen profession; to remain open and sensitive to human condition; to renew your energy; and to embrace on change; **Achieving creative balance:** Guterman (1994) proposes a model he calls generative balancing that focuses on three competencies: " creating success, finding meaning, and renewal." All three competencies are necessary for balancing and real thrill comes from movement, not from finding steady point but from the balance. Achievement of success however, is often not enough in itself. The balance comes from life view that provides joy along the way. Rabbi Harold Kushner, author of “When bad thing happen to good people “ (2001) says, in my opinion, I agree that success comes from practice, administration, teaching, research, advanced practice; balance comes from thee component of the model. Kushner discuss three ways to find meaning to life: belong to people, accept pain as part of life, and know that you have made a difference (Kushner, 2002). **Renewing energy** of the body by practicing physical activities you like to do it, refreshing your mind as with computer by data, and the spirit by reading, silence and review and strengthening your relation with god. **Strategies for renewal are**: to remain open mind and sensitive to human relations, to renew your energy, and to stand ready for change.

2.25.6 Continuing connections

Honest, clear communication takes a commitment to continue, to grow, to deal with change, to stay connected with people. The rewards are substantial. Work can bring joy, but the cost is too great is to lose the joy that come from having rich personal life, interest to people to whom you are connected. Lastly someone say: "Happiness is not a goal, it is a byproduct of something you do

2.26 Conceptual framework

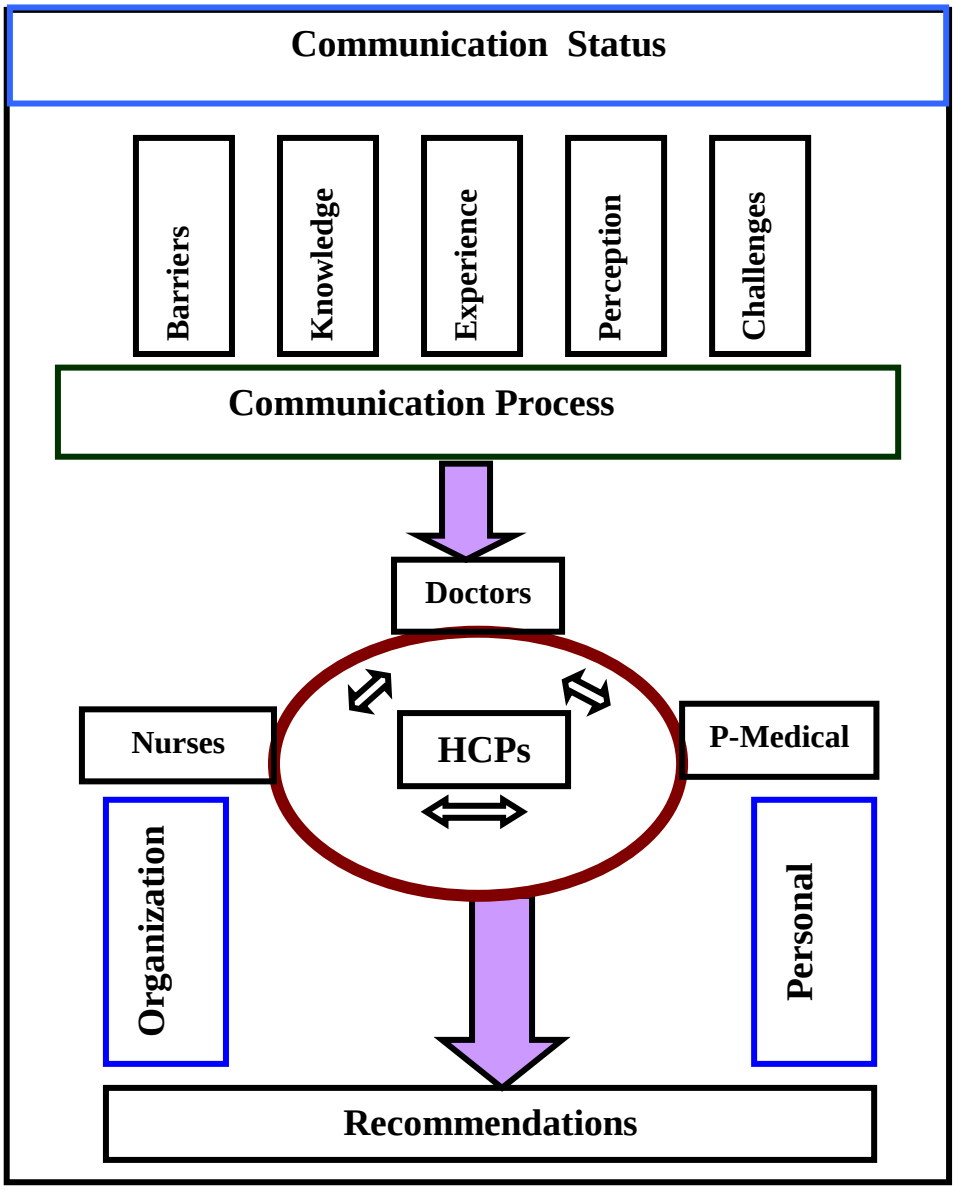

Figure 2. 5: Conceptual frame work of the research study

In this frame the researcher build on a model which contains most of the communication concepts incorporated in simple frame work. The framework used to guide the research process. This framework contains most of the communication concepts related to the study. Attention was paid keeping these concepts open and flexible to work situation at health center. According to, Mortensen, (1972) "In the broadest sense, a model is a

systematic representation of an object or event in idealized and abstract form. Models are somewhat arbitrary by their nature. The act of abstracting eliminates certain details to focus on essential factors". Models also clarify the structure of complex events. As (Kaplan 1964) noted, "Science always simplifies; its aim is not to reproduce the reality in all its complexity, but only to formulate what is essential for understanding, prediction, or control. A model is simpler than the subject- matter being required into and an essential for understanding, prediction, or control". The frame work of health care providers communication shows the dimensions of communication in relation to HCPs, knowledge, perception, experience, skills, and environment where communication present in addition to the state of infrastructure needed to achieve communication. In the center of frame communicators are doctors, nurses, and Para medicals, those are the study population in the process of communication, the frame show the challenges, and barriers facing them to achieve the goal through effective communication. By the end that frame will guide the researcher to describe, the status of HCPs communication among UNRWA health centers at Gaza Governorates and to provide recommendation according to research results. The details and explanation and specifications will have sufficient place in literature review.

Chapter Three

Methodology

3. Methodology

3.1 Overview

This chapter presents titles related to methodologies used to answer the research questions. This chapter contains the following headings: study design, method used, study population, study setting, questionnaire construction, control of the study instrument, eligibility criteria, ethical consideration, piloting, validity and reliability of the study instrument, data collection and analysis.

3.2 Study Design

The design of this study is a descriptive analytic design using a quantitative design. This type of design would be useful for descriptive analyses of study construct. It is less expensive than other designs and enables the researcher to get the study objectives in a short time (Coggen et al. 1993). It is suitable in terms of time, people, money, resources, and relatively practical and easily managed (Holm and Liewellyn, 1986). It also, provides detailed information and stimulates further research or studies.

3.3 Study setting

This study was conducted at the main five UNRWA health centers in GS as one health center from each governorate as follow: Jabalia HC from the north governorate, Rimal HC from Gaza governorate, Neusirate HC from middle governorate, KhanYounis HC from KhanYounis governorate, and Rafah HC from Rafah governorate. Those centers provide primary health care services to Palestinian refugees living inside and/or outside the refugee camps. The staff members in those centers represent 71% of the total staff working at the 20 HCs.

3.4 Study population

The study population consisted of all health care providers (HCPs) working in the chosen five main UNRWA health centers. The total number of the employees in the main five health centers was **508**. The total number of HCPs in the five main UNRWA health care centers in GGs was **291** as physician, nurses, and paramedical staff (Source of data was direct contact with UNRWA health department Gaza field personnel office Report on Sept. 2009).

3.5 Period of the study

The study was executed during the period from June 2009 to April 2010 including questionnaire construction, experts' opinion, quality check, pilot study, re-check and test, ethical approval and data collection and analysis.

3.6 Eligibility Criteria

3.6.1 Inclusion Criteria: The study included all permanent health care providers, who work at UNRWA primary health care centers**.**

3.6.2 Exclusion Criteria: The study excluded all non permanent health care providers assigned to work through Job-Creation Programme (JCP) or on Graduate- Training Programme (GTP) and the absent HCPs from permanent staff what ever the cause of absentia at the time of data collection.

3.7 Ethical Considerations and Procedures

1. An official letter of approval to conduct the research has obtained from the Helsinki committee - Gaza Strip (Ethical committee).
2. Each participant in the study has received a complete explanation about the research purpose, confidentiality, and it is optional according to his wish to share in or to refuse.
3. UNRWA health department at Gaza Field was informed and approval letter with recommendations has obtained, in addition to their direct supervision and support.
4. Anonymity and confidentiality has been given and maintained at all levels of study, with optional participation in the study was respected. A consent form has been given and signed before data collection**.**

3.8 Instrument

The questionnaire was a self-constructed questionnaire, which include close-ended questions, Likert scale, and open questions. It was designed to be clear and easy to read with no complex terms, no leading questions, and no duplication or double parallel questions. The original questionnaire was formulated in Arabic (annex 8) then translated into English (annex 6), the Arabic version was reviewed by a list of eleven experts (annex 10) to judge its validity and ability to answer the research questions. Later on, it was tested for reliability in the pilot study of 30 HCPs from five health centres among the five GG. The questionnaire was divided into four parts with a total of 106 questions. The first part contained 12 questions (1-12) about the sociodemographic data. The second part contained 83 questions (13- 95) that covered seven dimensions about HCPs knowledge, perception, experience, challenges, barriers, features, and characteristics of communication between HCPs. The seventh dimension

was about differences in communication characteristics among persons HCPs and their organizations. The characteristics are grip vine, rumors, mutual respect, transparency, equity, openness, discrepancy, competition, conflict; political balance and others as those reflecting the communication status. The third part included 9 questions about the process of communication where the sender was asked about the feedback, the receiver was asked about the aim of the message, and both of them about documentation, the channel, language and other points of the process. The fourth part was open questions to reflect HCPs opinions, areas of weak and strength points in communication and how to improve it.

3.9 Data Collection

Data has been collected by the researcher himself, an assistant of the senior medical officer (SMO) and a senior staff nurse (SSN) of each health center using the self- constructed questionnaire. The assistants have received a complete explanation about the purpose, objectives, construction and meaning of each question before data collection. They are qualified with Master Degrees in public health with an experience in data collection. The researcher supervises the work through the time of data collection, which had started in October 2009 and finished in a period of one month. Guidelines were applied to all centers in the same manner. The methodology was discussed at several stages before and during data collection to ensure similar and good quality during practice.

3.10 Data Analysis

3.10.1 Data Measurement

In order to be able to select the appropriate method of analysis, the level of measurement must be understood. For each type of measurement, there is/are appropriate method/s that

can be applied. In this research, ordinal scales were used. Ordinal scale is a ranking or a rating data that normally uses integers in ascending or descending order. The numbers assigned to the importance (1, 2, 3, 4, 5) do not indicate that the interval between scales are equal, nor do they indicate absolute quantities; they are merely numerical labels. Based on Likert scale we have the following rating:

Item	**Very Low**	**Low**	**Middle**	**High**	**Very High**
Scale	1	2	3	4	5

3.10.2 Statistical analysis Tools

The researcher use both qualitative and quantitative data analysis methods. The Data analysis was done by utilizing SPSS 15, and the following statistical tools:

1) Cronbach's Alpha for Reliability Statistics.
2) Spearman Rank correlation for Validity.
3) Frequency and Descriptive analysis.

3.11 Validity and reliability of the instrument

3.11.1 Validity of the instrument

3.11.1.1 Face validity: To ensure face validity, the questionnaire was arranged in a good manner written by clear easy fonts, without mistakes, papers of good quality and clear defined questions.

3.11.1.2 Content validity: The questionnaire submitted to a panel of experts to evaluate the content, domains, relevance and the ability of the questionnaire to achieve the objectives of the study. The questionnaire rechecked after notice and follow-up.

3.11.1.3 Construct validity index: The questionnaire is self-constructed structured to answer the research questions and composed of both open and close ended questions, where 5 point scale was used to give a chance to the participant to express himself correctly and to increase answers richness. It was arranged in an appropriate order to describe the status of communication between HCPs. The questionnaire was reviewed by (11) experts interested in management, quality experts, communications, and research. Their suggestions have been taken into consideration.

3.11.2 Reliability of the instrument

The questionnaire was revised and refined again, pre-tested with a pilot study of 30 participants, and the final questionnaire was generated before data collection and then was administered to all HCPs in the five main health centers. To enhance reliability of the instrument, the following actions have been done:

- Training of data collectors; senior medical officers (SMO) and senior stuff nurses (SSN) working in the five main health centers.
- Standardization of the tools used in the five main health centers.
- Unifying the implementation procedures.
- Pilot study and re-checking. Cronbach's Alpha was found later to be equal to 0. 93

3.12 Pilot Study The pilot study has been conducted by the researcher prior to data collection by using a sample of total 30 HCPs. As 6 HCPs from each center: two physicians, two nurses and two paramedical staff. It was conducted to examine the response rate, clarity, suitability or difficulties in the questions, time needed to answer the questionnaire. The response rate in pilot study was 100%. In the light of the pilot study some useful modifications were done, and the questionnaire was finalized. A plan of action

guidelines was set for data collection. The health care provides who participated in the pilot study were not included in the study population.

3.12.1 Construct validity: Testing each dimension and the whole questionnaire shown in the following table

Table (3.1) Correlation Coefficient of each dimension and of the whole Questionnaire

Dime. No.	Field	Spearman Correlation Coefficient	P-Value (Sig.)
1.	Knowledge of (HCPs) about communications.	0.16*	0.004
2.	Perception of HCPs about the subject communications.	.352*	0.000
3.	Experience of HCPs about communications.	.293*	0.000
4.	Features and characteristics of comm. between HCPs.	.468*	0.000
5.	Communication & Challenges facing HCPs during work.	.673*	0.000
6.	Communication and Barriers facing HCPs.	.661*	0.000
7.	Informal communication by Rumors Grip vine. (pers. & organ)	.233*	0.000
8.	Communication and Mutual respect. (pers. & organ)	.523*	0.000
9.	Communication and Transparency. (pers. & organ)	.490*	0.000
10.	Communication and Equity. (pers. & organ)	.520*	0.000
11.	Communications and Openness. (pers. & organ)	.357*	0.000
12.	Communications and Discrepancy. (pers. &organ)	.206*	0.000
13.	Communication and Competition / Conflict. (pers. & organ)	.574*	0.000
14.	Communication and Political balance. (pers. & organ)	.415*	0.000
15.	Comm. and Access to data /Information. (pers. & organ)	.333*	0.000
16.	Communications and Chain of commands. (pers. & organ)	.406*	0.000
17.	Communication and Documentation. (verbal or non verbal)	.338*	0.000
18.	**Differences between Personal (HCP) and Organ. Characters.**	**.781***	**0.000**

- Correlation is significant at the 0.05 level

Table (3.1) clarifies the correlation coefficient for each dimension and the whole questionnaire. The p-values (Sig.) are less than 0.05, so the correlation coefficients of the

entire dimensions are significant at $\alpha = 0.05$, so it can be said that the dimensions are valid to measure what it was set for and to achieve the aim of the study.

3.12.2 Reliability Statistics

Table (3.2) Cronbach's Alpha for each dimension and the entire questionnaire

Dim. No.	Field	Cronbach's Alpha	Reliability Coefficient*
1.	Knowledge of (HCPs) about communication	0.671	0.819
2.	Perception of HCPs about the subject communications.	0.828	0.910
3.	Experience of HCPs about communications.	0.846	0.920
4.	Features and characteristics of communication between HCPs.	0.248	0.498
5.	Communication & Challenges facing HCPs during work.	0.927	0.963
6.	Communication and Barriers facing HCPs.	0.868	0.932
7.	Informal communication by Rumors/Grip vine.	0.612	0.782
8.	Communication and Mutual respect. (pers. & organ)	0.600	0.774
9.	Communication and Transparency. (pers. & organ)	0.785	0.886
10.	Communication and Equity. (pers. & organ)	0.741	0.861
11.	Communications and Openness. (pers. & organ)	0.399	0.632
12.	Communications and Discrepancy.(pers. &organ)	0.298	0.546
13.	Commun. and Competition / Conflict.(pers. & organ)	0.577	0.759
14.	Commun. and Political balance. (personal & organ)	0.565	0.752
15.	Communication and Access to data/ Information.	0.801	0.895
16.	Commun. and Chain of commands.(pers. & organ)	0.475	0.689
17.	Communication and Documentation (verbal / non verbal)	0.497	0.705
18.	Differences between Personal (HCP) and Organization.	0.874	0.935
19.	**Total**	**0.868**	**0.931**

- **Reliability Coefficient = Square root of Cronbach's Alpha**

Table (2) shows the values of Cronbach's Alpha and the reliability coefficient for each dimension of the questionnaire and the entire questionnaire. For the fields, values of reliability coefficients were in the range from 0.498 and 0.963. This range is considered high; the result ensures the reliability of each dimension of the questionnaire. Reliability

coefficient equals 0.931 for the entire questionnaire which indicates an excellent reliability of the entire questionnaire. Thereby, it can be said that the researcher proved that the questionnaire was valid, reliable, and ready for distribution for the population.

3.13 Limitations of the Study

1) Time factor.
2) Family work load.
3) Work overload.
4) Unstable and intermittent electrical current.
5) Family needs in general as recreation.

3.14 Response rate

Out of the total of 291 subjects, Those who had responded and gave answers are 280, two questionnaire forms are discarded with acceptance of 278 subjects (99%) of the questionnaire forms. Response rate was 95.5%.

Chapter Four

Results & Discussion

4. Results & Discussion

This chapter is presenting the results and discussions created by researcher on the data collected from answers of respondents in relation to communication process, domains , different work situations at UNRWA health centers to achieve research objectives.

4.1 Characteristics of Study Population

Table (4.1) Shows the distribution of the study population according to selected sociodemographic data

Subject	Classification	Number	Percent
Profession	Doctors	96	34.5%
	Nurses	100	36.0%
	P.M	82	29.5%
Gender	Male	135	48.6%
	Female	143	51.4%
Age	20-29	51	18.35%
	30-39	81	29.1%
	40-49	95	34.2%
	50-60	51	18.35%
Level of Qualification	Diploma	114	41.0%
	Bachelor	126	45.3%
	Master	38	13.7%
Country of Qualification	Palestine	181	65.1%
	Arab Country	52	18.7%
	Non Arab	45	16.2%
Total Years of Experience	< 10 years	103	37.1%
	10-19 years	65	23.4%
	20-29 years	90	32.4%
	> 30 years	20	7.2%
Experience Years at UNRWA health Centers	< 10 years	144	51.8%
	10-19 years	71	25.5%
	20-29 years	56	20.1%
	> 30 years	7	2.5%

As shown in Table 4.1 profession was divided into three groups doctors 34.4%, nurses 36% and para medical (PM) 29.5%, the highest percent was for nurses.

In relation to gender distribution 51.4% of HCPs was female. In relation to age group; the study shows that the size of both age groups 20-29 and 50-60 was the same and equal to 18.35%. that's mean the percentage of replacement are nearly equal to the retired percentage.

The level of qualification shows that the higher percentage (45.3%) was for Bachelor compared with those having Master degree (13.7%).

In relation to country of last qualification, the highest percentage was for those who were qualified from Palestine, it was equal to (65.1%). It was attributed to the presence of medical universities and nursing schools in Palestine and preference of Palestinian to study in the local universities due to economical, political , and siege factors.

In relation to total years of experience, the results found that (37.1%) of the study population had total experience less than 10 years; when compared with the experience of less than 10 years at UNRWA health centers (51.8%) the difference was (14.7%), that's may be attributed to presence of many persons join to work at UNRWA after getting experience from other places, which may affect their knowledge, perception and experience in communication from different places.

The following tables are going to explore the status of HCPs knowledge, perception and experience in communication.

4.2 Knowledge of HCPs about communication

Table 4.2: Shows HCPs knowledge about communication.

Response	Did you study the communication subject during your academic curriculum (%)	Did you get training course about communication? (%)	Did you have any special course on communicatio n skills? (%)	Did you have any self-learning on the subject communication? (%)	**Knowledge** of HCPs about communicat -ion. (%)
Yes	**26.3**	**19.1**	**9.0**	**46.8**	**25.3**
No	**73.7**	**80.9**	**91.0**	**53.2**	**74.7**
Chi-Square Test Value	**62.68**	**106.42**	**186.99**	**1.17**	**272.03**
Degrees of freedom	**1**	**1**	**1**	**1**	**1**
P-Value	**0.000***	**0.000***	**0.000***	**0.280**	**0.000***

*There is a significant difference between the two proportions of Yes and No at p-value of 0.05 level.

The results give the following discreption

Only quarter (26.3%) of HCPs had previous knowledge about communication from their previos academic study; 19.1% had trainning on communication in general; and 9% only had training on communication skills. The net result of HCPs knowledge about communication was 25.3% of them had knowledge about communication. The results was statisticaly significant except one; the question was on the subject of self learning. These findings put the the light over the importance of teaching the subject of communication in schools and during academic study, and start implemntation of trainning on communication during work.

4.3 Perception of HCPs about communication

Table 4.3: Shows HCPs perception about communication

Response	Do you see that your communication with health care providers is vital for patients. (%)	Do you believe that; use of verbal communication skills provides you with more information about the patient? (%)	Do you believe that; for best patient service is to talk face-to-face with HCPs, that's provide you with more information about patient? (%)	According to perception ; Do you see that; it is essential to send a feedback to the sender? (%)	**Perception** of HCPs about the subject communication (%)
Very Low	1.1	0.7	0.4	2.5	1.2
Low	0.7	1.4	2.9	3.3	2.1
Middle	5.1	5.8	9.0	19.3	9.8
High	34.7	34.2	29.6	32.4	32.7
Very High	58.5	57.9	58.1	42.5	54.3
Mean	**89.75**	**89.42**	**88.45**	**81.82**	**87.33**
Sign Test Value	**15.54**	**15.38**	**14.68**	**12.68**	**15.67**
P-Value	**0.000***	**0.000***	**0.000***	**0.000***	**0.000***

*** The mean is significantly different from the 60% (Middle value) at 0.05 level**

The results shows higher level of significance of HCPs about communication as it is vital for patients by the mean of 89.75 %, verbal communication skills provides HCPs with more information about the patient by the mean of 89.42%, and HCPs face- to-face communication, provides them with more information about patients by the mean of 88.45%. The net result of the HCPs perception about communication was highly significant with the mean percent of 87.33% with P-value 0.000, which is accepted and reflect the positive perception of HCPs about importance and the need for communication for patients health, and effect of skills on the richness of information especially in situation of face to face communications.

4.4 Experience of HCPs in communication

Table 4.4: Shows HCPs experience in communication.

Response	Do you have an experience to use communication tools available in HC? (%)	Do you have practical experience in communication skills? (%)	Did you find HCPs working with you had experiences in practice of communication skills? (%)	Do you have the experience in communication during emergency? (%)	**Experience** of HCPs about communications (%)
Very Low	6.1	24.5	12.9	10.4	13.5
Low	10.1	15.5	22.3	18.0	16.5
Middle	18.1	24.9	39.6	32.4	28.7
High	32.5	23.1	20.1	21.6	24.3
Very High	33.2	11.9	5.0	17.6	16.9
Mean	75.31	56.46	56.40	63.60	62.89
Sign Test Value	9.03	-0.90	-2.08	2.12	3.09
P-Value	0.000*	0.184	0.019*	0.017*	0.001*

*The mean is significantly different from the 60% (middle value) at 0.05 level.

The mean of HCPs experience about communications equals to 62.89%, test value = 3.09, and p-value = 0.001 which is smaller than the level of significance of $\alpha = 0.05$. So the mean for HCPs experience about communication is significantly greater than the middle value of 60%. My conclusion is that, the respondents agree on HCPs had experience on the use of communications tools available at the HC, and no practical communication skills, but they had experiences on communication during emergency.

These results support the need for more training on practical communication skills.

4.5 HCPs Knowledge, Perception and Experience With the selected Sociodemographic Characters

Profesion

Table (4.5): Kruskal-Wallis test for Knowledge , Perception & Experience (KPE) with Profesion

Dimension	Test Value	df	P-value Sig.
Knowledge of HCPs about communication	5.381	2	0.068
Perception of HCPs about the communication	3.951	2	0.139
Experience of HCPs in communications	14.355	2	**0.001***

*Means differences are significant at $\alpha = 0.05$

Table (4.5) shows that the p-value (Sig.) is greater than the level of significance $\alpha = 0.05$ for the knowledge and perception dimensions, then there is insignificant difference among the respondents toward the knowledge and perception dimensions due to profesion.

Table shows that profesion has no effect on the knowledge and perception of HCPs but there is significant difference among the respondents toward the experience in communications due to profesion.

So we conclude that the respondents' experience in communications has statistically significant effect on the profesion.

The following tables shows ranking of Knowledge, Perception and Experience in relation to specific profesion.

Table (4.6): Shows the Mean rank of KPE with Profesion

Dimension	Mean Rank		
	Doctors	**Nurses**	**PMS***
Knowledge of HCPs about communication.	147.3	125.4	**147.5**
Perception of HCPs about communications	140.1	**149.7**	126.3
Experience of HCPs in communications	125.5	**163.8**	126.3

* Para Medical Staff

From table (4.6), we conclude the following differences:

Nurses have the highest mean among the others groups in their perception and experience of communication, but the PMS have the highest mean of knowledge among the others. Doctors had the lowest mean in experience than others. Nurses had the lowest knowledge. PM had the lowest mean in communication perception. Accordingly the communication status as follow: communication performed better by nurses and PM staff than doctors at UNRWA health centers. So, training for doctors to improve their communication status at UNRWA health centers.

4.5.2 Gender

Table (4.7): Mann-Whitney test of the dimensions with Gender

Dimension	Test value	P-value (Sig.)
Knowledge of HCPs about communication	-1.384	**0.166**
Perception of HCPs about communications	-0.283	**0.777**
Experience of HCPs in communications	-1.660	**0.097**

Table (4.7) shows that the p-value (Sig.) is greater than the level of significance $\alpha = 0.05$ for each dimension, then there is insignificant difference between the respondents toward the knowledge, perception, and experience of HCPs about communications due to gender.

We conclude that the respondents' gender has no effect on the knowledge, perception, and experience of HCPs about communications. These results was congruent with Abu Riala, A. (2006). results in relation to perception of communication and gender where no statistical differences present with P value= 0.562.

4.5.3 Age

Table (4.8): Kruskal-Wallis test for knowledge perception and experience with Age

Dimension	Test Value	df	P-value Sig.
Knowledge of HCPs about communication	**2.193**	3	**0.533**
Perception of HCPs about communications	**13.938**	3	**0.003***
Experience of HCPs in communications	**2.240**	3	**0.524**

- Means differences are significant at $\alpha = 0.05$

Table (4.8) shows that the p-value (Sig.) is greater than the level of significance $\alpha = 0.05$ for knowledge, and experience of HCPs about communications dimensions, then there is insignificant difference among the respondents toward the knowledge, and experience of HCPs about communications dimensions due to age. That's show the respondents' age has no effect on the knowledge, and experience of HCPs about communications, but there is significant difference among the respondents toward their perception of communications. So we conclude that the respondents' age group has significant effect on their perception of communications. These results was congruent with results obtained by Abu Riala, A. (2006) that there is significant statistical differences among age groups (21-32 and 33-44) with (p value= 0.009). The following table shows ranking of Knowledge, Perception and Experience in relation to age groups.

Table (4.9): Mean rank of knowledge perception and experience with Age group

Dimension	Mean Rank			
	20-29	**30-39**	**40-49**	**50-60**
Knowledge of HCPs about communication	129.8	**148.0**	135.7	142.7
Perception of HCPs about communications	105.7	139.3	**157.0**	141.0
Experience of HCPs in communications	139.4	130.3	**148.3**	137.7

From table (4.9), we conclude the following:

The highest knowledge was with age group 30-39. The highest perception and experience was with age group 40-49 years old. According to these results we can recommend planed lectures, workshops and training on communication with priority to young age groups to improve their knowledge about communication, also we can say that tasks needs special communication can be given to HCPs with age group 40-50 years old. The decrease in the mean after the age 50 years in knowledge, perception and experience could be explained by age frustration.

4.5.4 Level of qualification

Table (4.10): Kruskal-Wallis test for knowledge perception and experience with level of qualification

Dimension	Test Value	df	P-value Sig.
Knowledge of HCPs about communication	1.442	2	0.486
Perception of HCPs about communications	1.250	2	0.535
Experience of HCPs in communications	6.519	2	**0.038***

* Means differences are significant at $\alpha = 0.05$

Table (4.10) shows that the p-value (Sig.) is greater than the level of significance $\alpha = 0.05$ for knowledge and perception dimensions, then there is insignificant difference among the

respondents toward the knowledge and perception due to level of qualification. That's mean the respondents' level of qualification has no effect on their knowledge and perception of communication, but there is significant difference in experience of HCPs communications due to level of qualification. We conclude that the respondents' level of qualification has significant effect on their experience in communications. These results was congruent with results obtained by Abu Riala, A. (2006) that there is no statistical significance between perception and level of qualification (P value = 0.304).

The following table shows ranking of Knowledge, Perception and Experience in relation to level of qualification.

Table (4.11):Shows Mean rank of knowledge perception and experience with level of qualification

Dimension	Mean Rank		
	Diploma	**Bachelor**	**Master**
Knowledge of HCPs about communication	**144.3**	138.8	127.4
Perception of HCPs about the communications	137.0	137.8	**152.8**
Experience of HCPs in communications	149.8	126.1	**153.1**

From table (4.11) we conclude the following: Perception and experience of Master holders had the highest mean rank among others in communication.

4.5.5 Country of last qualification.

Table (4.12): Kruskal-Wallis test for knowledge perception and experience with country of last qualification

Dimension	Test Value	df	P-value Sig.
Knowledge of HCPs about communication	3.068	2	0.216
Perception of HCPs about the communications	1.133	2	0.567
Experience of HCPs in communications	4.288	2	0.117

Table (4.12) shows that the p-value (Sig.) is greater than the level of significance $\alpha = 0.05$ for each dimension, then there is insignificant difference among the respondents toward the knowledge, perception, and experience about communications due to country of last qualification. We conclude that the respondents' country of last qualification has no effect on the knowledge, perception, and experience of HCPs about communications. The same results obtained by Abu Riala, A. (2006) in relation to communication perception and country of last qualification as there is no significant relation ship between them with P value = 0.321.

4.5.6 Total years of experience.

Table (4.13): Kruskal-Wallis test for knowledge perception and experience with total years of experience

Dimensions	Test Value	df	P-value Sig
Knowledge of HCPs about communication	5.962	3	0.113
Perception of HCPs about communications	6.522	3	0.089
Experience of HCPs in communications	3.227	3	0.358

Table (4.13) shows that the p-value (Sig.) is greater than the level of significance $\alpha = 0.05$ for each dimension, then there is insignificant difference among the respondents toward the

knowledge, perception, and experience of HCPs about communications due to total years of experience. We conclude that the respondents' total years of experience has no effect on the knowledge, perception, and experience of HCPs about communications.

4.5.7 Years of experience at UNRWA Health Centers.

Table (4.14): Kruskal-Wallis test for years of experience at UNRWA Health Centers

Dimension	Test Value	df	P-value Sig.
Knowledge of HCPs about communication	**2.599**	3	0.458
Perception of HCPs about communications	**9.661**	3	**0.022***
Experience of HCPs in communications	**3.489**	3	0.322

*Means differences are significant at $\alpha = 0.05$.

Table (4.14) shows that the p-value (Sig.) is greater than the level of significance $\alpha = 0.05$ for knowledge, and experience of HCPs about communications dimensions, then there is insignificant difference among the respondents toward the knowledge, and experience due to years of experience in UNRWA Health Centers. That's mean the respondents' years of experience at UNRWA Health Centers has no effect on their knowledge and experience in communications, But there was a significant difference among the respondents toward the perception due to years of experience at UNRWA Health Centers. We conclude that the respondents' years of experience at UNRWA Health Centers has an effect on their perception about the subject communications**.** The following table shows ranking of Knowledge, Perception and Experience in relation to years of experience at UNRWA health centers.

Table (4.15): Shows mean rank of knowledge perception and experience with Years of experience at UNRWA H/Cs

Dimension	Mean Rank			
	0-10	10-19	20-29	30-40
Knowledge of HCPs about communication	139.7	131.4	144.9	**174.5**
Perception of HCPs about the communications	126.7	**159.3**	149.9	118.6
Experience of HCPs in communications	132.1	146.5	**152.0**	121.5

From table (4.15), we conclude the following differences: The highest mean rank of knowledge about communication was with years of experience at UNRWA (30-39) years. The highest mean rank of perception of communication was with years of experience at UNRWA (10-19) years. The highest mean rank of experience about communication was with years of experience at UNRWA (20-29)years.

4.6 Relationship between socio-demographic characters and selected componants from communication process

Cross tabulation of the independent sociodemographic variables with dependent communication process variables are shown in the following table

Table (4.16): show's the relationship between socio-demographic characters and selected componants in the communication process

Socio-demographic characters	Communication process components					
	Feedback	Message	Skills	Documentations	Channel	Language
Profession (Q# 1)	0.106	**0.049***	0.533	0.098	0.052	0.605
Gender (Q# 2)	0.859	0.856	0.554	0.258	0.641	0.372
Age[1] (Q# 3)	0.297	0.831	0.796	0.695	0.182	0.793
Level of qualification (Q# 7)	0.585	**0.011***	0.638	0.054	0.366	0.491
Country of last qualification (Q# 8)	0.305	0.231	0.518	**0.037***	**0.038***	0.347
Total years of experience[2] (Q# 9)	0.521	0.395	0.537	0.323	0.712	0.976
Years of experience in UNRWA H. Centers[2] (Q# 10)	0.677	0.660	0.477	0.518	0.889	0.873

*** There is a significant relationship between the two variables at 0.05 level**

1. Age is calssified as groups: 20-29, 30-39, 40-49, and 50-60.

2. Experience[2] is calssified s groups: 0-9, 10-19, 20-29, and 30-40.

4.6.1 Feedback

As shown in table (4.16) for each of socio-demographic characters and Feedback, according to chi-square test, the p-values are greater than the level of significance of 0.05, and hence there is insignificant relationship between socio-demographic characteristics and Feedback.

4.6.2 Message

As shown in table (4.16) there is a significant relationship between the message and profession also between message and the level of qualification, since the p-values = 0.049 and 0.011, respectively, which are smaller than the level of significance of 0.05. This significant relationship was going with the fact that suitable person for the suitable place.

4.6.3 Skills

As shown in table (4.16) socio-demographic characters had no significant relationship with the skills, where the p-values are greater than the level of significance of 0.05.. This result can be attributed to the lack of skills, and HCPs being nearly similar.

4.6.4 Documentation

As shown in table (4.16) there is a significant relationship between documentation and country of last qualification**,** since the p-value = 0.037, which is smaller than the level of significance of 0.05.

4.6.5 Channel

As shown in table (4.16)There is a significant relationship between Channel and Country of last qualification, since the p-value = 0.038, which is smaller than the level of significance of 0.05.

The selection of channel is a matter of available facilities in our special situation as Palestinians; always we are in a situation of emergency or semi emergency. So, locally qualified employees would have enough positive practice during their education or work.

4.6.6 Language

For each of the socio-demographic variables and Language, according to chi-square test, the p-value is greater than the level of significance of 0.05, and then there is no significant relationship between socio-demographic variable and Language.

In spite of the fact that the HCPs working with UNRWA official language of communication is English still they prefer to communicate in Arabic and they do not care speaking in English as the majority of them have graduated from local Palestinian higher education institutions.

4.7 Challenges facing HCPs communication

Table 4.17: Shows challenges facing HCPs and their Ranking.

No	Challenge	Mean	Proportional Mean%	Test value	P-value (Sig.)	Rank
1.	Overcoming the crowdedness.	4.10	81.94	13.30	0.000*	1
2.	Building good interpersonal relations with HCPs.	3.68	73.53	10.03	0.000*	12
3.	Community perception of gender.	3.72	74.46	9.96	0.000*	11
4.	Developing HCPs, source of knowledge on communication.	4.00	79.93	12.35	0.000*	3
5.	Developing HCP, practical skill on communication.	4.03	80.65	12.63	0.000*	2
6.	Achieving patients health needs.	3.96	79.28	12.24	0.000*	5
7.	Evaluation of communication process.	3.82	76.47	11.14	0.000*	8
8.	Supervision of communication process.	3.78	75.51	10.45	0.000*	10
9.	Training of HCP on communications.	3.79	75.90	9.87	0.000*	9
10.	Improving communication infrastructure of health centers management.	3.83	76.59	9.82	0.000*	7
11.	Training on skills of good listening	3.97	79.42	11.70	0.000*	4
12.	Developing the HCPs ability to understanding.	3.86	77.19	10.98	0.000*	6
	Total	3.88	77.55	13.62	0.000*	

*The mean is significantly different from 3.

As shown in table (4.17), this result indicates that the challenges mentioned in the table have strong relationship with communications among the HCPs at UNRWA health centers in the GG. Hence all the items mentioned in questions 31 to 42 represent real challenges to health workers at UNRWA, and should be taken care of by the responsible persons or the decision makers. The mean of the dimension "Communication & Challenges facing HCPs during work." equals 77.55%, test value=13.62, and P-value = 0.000, which is smaller than the level of significance of $\alpha = 0.05$. Then the mean of this dimension is significantly greater from the hypothetical value of 60%. Ranking of challenges according to table, the first three challenges were: Overcoming crowdedness, developing practical skills and developing source of knowledge.

4.8 Barriers facing HCPs communication

Table 4.18: Shows barriers facing HCPs and their ranking.

No	Barrier	Mean	Prop Mean%	Test value	P-value	Rank
1	Vague administrative instruction	4.03	80.58	12.01	0.000*	4
2	Contact with Selective personality	3.72	74.37	8.76	0.000*	8
3	Muddled message with unclear objective	4.22	84.35	13.16	0.000*	1
4	Selection of wrong channel	4.18	83.65	13.05	0.000*	2
5	Interpersonal problems	3.65	72.97	7.35	0.000*	9
6	Neglecting feedback from receiver side	3.85	76.95	10.54	0.000*	7
7	Political differences between HCPs	3.34	66.79	4.23	0.000*	10
8	Interruption during verbal communication	3.94	78.84	11.53	0.000*	6
9	One-way chain of communication.	3.99	79.78	12.05	0.000*	5
10	Lack of concentration.	4.09	81.87	12.45	0.000*	3
	Total	3.90	78.00	13.29	0.000*	

*The mean is significantly different from 3

As shown in table (4.18), this result indicates that the barriers mentioned in the table have strong relationship with communications among the HCPs at UNRWA health centers in the Gaza strip. Hence all the items mentioned in questions 43 to 52 represent real barriers to health workers at UNRWA, and should be taken care of by the responsible persons or the decision makers. These results are going with Robbins, P. Stephen (2003) Essentials of Organization Behavior who have similar results. Ranking of first three barriers were as follow: Muddled message with un clear objective, selection of wrong channel and Lack of concentration.

4.9 Channels and Tools most commonly used or preferred by HCPs

4.9.1 Commonly used channel The following table represent respondent answers on the most commonly used channel at UNRWA HC

Table 4.19: Shows mean percent of HCPs were using Verbal channel in communication

Paragraph	Mean	Proportional Mean%	Test value	P-value (Sig.)
Does most of your communications are verbal?	3.35	67.00	4.82	0.000*

*The mean is significantly different from 3

The table shows that 67.00% of respondents use verbal communication where the P-value = 0.000, which is smaller than the level of significance of $\alpha = 0.05$. So the majority of HCPs highly use verbal communication during their work at UNRWA health centers.

4.9.2 Preferred tool used in normal situation

The following table represent respondent answers on the preferred tool used for communication at UNRWA HC in normal situation.

Table 4.20: Shows ranking of Preferred Tool for Communication in normal situations

Preferred tool for communication	No of Respondents	Percent	Rank
Face to face	234	84.17%	1
Telephone	18	6.47%	2
Written message	8	2.88%	3
Email	6	2.16%	4
Intercom	4	1.44%	5
Wireless Call	4	1.44%	5
SMS	2	0.72%	7
Voice messages	2	0.72%	7
Total	278	100.00%	

As shown in the above table, about 84.17% of the respondents prefer face to face communication in normal situations.

4.9.3 Preferred tool used in emergency situation

Table 4.21: Shows ranking of the preferred tool for communication in emergency

Tools used during emergency	No of Respondents	Percent	Rank
Telephone	86	31.73%	1
Wireless Call	80	29.52%	2
Face to face	76	28.04%	3
SMS	20	7.38%	4
Intercom	4	1.48%	5
Written message	2	0.74%	6
Voice messages	2	0.74%	6
Email	1	0.37%	8
Total	271	100.00%	

As shown in the above table, 31.73% of HCPs prefer telephone while 29.52% prefer wireless and third one was for face to face communication the results shows that during emergency HCPs tend to use different tools.

4.9.4 Preferred tool used during meetings

Table 4.22: Shows ranking of the preferred tool for communication during meetings

Preferred tool for communication	**No of Respondents**	**Percent**	**Rank**
Face to face with power point	181	67.04%	**1**
Face to face	87	32.22%	**2**
Videoconference	2	0.74%	**3**
Total	**270**	**100.00%**	

The above table (4.22) shows that face to face with power point presentation is the preferred communication tool during meeting.

From the previous results it is found that the preferred tool for communication in normal situation was face to face while telephone and wireless preferred during emergency, that's assure the need for more investment in the infrastructure in wireless and recent electronic communication tools; on the other side during meeting the priority was for face to face meeting with power point communications.

4.9.5 Communication Tools Available at Workplaces

Table 4.23: show the tools of communication present at work places

Tools of Communication	Number	Percent
Telephone	150	54
Mobile	5	1.8
Nothing	123	44.2
Total	278	100.0

Table (4.23) shows that 54% of respondents had telephone in their work place that's direct the attention toward to offer at least telephone in each station. Second, UNRWA offers mobile phone freely charged and wireless station for health center communication, 44.2%the respondents answers were nothing available, that's reflect lack of knowledge about the available tools they can use. Other thing wireless is available at each center and can be used for emergency calls, but the respondents does not mention it, also that's may be due to lack of practice how to use it in emergency situation; may be due to lack of training on it.

These findings direct our attention toward increasing the awareness of staff members about the available resources and to start practical training for all HCPs on skills of using available resources. Recently at the time of this study, UNRWA started to support the infrastructure by internet for each health center for communication and computerized system for data collection and announce year 2010 as year of communication.

4.10 Features of Communications

The following table represent respondent answers on the features and Characteristics of communications at UNRWA health centers

Table 4.24: Features of HCPs communication

No	Paragraph and question number	Mean	Proportional Mean%	Test value	P-value	Rank
1	Does the communication between HCPs aimed to clarify or explain procedures that should be done to the patient?	3.90	77.99	11.62	0.000*	1
2	Does community culture support man as HCP more to achieve his goals by verbal communication?	3.34	66.79	4.94	0.000*	2
3	During emergency, do verbal instructions are sufficient for you to provide the service for patient?	3.33	66.62	5.90	0.000*	3
4	Does; community culture supports women as HCP more, to achieve her goals by verbal communication?	3.18	63.53	3.02	0.003*	4
5	Are women able to achieve difficult tasks by verbal communications rather than men?	2.91	58.11	0.36	0.715	5
	Total	3.33	66.66	7.75	0.000*	

***The mean is significantly different from 3

The results shows that the main features are: The first rank was 77.99% to clarify and to explain the procedures that should be done for the patient, the second rank 66.79% of respondents emphasize on community culture support man to achieve goal by verbal communication. The third feature was 66.62% of respondents provide verbal instructions are sufficient during emergency. The fourth feature was community culture supports woman to achieve their goals by verbal communications. The fifth rank was insignificant result in relation to woman ability to achieve difficult task by verbal communications.

4.11 Characterestics of HCPs Communication

Ranking of communication characters according to HCPs perception

The following table 4.25 shows the results according to HCPs answers which describes the communication characteristics of HCPs and their ranking.

Table (4.25): Shows ranking of communication characters according to HCPs perception

UNRWA		Health Care Providers perception				
Communication characteristics		Mean	Proportional Mean%	Test value	P-value (Sig.)	Rank
1	Mutual respect.	3.61	72.14	10.18	0.000*	1
2	Transparency.	3.39	67.81	6.60	0.000*	2
3	Equity.	3.32	66.47	6.24	0.000*	3
4	Political balance.	3.15	63.02	2.20	0.028*	4
5	Competition OR Conflict	3.06	61.21	2.52	0.012*	5
6	Openness.	3.04	60.76	0.07	0.946	6
7	Rumors and Grip vine	2.97	59.47	0.00	1.000	8
8	Discrimination	2.95	59.00	-1.09	0.275	7

- The mean is significantly different from 3
-

The results of communication characterestics analysis at personal and organizational levels shows high degree of statistical significans; where HCPs communication characterized by mutual respect 72.14% , transperancy 67.81%, equity 66.47%, political balance 63.02%, and compititiion 61.21%, while the lowest rank was insignificant for characters of openess 60.76% . Both rumors and gripvine are present but not significant at both HCPs levels including the leaders and at organizational level with p-value= 1(in the mid point). The result of discremenation character was insignificat with negative test value, that mean it is not presnt at both personal and organizational level.

4.12 Differanceses in characters personal and organizational

Table (4.26): Shows the Differences in Communication Characteristic between HCPs, leaders and their organization

Subject of characterestic differences	UNRWA as Organization	UNRWA HC staff Leaders & HCPs		Test Value	P-value (Sig.)
Rumors	3.36	3.51		-1.897[(a)]	0.029*
Grip vine	2.89	3.43	1.68	210.923[(b)]	0.000*
Mutual Respect	3.16	3.41	3.94	148.909[(b)]	0.000*
Transperancy	3.17	3.64	3.36	40.136[(b)]	0.000*
Equity	3.29	3.16	3.52	18.938[(b)]	0.000*
Openess	3.00		3.07	-.832[(a)]	0.406
Discremenation	3.00	3.00	2.83	6.087[(b)]	0.048*
Competition	2.94		3.23	-4.523[(a)]	0.000*
Conflict	2.89		3.18	-3.635[(a)]	0.000*

(a) Wilcoxon signed-rank test is used

(b) Friedman test is used

* The mean difference is significant at 0.05 level

Table (4.26) shows the results according to respondents answers in relation to the mean of each questions with its degree of significance. Wilcoxon signed- rank test was used when related two samples and Friedman test used when three related samples are present (organizational, leaders, HCPs). Annex (12) can demonstrate the proportional mean percent. The differences were summarized as follow:

Rumors as an informal news present at organizational level by 67.12% with mean 3.36 and practiced at leaders level by mean of 3.51 with 70.18% with significant P- value = 0.029. This is accepted and encouraged at organizational level and provided as motivator and essential for organization life (Davis K, 1992). The differences was more to the leaders side.

Grip vine present at organization level by mean of 2.89 equal to 57.89%, at managerial level preferred by managers by mean of 3.43 equal to 68.49%, but the mean at HCPs was 1.68 that's equal to 33.6%. Testing the differences by Friedman test give significant P- value = 0.000. That mean of grip vine is present at all levels with significant differences and highest percent was at leaders level and the least percent was at HCPs level.

Mutual respect present at all levels. At levels organizational, managerial, and HCPs level. The differences was the higher mutual respect among HCPs communication.

Transparency present at organization level by the mean of 3.17, at managerial level by mean of 3.64, and at HCPs level by the mean of 3.36. The P- value = 0.000 was highly significant. The differences was with higher transparency at leaders level.

Equity present in UNRWA communication by mean of 3.29, at leaders level by the mean of 3.16, and at HCPs by the mean of 3.52. The P-value= 0.000 was highly significant. The differences was with highest equity at HCPs level.

Openness at UNRWA communication level by the mean of 3.00, and with HCPs communication by the mean of 3.07. The P- value = 0.406 it did not reach the level of significance of 0.05. That's mean the differences were not significant at organizational communication with HCPs and in between HCPs openness in communications especially if there is medical mistake from HCP.

Discrimination in communication at organizational level by the mean of 3.00, at the leaders by the mean of 3.00, and at HCPs by the mean of 2.83. The P- value = 0.043 was significant. The differences was least feeling of discrimination at HCPs level.

Competition positively created at UNRWA level by the mean of 2.94 equal to 58.1%, and at HCPs level by mean of 3.23 equal to 64.55%. The P- value = 0.000 was highly significant with

significant difference more at personal level. Positive competition was leading cause of effective communication from HCPs point of view.

Conflict negatively created at UNRWA level by the mean of 2.89 equal to 58.1%, and at HCPs level by mean of 3.18 equal to 64.55%. The P- value = 0.000 was highly significant with significant difference more at personal level. Negative conflict was leading cause of ineffective communication from HCPs point of view.

Chapter Five

Conclusion

5. Conclusion

The status of communication among HCPs at the time of conducting the study was as follow:

HCPs **Knowledge** about communication was generally low (25.3%), where 73.7% of HCPs did not study the subject of communication during their academic course, 19% of respondents were trained on communication and only (9%) of HCPs were trained on communication skills.

Perception of HCPs about communication was high (87.3%) as it is vital for patients (89.7%), the importance of feedback (81.8%) in the communication process, and the importance of face to face communications between HCPs during work in normal and emergency situations.

Experience of HCPs in communication was moderate (62.8%). Significant relationship was found between; profesion and experience, also between the level of qualification and experience.

The best experience in communication was among nurses, and those of Master holders.

The best perception of communication among the age group 40-49 years old.

The best experience in communication attained to those had 10-19 years experience at UNRWA health centers.

Testing socio demographic data with each component of communication process showed significant relation ship between profesion and message (concise and clear aim message).

Also significant relation ship between the level of qualification and the message.

The third significant relation was between country of last qualification with documentation of verbal communication (if it is important to patient life) and selection of channel used in communication.

Ranking of challenges were as follow:
Overcoming crowdedness (81.94%), developing HCPs practical skills (80.65%), developing source of knowledge about communication (79.93%), and training on good listening (79.42%). Ranking of barriers were as follow: muddled message with unclear objective (84.35%), selection of wrong channel (83.65%), lack of concentration (81.87%), vague administrative instructions (80.58%), and one way- communication (79.78%).

To face these challenges and to overcome the barriers; training programme on the related topics was recommended to improve the status of communication among HCPs.

In normal situation, face to face was the preferred tool for communication (84.1%), but in emergency situation the preferred tool was the telephone (31.7%), followed by wireless (29.5%), and face to face (28%). During meeting, HCPs prefer face to face with power point presentation (67%).

Telephone was available to 54% of health care providers, and free charged mobile cell phone available only to 1.8% of health care providers.

The dominant feature of communication among HCPs was to clarify or to explain the procedures that should be done for patients (77.99%), verbal communication is sufficient for HCPs to follow the instruction during emergency situations (66.62%), another feature was the community culture support's women to achieve her goal by verbal communication (63.53%), but on the same time HCPs dose not agree on women ability to achieve difficult tasks by verbal communication (58.11%); the later result reflect cultural attitude to give difficult tasks for men.

Results shows that communication among HCPs at UNRWA health centers in Gaza Governorates were positively characterized by mutual respect (72.14%), transparency(67.81%), equity (66.47%), and political balance (63.02%), and positive competition was (61.21%), all these results was highly significant and agreed upon by HCPs but the insignificant results was in the answers related to openness with agreement of only (60.7%) P-value = 0.946, rumors and grip vine was 59.47% with P-value = I.00 where the respondents stay just in the mid point, but in relation to HCPs feelings of

discrimination the result was (56.7%) with P- value = -2.02 that's mean HCPs does not had this feeling when others talk to them.

Differences in characters at organizational (UNRWA), leaders(Managerial), and personal (HCPs) level was as follow:

Rumors are present at both UNRWA and leaders level with more percent at leaders level.

Grip vine present at the three level with least percent at HCPs level. Mutual respect present at all levels with higher percent at HCPs level.

Transparency present at UNRWA and leaders levels with more percent at leaders level.

Equity is present at all level with higher practice at HCPs level. Openness from HCPs point of view was not clear and the mean answers was in the mid point.

Discrimination according to HCPs point of view stay in the mid point in relation to organization and leaders but HCPs feels no discrimination in their communications.

Competitions are positively present at organizational and HCPs level with their end product as effective communication.

Conflicts are negatively present at organizational and HCPs level with their end product as ineffective communication.

Chapter Six

Recommendation

6. Recommendations

This study was conducted to understand the status of communication between HCPs at UNRWA health centers at GGs. Knowledge, perception, experience of HCPs about communication, challenges, barriers facing their communication and the most commonly used tool for communication during normal and emergency situation to put recommendation accordingly to the planners and decision makers at UNRWA health department. The following points are the recommendations of this study to improve the status of communication among HCPs at UNRWA health centers at Gaza governorates.

6.1 Recommendation to improve communication among HCPs

1-Trainning programme on the verbal, non verbal communication and their skills.

2-Including the communication subject in the curiculum of education at all levels.

3-Improving the enviroment of work places to be noise free and calm places.

4-Preparing areas spicified for protection with sutable communication infrastructre.

5-Field trainning on sendind clear messages by using avilable tools.

6-Review to all mistakes and lessons learned from the last war.

6.2 Further Studies needed on the following subjects

1-Communication between HCPs & patients.

2-Communication between HCPs & Community.

3-Interdepartmental Health Communication.

4-Electronic Health Communication.

5-Skills of communication in conflict situation.

6-Communication & breaking bad news.

7-Informal Communication.

8-Communication with women during work.

Chapter Seven

References and Anexes

7.1 References

Abedalbaqi, M. Salah Eldeen (2003)' Organizational Behavior: Modern Applied Entrance' Alexandria, Egypt, Dar Eljamea'a.

Abu Riala, A. (2006), Communication Among Gaza Nurses: Gaps and Challenges. Master thesis submitted and accepted at Al Quds University.

Adams MH, et al : Social support and health promotion life styles of the rural women, online J Rural Nurs Health Care1 (1), 2003, available on line at http://www.rno.org/journal.

Alamry, M. Saleh and Alghalby, M. Taher (2007). " Management and Business (first edition)" Amman, Jordan, Dar Hamed. Arabic Book

Alamian, S. Mahmoud (2005) ' Organizational Behavior in Business Organizations (third edition) Amman, Jordon, Dar Wael. Arabic Book

Ambrose L, Moscinski P: The power of feedback, Health care Exc 17(5):56,2002.

Anderson K: Don't worry, be happy, *Nursing* 32(1):69, 2002

Arnold E, Boggs KU: Interpersonal relationships : professional communication for nurses, Philadelphia, 1997, WB Saunders.

Antai-Otong D : Creative stress management techniques for self – renewal, *Dermatol Nurse* 13 (1): 31, 2001

Astedt-Kurki P, Isola A: Humor between nurse and patient, and among the staff: analysis of nurses diaries, J Adv Nurs 35 (3): 452, 20.

Bateman, S. Thomas and Snell, Scott (2004)' Management: The new completive Landscape (Sixth edition)' New York, USA, Mc Graw- Hill/Irwin.

Berent IM, Evan RL: The right words 350 best things to get along with people, New York, 1992, Warner Book.

Bower SA, Bower GH: Asserting yourself : Practical guide for positive change, Reading, Mass, 1991, Addison – Wesley.

Brillhart B: Henry J, Leblanc H, et al : Incorporating spirituality and life satisfaction among persons with spinal cord injury, Rehabil nurse 30 ,31, 2005.

Coggen, D., Rose, G. and Parker, D. (1993) " Epidemiology for the Uninitiated. London: British Medical Journal Publishing Group. Company: Philadelphia

Creel R: 20 ways to say no retrieved July20, 2006 at http://www on line organizing.com/Expert Advice Toolbox Tips .asp? Tip sheet =16.

Cushine P: Conflict : Developing resolution skills, ARON J 47 (3): 732, 1988.

David M. Herold and Charles K. Parsdn, "Assessing the feedback Environment in Work Organization: Development of the Joy Feedback Survey, "Journal of Applied Psychology. May1985, pp,290-305.

Dessler, Gary (2004) ' Management: Principals and practices for Tomorrow's Leaders (third edition)' New Jersey, USA, Pearson Education, Inc.

Durham, O. Marcus et al (2005) " Leadership & Success in relationship & communication" personal or internal actions, Tulsa, Dream point publishers.

Dutton J E, et al: Leading in times of trauma, Harvard Business Review 80(1):55, 2002

Egan G: The skilled helper: a problem-management and opportunity-development approach to helping, 7th edition, New York, 2006, Brooks/Cole.

Gregory H, Robert L. Cardy , Donald M. Truxillo," The effect of purpose of appraisal and individual differences in stereotype of women on sex differences in performance rating: A laboratory and field study," Journal of applied psychology, August 1989, pp.551-558.

Green L: Making a sense of humor: how to add joy to your life, Manchester, Conn, 1994, Knowledge, Ideas, and Trend.

Gregory H, Robert L. Cardy , Donald M. Truxillo. (1989):" The effect of purpose of appraisal and individual differences in stereotype of women on sex differences in performance rating: A laboratory and field study". Journal of applied psychology, August 1989, pp.551-558.

Grover SM: Shaping effective communication skills and therapeutic relationship at work the foundation of collaboration, *AAOHJ* 53(4):177(2005).

Gundry L, La Mantia L: Dreams, Executive Excellences 18 (10):13, 2001

Guteman MS: Common sense for uncommon times: the power of balance in work family, and personal life, Palo Alto, Calif, 1994 CPP Book.

Hareem, Hasan (2004)'Organizational Behavior: Behavior of individuals and groups in Business Organizations' Amman, Jordon, Dar Hamed.

Harrington-Macklin D: *The team building tool kit: tips, tactics, and rules for effective workplace team*, New York, 1994, American Management Association.

Hall DR: Social support, available on line at http://vanderbiltowc.well source . com.

Hegle D: Positively channeling workplace anger and anxiety, part2 , *AAOHJ* 49(10):482,2001b.

Hegle D: Turning workplace anger and anxiety into peak performance : strategies for enhancing employee health and productivity, *AAOHJ* 49(8):399,2001c.

Hollinsworth H, Clark C, Harland R, Johnson L, Gareth P: Understanding the arousal of anger: a patient centered approach, *Nurs Standard* 19(37):14, 2005.

Holm, K., Liewellyn, J. (1986) Nursing Research for nursing Practice. W.B. Sounders Company: Philadelphia

Jakubowski P, Lange AJ: The assertive option: your rights and responsibilities, Champaign, 3, 1978, Research Press

Karlgarrd R: Conversation with giant, Forbes 174(12):45, 2004.

Katherine I. Miller, " Cultural and role- Based predictors of Organizational Participation and Allocation Preferences ", Communication Research , December 1988,pp699-72.

Kaufman P, Wetmore C: *The brass tacks manager: getting down to what really count in the work place*, New York, 1994, Bantam Doubleday.

Kemp C: Spiritual care interventions. In Ferrell B, Coyle N, editors: *Textbook of palliative care*, New York, 2001, Oxford University Press.

Kinder JS: Conflict and diploma nursing education. In *management of conflict*, New York,1981, National League for nursing.

Kipplinger B: Humor in psychotherapy: a shift to a new perspective. In Fry WF Jr, Salameh WA, editors: Hand book of humor and psychotherapy: advances in the clinical use of humor, Sarasota, Fla, 1987, Professional Resource Exchange.

Komblith AB, et al: Social support as a buffer to the psychological impact of stressful life events in a women with Brest cancer, cancer91(5):443, 2001.

Kreitner R, Kinicki A. (1991): Organizational Behavior: Interpersonal communication' IRWIN Burr Ridge, Illinois Boston, Massachusetts.

Kushner H: When bad thing happen to good people, New York, 2001, Schocken Books.

Kushner H: When all you've ever wanted is n't enough: A search for life that matter, New York, 2002 Fireside.

Lee-Hsieh J, Fang Y, Kuy C, Turtno MA: Patient experiences in development of a caring code for clinical nursing practice, Int J Hum Caring 8 (3):21,2004.

Levine DR, Adelman MB: Beyond language: intercultural communication for English as second language, Englewood Cliffs, NJ, 1982, Prentice-Hall Regents.

Maher, Ahmed (2000) ' How to increase your Skills in Business Communication' Alexandria, Egypt, Aldar Eljamea'a.

Marick MF, Albright RR: The complete guide to conflict resolution in the work place, New York, 2002, AMACOM.

Mehrabian and Ferris (1967). "Inference of, Attitude from Nonverbal Communication in Two Channels". In: *The Journal of Counseling Psychology* Vol.31, 1967, pp.248-52.

Micozzi MS: Fundamental of complementary and integrative medicine, St Louis, 2006, Elsiver.

Mina, Eli (2002) "The Business Meeting Sourcebook: A practical Guide to Better Meeting and shared Decision- making" New York, USA, Ama com.

Mosby's Medical Dictionary, 8th edition. 2009, Elsevier (http://medical-dictionary.thefreedictionary.com/health+care+provider) access on 29/6/ 2009 at 3a.m

Nelson, Bob and Economy, Peter (2005) "The management Bible" Hoboken, New Jersey, John Wiley & Sons, Inc.

Nelson, Bob and Economy, Peter (2005) "The management Bible" Hoboken, New Jersey, John Wiley & Sons, Inc.

Ministry of Health, Health Status in Palestine-Ministry of Health Annual report 2004, August 2005.

Patterson K, Grenny J, Mc Millan R, Switzeler A: Crucial confrontation: Tool for resolving broken promises, Violated expectations, and bad behavior, New York, 2005, Mc Grow-Hill.

Ryman L, Rankin-Box D: Relaxation and visualization. In Rankin-Box D, editor: The nurse handbook of complementary therapies, Edinburgh, 2001, Baillie're Tendall.

Riley BJ : Saying what you mean and meaning what do you say, Work Shop presented at the Faculty Development Institute. Scottsdale, Ariz,2002.

Riley. J Balzer (2008) Communication in Nursing (Sixth edition) Mosby Elsevier.

Robbins, P. Stephen (2003) Essentials of Organization Behavior (8th edition) New Jersey, USA, Pearson Education, Inc.

Robbins, P. Stephen (1997) Organization Behavior: Concepts, Controversies, Applications (7th edition) New Delhi, India, Prentice-Hall Private Limited.

Robert Kreitner , Angelo Kinicki , Organizational Behavior 2nd Edition 1992 chapter12 page 461-463.

Rogers CR: A way of being, Boston, 1980, Houghton Mifflin.

Riley. J Balzer (2008) Communication in Nursing (Sixth edition) Mosby Elsevier.

Rosenthal MJ: High – performance team, *Executive Excellences* 18 (10): 6, 2001.

Lippincott - Raven 1996 Fundamentals of nursing. Lippincott- human health and function –second edition.

Samuel C. Certo (2003) *Modern Management ,Adding Digital Focus* (9th edition) Prentice Hall, Upper Saddle River, New Jersey, USA.

Schermerhorn, R. John et al (2002)' *Organizational Behavior* (7th edition) USA, John Wiley & Son, Inc. English Book.

Spector PE: Employee control and occupational stress, Curr Dir Psychol Sci 11(4):133, 2002.

Spencer JW, Jacobs JJ: Complementary and alternative medicine: an evidence –based approach, St Louis, 2003, Mosby.

Stuart GW, Laraia MT: *Principles and practice of psychiatric nursing*, 8th ed, St Louis 2005, Mosby.

Smith SB, et al: Resolving conflict realistically in today's health care environment ,*J psychosis Nurse Mental Health Serve* 39 (11):36, 2001.

Tindall J: Peer Power: Book one, becoming an effective peer helper and conflict mediator, Work book, Muncie, Ind, 1944, Accelerated Development.

Marick MF, Albright RR: *The complete guide to conflict resolution in the work place,* New York, 2002, AMACOM.

Flanagan L : What you need to know about today's workplace: a survival guide for nurses, Washington, DC, 1995, American Nurses Association.

Palestinian Central Bureau of Statistics, 2007. Palestinian Family Health Survey, 2006: Final Report. Ram Allah-Palestine.

Palestinian**.** MoH (2006): Health Status in Palestine. Annual Report, 2005 Gaza.

Poilt, D., and Hungler, B., 1985. Essentials of nursing research; Methods and applications, J. B. Lippincott company.

Porter-O'Grady T: The nurse manager's problem solver, St Louis, 1994, Mosby University of Illinois Counseling Center: Overcoming procrastination, Self- help brochures, retived june 20, 2006, at http://www.couns,edu/ brochures/procres /procras.htm

UNRWA Annual Report of the Department of Health, 2008: "Delivering Health to the Victims of Conflict". ch.6, pp. 106, UNRWA, HQ, Amman, Jordan).

UNRWA. Emergency Appeal 2008, resource available on web http://www.un.org/unrwa/ publication/pubs07.html.

UNRWA Health Director's report to the World Health Assembly in May 2009: ""Health condition of, and the Assistance to, the Arab population in the occupied territories including Palestine refugee".

Tuckman B: Developmental sequence in small groups, *Psychol Bull* 63:384, 1965.

Vivar CG: Putting Conflict management into practice: a nursing case study, J Nuree Admin 14 (3): 201, 2006.

WHO "Gaza Strip Initial Health Needs Assessment" February 2009.

Accessed at http://www.who.int/hac/crisis/international/wbgs/

Gaza_early_health_assessment_16feb09.pdf on the 12th of March 2009.

World development indicators, 2008. Poverty data A supplement to world development indicators 2008. Available at http://siteresources.worldbank.org/DATASTATICS/ Resources/WDI08suplement1216.pdf Accessed on 27/12/2009.

Web sites:

http://www.buzzle.com/articles/types-of-communication.html Access on 29l12/2009

http://www.communicationskills.co.in/effective-communication-skills.htm.Access on 29/12/2009

http://www.communicationskills.co.in/verbal-communication-skills.htm.Access on 29/12/2009

http://www.google.com/search?q=communication+barriers&hl=ar&hl=&start=10&sa=N .Accessed on 8/7/2009

http://www.k12.wa.us/CurriculumInstruct/communications/default.aspx. Accessed on 8/7/2009

http://en.wikipedia.org/wiki/Communication#Overview. Accessed on 12/8/2009 10pm.

http://www.chsrf.ca/other documents/insight action/html/ia47 e.php Accessed on 26/6/2009 "How can we improve communication between health care providers? Lessons from SBAR(Situation, Background, Assessment, Recommendation) Technique. (Issue 47 November 2008).

http://www.un.org/unrwa/programmes/ health/index.html Accessed on the 28th of March2009

www.k12.wa.us/CurriculumInstruct/communications/default.aspx

Wikipedia free encyclopedia. Access on 23/6/2009

http://en.wikipedia.org/wiki/Communication#Overview. Access on 12/8/2009 10pm.

7.2 Annexes

Annex 1

Map of Palestine

Source Palestine Central Bureau of Statistics (2006)

Annex 2

Map of Gaza Strip

The map shows the five governorates of Gaza Strip. Source Dr, Abed, Y (2009).

Annex 3

Palestinian National Authority
Ministry of Health
Helsinki Committee

السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

13/9/9

التاريخ2009/9/9

Name:

الاسم: رزق رمضان

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

Status of Communication among Health Care Providers at UNRWA Health centers in Gaza Governorates

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

In its meeting on September 2009 and decided the Following:-

To approve the above mention research study.

و ذلك في جلستها المنعقدة لشهر 9 2009

و قد قررت ما يلي:-

الموافقة على البحث المذكور عاليه.

Signature

Member
عضو
D. Hersi

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 4

Al-Quds University
Jerusalem
School of Public Health

جامعة القدس
القدس
كلية الصحة العامة

2009/10/10

الأخ/د. محمد المقادمة المحترم
مدير دائرة الصحة–وكالة الغوث
تحية طيبة وبعد،،،

الموضوع: مساعدة الطالب رزق عيد العبد رمضان

يقوم الطالب المذكور بأعلاه بإجراء بحث بعنوان :

"Status of Communication among Health Care Providers at UNRWA Health Centers in Gaza Governorates "

كمتطلب للحصول على درجة الماجستير في الصحة العامة–مسار إدارة صحية و عليه نرجو التكرم للإيعاز لمن ترونه مناسب لتسهيل مهمة الطالب في جمع البيانات اللازمة من عيادات الرعاية الأولية التابعة لإدارتكم الموقرة حيث سيتم الحصول على البيانات من قبل طاقمي الأطباء والتمريض .
علماً بأن المعلومات ستكون متوفرة لدى الباحثة و الجامعة فقط.

و اقبلوا فائق التحية و الاحترام،،،

د. بسام أبو حمد
منسق عام برامج الصحة العامة

نسخة:

Jerusalem Branch/Telefax 02-24799234
Gaza Branch/telefax 08-2884422-2884411
Sphealth@admin.alquds.edu
فرع القدس/تلفاكس 02-2799234
فرع غزة/تلفاكس 08-2884422-2884411
ص.ب/51000-القدس

Annex 5

Explanatory letter

"The status of communication among health care providers' at UNRWA health centers in Gaza- Governarats."

Dear participant,

Thank you for accepting to participate in this study, which is a part of my master degree at the School of Public Health- Al Quds University. The purpose of this study is to describe the status of your communication with other HCPs at UNRWA Health Centers in Gaza Governorates during work. This questionnaire reflects your views; the information to be collected in this study is expected to describe and identify the status of communication among HCPs to be able to describe the process of communication, challenges and barriers facing your communication at UNRWA health centers. We hope the results of this research will be valuable and brings recommendations to be considered by the decision makers to further improve the current communication status. Confidentiality is assured and you will not be known if you participate. No name is needed. Please answer all questions according to your opinion and views. No right or wrong answers. You may not answer any of the questions if you wish. Answering these questions might take 20 minutes. Although I welcome your participation, be sure that participation is optional and you have the right not to participate if you don't wish. Thank you for your time and cooperation.

Researcher

Rezeq Eid Abed Ramada

Mobile: 0599918777

E- mail: Rizik1200@ hotmail.com

Annex 6

Questionnaire

"Status of communication among health care providers' at UNRWA health centers in Gaza- Governarats."

Date : 27/12/2009 Serial Numbe: ( ) Health Center:_____

First Part:- Personal Data

Please answer the following questions about your self:-

1.Profesion:- ☐ Physician. ☐ Nurse. ☐ Ass.phar. ☐ Lab Tech. ☐ X.R.Tech. ☐ Physio.Th. ☐ Ass.Phys. Th. ☐ Dent. Sur. ☐ Dent. Hyg.

2. Gender:- ☐ Male**.** ☐ Female**.**

3.Age :- _____Years.

4.Marital status:- Single. ☐ Married. Widow. Divorced **.**

5. Number of family members including your self:- _____.

6. Monthly income:- ☐ Less than 1000$ ☐ 1001- 1500$ ☐ More than1501.

7. Level of qualification:- ☐ Diploma ☐ Bachelor ☐ Master ☐ PHD.

8. Place (country) of last qualification:- _____.

9, Total years of experience:- _____ Months _____Years**.**

10. Years of experience in UNRWA Health Centers:- ____ Months _____Years.

11. Title of current position:- ☐ Gen.Cli. ☐ NCD ☐ Mat.H ☐ Ch.H ☐ Phys.Th. ☐ Lab. ☐ Pharm. ☐ X-Rays. ☐ F.P. ☐ Director H.C.

12. Tools of communicate available at work place:-

☐ Telephone ☐ Mobile ☐ Wireless. Call ☐ Nothing.

Research questions:

Second Part:-First dimension:- Knowledge of HCPs about communication.			
13	Did you study the communication subject during your academic curriculum	Yes	NO
14	Did you get training course about communication?		
15	Did you have any special course on communication skills?		
16	Did you have any self-learning on the subject of communication?		

Second Dimension: Perception of HCPs about communication		Very Low	Midd	High	Very
17	Do you see that; your communication with health care providers is vital for patient?				
18	Do you believe that; use of verbal communication skills provides you with more information about the patient?				
19	Do you believe that; for best patient service is to talk face-to-face with HCPs, that's provide you with more information about patient?				
20	According to perception ; Do you see that; it is essential to send a feedback to the sender ?				
Third Dimension: Experience of HCPs in communications.					
21	Do you have experience to use communication tools available in HC?				
22	Do you have practical experience in communication skills.?				
23	Did you find HCPs working with you had experiences in practice of communication skills?				
24	Do you have the experience in communication during emergency?				
Fourth Dimension: Features and characteristics of HCP communication.					
25	Does the communication between HCPs aimed to clarify or explain procedures that should be done to the patient?				
26	During emergency; did verbal instructions are sufficient for you to provide the service for patient ?				
27	Does; community culture support's man as HCP more , to achieve his goals by verbal communication?				

28	**Does; community culture support's women as HCP more, to achieve her goals by verbal communication?**					
29	**Did women able to achieve difficult tasks by verbal communications rather than men?**					
30	**Does most of your communications you did are verbal?**					
Fifth Dimension: Challenges facing HCPs Communication during work.						
31	**Over coming the crowdedness, is a challenge facing you to communicate with HCPs during work.**					
32	**Building good interpersonal relations with HCPs , are challenges in front my communications.**					
33	**Community perception about gender, is challenges facing HCPs communications.**					
34	**Developing HCPs, source of knowledge about communication, is a challenge to achieve effective communication.**					
35	**Developing HCP, practical skill about communication, is a challenge to achieve effective communications.**					
36	**Achieving patients health needs, are challenges facing effective communications?**					
37	**Evaluation of communication process, is challenge to achieve effective communication.**					
38	**Supervision of communication process, is challenge to achieve effective communication.**					
39	**Training of HCP on communications, is challenges facing health centers management.**					
40	**Improving communication infrastructure of health centers, is challenge facing health center management.**					
41	**Training on skills of good listening, is one of the most common challenges facing communications management.**					

42	**Developing the HCPs ability to under standing, is challenge facing admin. communications.**					
Sixth Dimension: Barriers facing HCPs Communication.						
43	**Vague administrative instruction, is a barrier for my communication**					
44	**Contact with Selective personality, is a barrier to my communications**					
45	**Muddled message with un clear objective, is a barriers to effective HCPs communications.**					
46	**Selection of, wrong channel is a barrier to effective communications between HCP.**					
47	**Interpersonal problems between you & HCP, is a barrier to effective communications.**					
48	**Neglecting feedback from receiver side, is barrier in the process of communication.**					
49	**Political differences between HCPs, are barriers to effective communications.**					
50	**Interruption during verbal communication, is a barrier to effective communication.**					
51	**One-way chain of communication, is a barrier to effective communication.**					
52	**Lake of concentration, is barrier in the process of communication.**					
Seventh Dimension: Differences between Personal and Organizational Characteristics. **First point Informal communication by Rumors and Grip vine.**						
53	**The degree UNRWA news start as, informal rumors & informal (grip vine) news ?**					
54	**The degree, UNRWA communications practice, rumors & grip vine methods?**					
55	**The degree, Your director prefers his own grip vine informal persons?**					
56	**The degree, your director constructs his perceptions, from grip vine news?**					

57	**The degree, you like to be a grip vine person, form and to the director during work?**					
Second point:- Communication and Mutual respect.						
58	**The degree, UNRWA policy, practice mutual respect in its communications?**					
59	**The degree, HCP practice mutual respect during their communications?**					
60	**The degree; the director respect HCPs during his communication with them?**					
61	**The degree; you found that, mutual respect lies behind any effective communication?**					
Third point:- Communication and Transparency.						
62	**The degree, UNRWA communications are characterized by transparency e.g. during regular management team meeting (MTM)? (from your experiences)**					
63	**The degree, the director, was transparent during his communication with you e.g. as he transmit the results and message of regular MTM.**					
Fourth point:- Communication and Equity						
65	**The degree, UNRWA practices equity in gender in communication with HCPs?**					
66	**The degree, communication with director through proper channels only, is sort of equity?**					
67	**The degree, you practice gender equity in your communication with HCPs?**					
Fifth point:- Communications and Openness						
68	**The degree, UNRWA practice openness in it's communications with all HCPs?**					
69	**The degree, your colleague talks to you openly, if he had a medical mistake with patient?**					

Sixth point:- Communications and Discrimination						
70	**The degree, UNRWA was far away from discrepancy in it's communications with HCPs?**					
71	**The degree, director practices discrepancy between HCPs in his communications.?**					
72	**The degree, you are suffering from discrepancy, when colleague communicate with you?**					
Seventh point:- Communication and Competition OR Conflict.						
73	**The degree, UNRWA communications cerate's positive competition between HCPs?**					
74	**The degree, UNRWA communications cerate's conflict situation between HCPs?**					
75	**HCP positive competition results in effective communications.**					
76	**HCP conflicts results in ineffective communication.**					
Eighth point:- Communication and Political balance.						
77	**The degree, UNRWA communications with others described as politically balanced.**					
78	**UNRWA communications with other organizations, are far away from state division and separation between parties.**					
79	**Communications of HCPs has negatively affected by situation of political closure.**					
80	**Your communication with HCPs has negatively affected by situation of political closure.**					
Ninth point:- Communication and Access to data OR Information						
81	**UNRWA general information is available to public without password.**					
82	**UNRWA health data is available to HCPs without password.**					
83	**Health center general information is available to public without pass ward.**					

84	**Health center data is available to HCPs without pass ward.**					
85	**The degree, HCP has electronic access to their personal data directly e.g. salary & Vacation.**					
Tenth point:- Communications and Chain of commands.(personal & organizational)						
86	**The degree UNRWA chain of commands from up to down only is very suitable?**					
87	**The degree, UNRWA chain of commands needs evaluation to suit emergency situation?**					
88	**The degree, health Office chain of commands from up to down only is very suitable?**					
89	**The degree, health Office chain of commands needs evaluation to suit emergency?**					
90	**The degree, HCPs chain of commands from up to down only is very suitable?**					
91	**The degree HCPs chain of commands from up to down only needs evaluation to suit emergency situations.**					
Eleventh point:- Communication and Documentation (verbal or non verbal)						
92	**The degree, UNRWA Health Office document all their verbal communications.**					
93	**The degree, UNRWA Health Office document their non-verbal communications.**					
94	**The degree, HCP at health center document all their verbal communications.**					
95	**The degree HCP at health center document all their non-verbal communications.**					

Part Three

The following six questions are, about the components of communication process.

If your answer was(YES); please put to which extent you rank it:-

Answer those questions about the process of communication.	(96) 1st Question		(97) 2nd Question		(98) 3rd Question		(99) 4th Question		(100) 5th Question		(101) 6th Question	
	♀ If you are the Sender?		About the aim of the message		♀ If you are the Receiver?		About the Documentation		About the Channel		About the Language	
	Do you have feedback for each message?		Did the message you received has clear goal?		Did the sender explain his massage?		Did you document the verbal and non-verbal communication e if it is life saving?		What is the most commonly used channel by HCPs?		What is the Language used during work?	
	Yes	NO	Yes	NO	Yes	NO	Yes	NO	Verbal	Non Verbal	Arabic	
											English	
											Both	
If your answer is yes rank to which degree	Outstanding		5		5		5		5	5		5
	Very good		4		4		4		4	4		4
	Satisfactory		3		3		3		3	3		3
	Below standard		2		2		2		2	2		2
	poor		1		1		1		1	1		1

Mention tools you prefer for communication with HCPs according to your priorities:-

102)<u>First during normal situations</u>; Please put number inside the square accordingly.

☐ Face to face ☐ Telephone ☐ written message ☐ SMS ☐ Intercom

☐ E-mail ☐ Wireless Call ☐ Voice messages.

103) <u>Second during emergency</u>; Please put number inside the square accordingly.

☐ Face to face ☐ Telephone ☐ written message ☐ SMS ☐ Intercom

☐ E-mail ☐ Wireless Call ☐ Voice messages.

104) <u>Third during meeting</u>; Please put a number inside the square accordingly.

☐ **Face to face.** ☐ **Face to face with power point put** ☐ **Video- conference.**

<u>Part 4:-</u>

Please, write your recommendation to improve the status of communication among health care providers' at UNRWA health centers in Gaza- Governarats.

---

105) <u>First at normal work situation:-</u>

1. _____
2. _____
3. _____
4. _____

106) <u>Second during emergency situation:-</u>

5. _____
6. _____
7. _____
8. _____

Dear participant: -

Thanks for your efforts and care in answering the questionnaire, hoping for you good health and continuous success.

Researcher / Rezeq Eid Abed.Ramadan.

Tel # 2856162

Mobile # 0599918777

E-Mail : Riziq1200@hotmail.com

Annex 7

رسالة إيضاح للمشارك في الإجابة على الاستبيان

"واقع الاتصال والتواصل بين مقدمي الرعاية في المراكز الصحية التابعة للأونروا في محافظات قطاع غزة "

عزيزي المشارك:

أشكرك لموافقتك على المشاركة في هذه البحث ، الذي هو جزء من دراستي لنيل درجة الماجستير في كلية الصحة العامة ، جامعة القدس أبو ديس. الغرض من هذه الدراسة هو وصف الوضع القائم للاتصال والتواصل بين مقدمي الخدمات الصحية بالمراك ز الرعاية الصحية في محافظات غزة أثناء العمل. هذا الاستبيان يعكس وجه ة نظرك وتجربتك ، والمعلومات التي سيتم جمعها من هذه الدراسة ستكون سريه للاستخدام البحثي, ومن المتوقع منك أن تصف وتعرف حالة الاتصال والتواصل بين مقدمي الخدمات الصحية لتكون الدراسة قادرة على وصف واقع عملية الاتصال ، التحديات والعوائق التي تواجه الاتصال بينكم كمقدمين لخدمات الرعاية في المراكز الصحية الاونروا . نأمل أن تكون نتائج هذا البحث ذات قيمة لتمكن صناع القرار من اتخاذ قرارات تساهم في تحسين الوضع الحالي للاتصالات. إن سرية المعلومات مكفولة ، وأنك لن تعرف إذا كنت ستشارك. حيث أن كتابة اسمك غير مطلوبة. أرجو منك الإجابة على جميع الأسئلة وفقا لرأي ك وخبرتك والواقع الموجود . لا توجد إجابات صحيحة أو إجابات خاطئة. كما انه يحق لك/لكي عدم الإجابة على أي من الأسئلة إذا كنت لا ترغب في ذلك . الإجابة على هذه الأسئلة قد يستغرق منك 20 دقيقة.

على الرغم من أنني أرحب بك وبمشاركتك في هذا البحث القيم من خلال تعبئتك للاستبيان المرفق ، هذا ومما لا شك فيه أن المشاركة اختيارية ، و لديك الحق والحرية في عدم المشاركة إذا كنت لا ترغب في ذلك. شكرا لك.

للاستفسار عن أي ملاحظه تتعلق بالاستبيان أرجو منك الاتصال

بالباحث: رزق عيد العبد رمضان

جوال: 0599918777

بريد اليكتروني: Rizik1200@hotmail.com

Annex 8

استبيان

" واقع الاتصال والتواصل بين مقدمي الخدمات الصحية بالمراكز الصحية التابعة لوكالة الغوث (ينوروا) بمحافظات غزة"

التاريخ: 29 /11 / 2009 رقم الاستبيان:( ) أسم المركز الصحي:-_____

ألجزء الاول:- المعلومات الشخصية:-

1.المهنة:- ☐ طبيب/طبيبة ☐ □ □ □ □ □ □ ☐ ممرض/ممرضه.

☐ م.صيدلي ..☐ني مختبر ف☐عة ع☐طبيعي ☐م. علاج طبيعي

. ط. أسنان ف. أسنان.

2.الجنس:- ☐ ذكر. ☐ أنثى .

3.العمر:-_____سنه.

4.الحالة الاجتماعية:- ☐أعزب/اء. ☐ متزوج/ه ☐مل/ه. ☐طلق/ه

5.عدد أفراد ألأسرة التي تعيلها:-_____ أفراد.

6.الراتب الشهري:- ☐أقل من 1000 $ ☐1001-1500 ☐ أكثر من 1501$

7.المؤهل العلمي :- ☐دبلوم ☐ بكالوريوس ☐ ماجستير ☐ دكتوراه.

8.الجهة التي حصلت منها علي آخر مؤهل علمي:-_____.

9.عدد سنوات الخبرة الكلي:-_____ شهر و_____سنة.

10.عدد سنوات العمل في مراكز الوكالة:-_____ شهر و _____سنة .

11.القسم الذي تعمل بة حاليا:- ☐ عامه ☐مزمنه ☐حوامل ☐أطفال ☐أسنان

☐ طبيعي ☐ مختبر ☐ صيدليه ☐ أشعة ☐نظيم اسرة ☐دير عياده.

12.أدوات الاتصال المتوفره في مكان العمل:- ☐هاتف ☐جوال ☐نداءلاسلكي ☐يوجد

الجزء الثاني:- **أسئلة البحث**							
ألبعد الاول: **معرفة مقدمي الخدمة الصحية عن موضوع الاتصال :-**			**نعم**			**لا**	
13.	هل درست موضوع الاتصالات أثناء دراستك الاكاديمية؟						
14.	هل حصلت على دورات تدريبية عن الاتصالات؟						
15.	هل حصلت على دورات متخصصة في مهارات الاتصال؟						
16.	هل اطلعت من تلقاء نفسك على موضوع الاتصال؟						
ألبعد الثاني:- **مفهوم مقدمي الخدمة الصحيةعن موضوع الاتصال**		**5 درجة عالية جدا**	**4 درجة عاليه**	**3 درجة متوسطه**	**2 درجة منخفضه**	**1 درجة منخفضه جدا**	
17.	هل ترى ان الاتصال بينك وبين مقدمي الخدمة مهم لحياة المريض؟						
18.	هل تعتقد أن استخدامك لمهارات الحديث تعطيك معلومات اكثر عن المريض ؟						
19.	هل تعتقد أن الافضل لخدمة المريض الحديث وجها لوجه مع مقدمي الخدمة ؟						
20.	حسب مفهومك هل ترى أن من الضروري ارسال تغذية راجعة للمرسل؟						
البعد الثالث:- **خبرة مقدمي الخدمة الصحية في الاتصال**							
21.	هل لديك الخبرة في استخدام وسائل الاتصال بالمركز(تلفون، لاسلكي)؟						
22.	هل لديك الخبرة في استخدام مهارات الاتصال؟ (لغة الجسم ،الصمت، الاشارات)						
23.	هل وجدت العاملين معك لديهم الخبرة في استخدام مهارات الاتصال؟						
24.	هل لديك الخبرة في الاتصال أثناء الطوارىء؟						
البعد الرابع :- **مظاهر و خصائص الاتصال بين مقدمي الخدمة الصحية**							
25.	هل الاتصال بينكم كمقدمي خدمة هدفه شرح أو ايضاح المطلوب عمله للمريض؟						
26.	أثناء الطوارىء، هل التعليمات الشفوية كافية لك لتأدية الخدمة المقدمة للمريض ؟						
27.	هل ثقافة المجتمع، تجعل الرجل مقدم الخدمة أكثرقدرة على تحقيق هدفه بالاتصال اللفظي؟						
28.	هل ثقافة المجتمع، تجعل المرأة مقدمة الخدمة أكثر قدرة على تحقيق هدفها بالاتصال اللفظي؟						
29.	هل تستطيع المرأة انجاز المهام الصعبة بالاتصال اللفظي أكثر من الرجال؟						

30. هل معظم الاتصالات، التي تقوم بها لفظية؟						
البعد الخامس:- ألاتصال و التحديات التي تواجه مقدمي الخدمة الصحية						
31. التغلب على الازدحام هو تحدي يواجهك للاتصال مع مقدمي الخدمة أثناء العمل.						
32. بناء علاقات شخصية جيدة مع مقدمي الخدمة هو تحدي أمام اتصالي.						
33. مفهوم المجتمع الخاطيءعن الاتصال بين الجنسين هو تحدي أمام مقدمي الخدمة.						
34. تطويرمعلومات مقدمي الخدمة عن الاتصال يشكل تحديا لتحقيق اتصال فعال.						
35. تطوير مهارات مقدمي الخدمة في الاتصال يشكل تحديا لتحقيق اتصال فعال .						
36. تلبية احتياجات المريض الصحية تشكل التحدي لتحقيق الاتصال الفعال .						
37. أعتبر تقييم عملية الاتصال تشكل تحديا لك لتحقيق اتصال فعال .						
38. أعتبر الاشراف على عمليةالاتصال تشكل تحديا لك لتحقيق اتصال فعال.						
39. أعتبر تدريب مقدمي الخدمة على عمليةالاتصال يشكل تحديا أمام ادارة المركز.						
40. أعتبر تطويرالبنية التحتية للاتصالات بالمركز تشكل تحديا أمام ادارة المراكز.						
41. أعتبرالتدريب على مهارات الاستماع الجيد أحد التحديات أمام ادارة الاتصالات.						
42. أعتبرتطوير قدرة مقدمي الخدمة على الفهم الجيد هي تحدي أمام ادارةالاتصالات.						
البعد السادس:-الاتصال و المعيقات التي تواجه مقدمي الخدمة الصحية						
43. أعتبرعدم وضوح التعليمات يشكل **عائقا** عند اتصالي مع مقدمي الخدمة بالمركز.						
44. ان اتصالي بشخصية انتقائية(يختارمن الكلام ما يناسبه) يشكل **عائقا** امام اتصالي.						
45. الرسائل الغيرواضحة الهدف هي **عائقا** لعملية الاتصال بين مقدمي الخدمة.						
46. اختيار قناة اتصال غير مناسبة تشكل **عائقا** امام ألاتصال بين مقدمي الخدمة.						
47. المشاكل الشخصية بيني وبين مقدمي الخدمة تشكل **عائقا** أمام اتصالي بهم.						
48. عدم أرسال تغذية راجعة لي من المستقبل تشكل **عائقا** لعملية الاتصال.						
49. الاختلافات السياسية بين مقدمي الخدمة تشكل **عائقا** لعملية الاتصال.						
50. المقاطعة أثناء الحديث هي **عائقا** امام القيام باتصال فعال.						
51. الاتصال في اتجاه واحد فقط **عائقا** أمام ألقيام باتصال فعال بين مقدمي الخدمة.						

52.	عدم تركيز المستقبل أثناء الحديث معه تشكل **عائقا** لعملية ألاتصال.					
البعد السابع: الاختلاف بين صفات المؤسسة وصفات الاشخاص مقدمي الخدمة: أجب حسب وضعك؟						
الصفة ألأولى: ألاتصال ونقل الأخبار غير الرسمية أو الإشاعات (المؤسسة والأفراد)						
53.	إلى أي درجة، أخبار **الوكالة تبدأ** إشاعات وبطرق غير رسمية؟					
54.	إلى أي درجة، اتصالات **الوكالة تمارس**، الإشاعة والأخبار غير الرسمية؟					
55.	إلى أي درجة، **يفضل المدير** المقربين منه، ممن ينقل له أخبار مقدمي الخدمة؟					
56.	إلى أي درجة، **يبني المدير معلوماته** بناء على أخبار المقربين منه؟					
57.	**إلى أي درجة ترغب**، أن تكون شخصا ينقل الأخبار من والى المسئول؟					
الصفة ألثانية:- ألاتصال و الاحترام المتبادل (المؤسسة والأفراد)						
58.	إلى أي مدى ترى أن سياسة الاتصال **بالوكالة** تمارس مبدأ الاحترام المتبادل ؟					
59.	إلى أي مدى، يمارس العاملين مبدأ الاحترام المتبادل أثناء الاتصال بينهم؟					
60.	إلى أي مدى، يحترم المدير العاملين معه أثناء اتصاله وتواصله بهم؟ (من خبرتك)					
61.	إلى أي مدى وجدت ،أن الاحترام المتبادل هوالسبب وراء أى اتصال فعال ؟					
الصفة ألثالثة:- ألاتصال و الشفافيه: (المؤسسة والأفراد)						
62.	**الوكالة** تعتمد الشفافية في اتصالاتها مثلا في الاجتماعات الدورية.(حسب خبرتك)					
63.	ألمدير يعتمد الشفافية، اثناء اتصاله بكم مثلا عند نقل نتائج الاجتماعات بالادارة.					
64.	إلى أي مدى، الشفافية وأطلاعك على نتائج الاجتماعات مع الادارة قد طورالعمل.					
الصفة ألرابعة:- ألاتصال و المساواة: (المؤسسة والأفراد)						
65.	إلى أي درجة، **الوكالة** تمارس المساواة في اتصالها مع مقدمي الخدمة من الجنسين؟					
66.	إلى أي درجة ، ألأتصال بالمدير عبرالقنوات الرسمية فقط نوع من المساواة؟					
67.	الى أي درجة، تطبق المساواة في اتصالاتك مع مقدمي الخدمة من الجنسين؟					

الصفة الخامسة:- ألاتصال و الانفتاح (المؤسسة والأفراد)						
68.	إلى أي درجة، تطبق الوكالة الصراحة في الاتصال مع كل مقدمي الخدمة بها؟					
69.	إلى أي درجة، تجد الصراحة من زميلك إذا قام بخطأ طبي مع المريض؟					
الصفة السادسة:- ألاتصال و التمييز: (المؤسسة والأفراد)						
70.	**الوكالة** بعيدة عن التمييز في اتصالها مع مقدمي الخدمة الصحية.					
71.	المدير يمارس التمييز في اتصاله مع مقدمي الخدمة الصحية؟					
72.	إلى أي درجة تعاني من التمييز عند اتصال زميلك بك؟					
الصفة السابعة :- ألاتصال و التنافس الايجابي أو الصراع (المؤسسة والأفراد)						
73.	**تعتمد الوكالة على** خلق حالة من التنافس الايجابي بين مقدمي الخدمة.					
74.	أن **اتصالات الوكالة تعتمد على** خلق حالة من الصراع بين مقدمي الخدمة.					
75.	أن **التنافس** الايجابي بين مقدمي الخدمة **ساهم في تحقيق اتصالات فعالة**.					
76.	أن **الصراع** بين مقدمي الخدمة **أدى إلى اتصالات غير فعالة**.					
الصفة الثامنة:- ألاتصال و التوازن السياسي و الانقسام الحزبي (المؤسسة والأفراد)						
77.	**اتصالات الوكالة** مع الآخرين توصف ايجابيا بالتوازن ألسياسي.					
78.	**اتصالات الوكالة** مع الآخرين بعيدة عن حالة الانقسام الحزبي الحالية.					
79.	**اتصالات مقدمي الخدمة الصحية** قد تأثرت سلبا بحالة الانغلاق السياسي.					
80.	**اتصالك بمقدمي الخدمة** تأثر سلبامن وضع الانقسام الحزبي والانغلاق السياسي.					
الصفة التاسعة:- ألاتصال و الوصول الى البيانات و اتاحة المعلومات (المؤسسة والأفراد)						
81.	**معلومات الوكالة العامة** متاحة للمواطنين، دون الحاجة الى كلمة مرور للموقع.					
82.	**قاعدة بيانات الوكالة الخاصة بالعمل** متاحة لمقدمي الخدمة بدون كلمة مرور.					
83.	**معلومات المركزالعامة** متاحة للمواطنين دون الحاجة الى كلمة مرور للموقع.					

84.	**قاعدة بيانات المركزالخاصة بالعمل** متاحة لمقدمي الخدمة بدون كلمة مرور.					
85.	إلى أي درجة، يستطيع مقدمو الخدمة **الوصول للمعلومات الخاصة بهم** اليكترونيا.					
ألصفة العاشرة:-	**ألاتصال و تسلسل الاوامر** (المؤسسة والأفراد)					
86.	**اتصال الوكالة حسب التسلسل الوظيفي** من أعلى إلى أسفل فقط، مناسب جدا.					
87.	**اتصال الوكالة بمقدمي الخدمة حسب التسلسل الوظيفي** بحاجة إلى مراجعة لتناسب حالات الطوارئ.					
88.	**اتصال مكتب الصحة حسب التسلسل الوظيفي** من أعلى إلى أسفل فقط، مناسب جدا.					
89.	**اتصال مكتب الصحة بمقدمي الخدمة حسب التسلسل الوظيفي** بحاجة إلى مراجعة لتناسب الطوارئ.					
90.	الاتصال بين مقدمي الخدمة من أعلى إلى أسفل فقط، **حسب التسلسل الوظيفي** مناسب جدا.					
91.	طريقة اتصال مقدمو الخدمة فيما بينهم **حسب التسلسل الوظيفي** بحاجة إلى مراجعة لتناسب الطوارئ.					
ألصفة الحادية عشر:- الاتصال و التوثيق (اللفظي وغير اللفظي) (المؤسسة والأفراد)						
92.	إلى أي درجة، **مكتب الصحة يوثق** اتصالاته اللفظية. (خذ مثلا الحديث الهاتفي)					
93.	**مكتب الصحة يوثق** اتصالاته غير اللفظية. (مثلا في الرسائل الخطية والاليكترونية)					
94.	**مقدمو الخدمة بالمركز يوثقون** اتصالاتهم اللفظية. (مثلا الأوامر بإعطاء علاج)					
95.	**مقدمو الخدمة بالمركز يوثقون** اتصالاتهم غير اللفظية. (مثلا الأوامر بإعطاء علاج)					

الجزء الثالث: **ألاسئلة التالية عن عناصرومكونات الاتصال.**

أذا كانت الاجابة بنعم، من فضلك حدد الى أي مدى.

(96)		(97)		(98)		(99)		(100)		(101)		
ألسؤال الاول		السؤال الثاني		السؤال الثالث		السؤال الرابع		السؤال الخامس		السؤال السادس		
اذا كنت متصلا؟		عن هدف الرسالة؟		اذا كنت مستقبلا؟		عن التوثيق؟		عن قناة الاتصال؟		عن لغة الاتصال؟		
هل تحصل على رد يفيدك أن المستقبل قد فهم رسالتك؟		هل الرسائل التي تستقبلها تكون واضحة الهدف؟		هل توافق أن المتصل بك ماهرا في العرض والشرح والايجاز؟		هل توثق الاتصال الهاتفي اذا كان مهما لحياة المريض؟		ما هي القناة الاكثر استخداما من قبلك اثناء العمل؟		ما هي لغة الحديث التي تستخدمها أثناء العمل؟		
نعم	لا	نعم	لا	نعم	لا	نعم	لا	لفظية	غير لفظية	العربية	الانجليزية	العربية والانجليزية
5 دائما		5		5		5		5	5	5	5	5
4 أحيانا كثيره		4		4		4		4	4	4	4	4
3 أحيانا		3		3		3		3	3	3	3	3
2 نادرا		2		2		2		2	2	2	2	2
1 نادرا جدا		1		1		1		1	1	1	1	1

أذكر وسائل الاتصال التي التي تفضلها للتواصل مع زملائك مقدمي الخدمة أثناء العمل حسب الاولوية؟

(102) <u>أولا في الوضع العادي</u>:- من فضلك ضع رقما داخل المربع حسب الاولوية التي تراها مناسبة من وجهة نظرك.

☐ وجها لوجه ☐ الهاتف ☐ بالرسائل المكتوبة ☐ برسائل الجوال SMS ☐ بالانتركوم

☐ البريد الاليكتروني ☐ الاسلكي جهاز النداء ☐ بالرسائل الصوتية

(103)<u>ثانيا: أثناء الطوارىء</u>:- من فضلك ضع رقما داخل المربع حسب الاولوية التي تراها مناسبة من وجهة نظرك.

☐ ☐ ☐ ☐ ☐

وجها لوجه بالهاتف بالرسائل المكتوبة برسائل الجوال SMS بالانتركوم

☐ البريد الاليكتروني ☐ بالاسلكي جهاز النداء ☐ بالرسائل الصوتية.

(104) ثالثا: في الاجتماعات:- من فضلك ضع رقما داخل المربع حسب الاولوية التي تراها مناسبة من وجهة نظرك. ا ل

☐ ك وجها لوجه ☐ الـ وجها لوجه مع power point ☐ الـ عن بعد باستخدام Vidio conf

الجزء الرابع:

أذكر ما ترغب اضافته لتحسين الاتصال بين مقدمي الخدمات بالمراكز الصحية ؟

"عدم التعليق او الاضافة معناه الوضع ممتازوالتواصل فعال من جميع النواحي كالبنية التحتية، والافراد، والبيئة المحيطة، وعملية الاتصال والتواصل ولا يوجد عوائق بين مقدمي الخدمة في الوضع العادي، أواثناء الطوارىء."

(105)أولا:- أرغب في الوضع العادي اضافة ما يلي لتحسين الوضع:-

1. _____
2. _____
3. _____
4. _____

(106) ثانيا:- أرغب أثناء الطوارىء اضافة ما يلي لتحسين الوضع:-

5. _____
6. _____
7. _____
8. _____

شكرا جزيلا على جهدك المقدر.

الباحث د. رزق عيدالعبد رمضان

هاتف: 2856162جوال- 0599918777

بريد اليكتروني: Rizik1200@hotmail.com

Annex 9.1

مفتاح الاستبيان

Objectives of the study & number of questions related to each one :-

1st Objective:-To identify health care providers' knowledge, perceptions, and experiences regarding work related communications.

Questions related to the first objective are:-

*HCPs knowledge**: - questions No (13, 14, 15, 16)**

*HCPs perceptions **questions No (17, 18, 19, 20)**

*HCPs experiences **questions No (21, 22, 23, and 24)**

2nd Objective:- To identify the relationship between socio-demographic characters and communication.

Questions on the second objective are

* Socio-demographic characters **questions No** (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12)

In relation to communication process from the answers Yes or No:-

* Feedback (questions **No** 96)

* Message (questions No 97)

* Skills (98)

* Documentations (questions No 99)

* Channel (questions 100)

* Language (questions 101)

3rd Objective:-To explore the barriers and challenges of communication that face the UNRWA health care providers.

Questions on third objective are:-

* Challenges(12-questions, the question# 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42)

* Barriers (10-questions, the question# 43, 44, 45, 46, 47, 48, 49, 50, 51, 52)

4th Objective:-To identify the most common communication channel used by UNRWA health care Providers.

Questions on the fourth objective are:-

* Most common communication channel used by HCPs 5-questions, the question# (30, 100, 102, 103, 104)

5th Objective:- To identify the main features and characteristics of communications among UNRWA health staff

Questions on the fifth objective are:-

- features and characteristics of communication among HCPs (5-questions, the question# 25, 26, 27, 28, 29, 30)

6th Objective:- To identify the differences among UNRWA staff in relation to organizational and personal characterestics.

Questions on the sixths objective are (28) questions # is (53,54,55,56,57,58,59,60,61,62,63,64,65,66,67,68,69,70,71,72,73,74,75,76,77,78,79,80).

7th Objective:-To conclude recommendations among health care providers to improve the communication process.

Questions on the seventh objective are tow questions # 105, 106

Open question (Qualitative analysis).

A) Recomendatio t0 improve communication between HCPs in normal situation.

B) Recomendatio t0 improve communication between HCPs in emergency situation.

Annex 9.2

Domaines & Dimensions of communication statuts :

Domaines & Dimensions	No Q	**question No**	
HCPs 1-Knowledge	4 Qs	questions No (13,14,15,16)	
2-Perception	4 Qs.	questions No (17, 18, 19, 20)	
3-Expérience	4 Qs.	questions No (21, 22, 23, 24)	
Communication Statuts			
1-Features & 2-Characteristics	6 Qs.	question# 25, 26, 27, 28, 29,30	
3-Challenges	12 Qs.	question# 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42	
4-Barries	10 Qs.	question# 43, 44, 45, 46, 47, 48, 49, 50, 51, 52	
Communication Differences B/W . HCPs. Related to Personal & Organizational Characteristics	28 Qs.	1-Rumors----------Q# 53,55 2-Grip vine----------Q# 54,56,57 3-Mutual Respect---Q# 58,59,60,61 4-Transperancy------Q# 62,63,64 5-Equity----------Q# 65,66,67 6-Openess----------Q# 68,69 7-Discremenation----Q# 70,71,72 8-Competition--------Q# 73, 75 9-Conflict----------Q# 74,76 9-Political balance---Q#77,78 10-Separation----------Q#79,80	
Communication (**Others**)			
1-& Data Access	5 Qs	question# 81,82,83,84,85	
2-& Chain of Command	6 Qs	question# 86,87,88,89,90,91	
3-& Documentation	4Qs	question# 92,93,94,95	
Communication Process:	6	**question# 96, 97, 98, 99, 100, 101,**	
1-Source (skills)	1Qs	question#98	
2-Message (aim)	1Qs	question#97	
3-Receiver (feedback)	1Qs	question#96	
4- (Documentation)	1Qs	question#99	
5- (Channel)	1Qs	question#100	
6- (Language)	1Qs	question#101	
Preferred tool for communication			
1-In Normal situations	1Qs	question#102--------(1,2,3,4,5,6,7,or8)	
2-In Emergency situation	1Qs	question#103--------(1,2,3,4,5,6,7,or8)	
3-In Group meeting	1Qs	question#103--------(1,2,3)	
Communication Improvements Recommendations	2 Qs	question# 104 open qualitative question question# 105 open qualitative question	

Annex 9.3

Questions on the Differanceses in communication characterestics between UNRWA as Organization and UNRWA staff as leaders and HCPs & their question number :-

UNRWA as an Organization	**UNRWA staff as Leaders & HCPs**		**Subject of differences**
53	55		*** Rumors** (Informal power)
54	56	57	***Grip vine** (informal power)
58	60	59, 61	*** Mutual Respect** (Policy) (Effect)
62	63	64	***Transperancy** (Practice) (Effect)
65	66	67	*** Equity** (Practice)
68		69	*** Openess** (Practice)
70	71	72	*** Discremenation**
73		75	*** Competition** (Practice) (Effect)
74		76	*** Conflict** (Practice) (Effect)
77, 78		79, 80	*** Political balance, Separation, division**
81		82,83,84, 85	*** Access to data & informations**
86, 87	88, 89	90	*** Ways of communications**
92	93	94,95	*** Documentation**

Annex 10

List of experts control names (panel)

1. Professor Ezzo Afana.	Prof. of curriculum and Teaching Methodology IUG.
2. Dr Yahia Abed	Prof. of Public Health -Al Quds University.
3. Dr Bassam Abu Hamad	Programme Co- Coordinator Al Quds University.
4. Dr. Erik Sariot	Visiting Expert in management to Al Quds University.
5. Dr. Elian Al Hole.	Dean of Faculty of Education, IUG.
6. Dr. Ashraf Al Jade.	Dean of Faculty of Nursing School, IUG.
7. Dr. Mosa Al Zaabout.	Ass. Prof. In Medicine, The Islamic University Gaza.
8. Dr. Sana Abu Daqaa.	Head of Quality Unit, IUG.
9. Dr. Attef El Agga.	Ass. Prof. in Psychology -The Islamic University Gaza.
10. Dr. Ettaf Abed.	The Islamic University Gaza.
11. Dr. Ali Al Jeesh	Disease Control Field Officer Health Programme UNRWA.
12- Dr. Ettaf Abd	Head of quality unit at faculty of Nursing IUG.
13. Ali Hassan Abu Riala.	Director of Nursing / Waffa Hospital.

Annex 11

Table (4.13) Shows Relation ship between Knowledge, Perception, Experience and selected sociodemographic data

selected sociodemographic	Relationship	Test Value	df	P- Value
1- Profesion	Knowledge	6.381	2	0.068
	Perception	3.951	2	0.139
	Experience	14.355	2	0.001*
2- Gender	Knowledge	- 1.384		0.166
	Perception	- 0.283		0.777
	Experience	- 1.660		0.097
3 -Age	Knowledge	2,193	3	0.533
	Perception	13.938	3	0.003*
	Experience	2.240	3	0.524
4- Level of Qualification	Knowledge	1.442	2	0.486
	Perception	1.250	2	0.535
	Experience	6.519	2	0.038*
5- Country of Qualification	Knowledge	3.068	2	0.216
	Perception	1.133	2	0.567
	Experience	4.288	2	0.117
6- Total Years of Experience	Knowledge	5.962	2	0.113
	Perception	6.522	2	0.089
	Experience	3.227	2	0.358
7- Experience at UNRWA	Knowledge	2.599	3	0.458
	Perception	9.661	3	0.022*
	Experience	3489	3	0,322

The result of analysis shows that their was a significant relation ship between HCPs profesion and their experience in communication with P- value= 0.001.

Their was a significant relation ship between HCPs age and their perception about communication with P- value= 0.003.

Their was a significant relation ship between HCPs level of qualification and their experience in communication with P- value= 0.038.

Their was a significant relation ship between HCPs experience at UNRWA and their perception about communication with P- value= 0.022.

Annex 12

Analysis according to points of characteristics differences between Personnel (HCP) and Organization.

<u>First point</u>:- Informal communication by Rumors and Grip vine. (personal & organizational)

Table (1):

No	Paragraph	Mean	Proportional Mean%	Test value	P-value (Sig.)	Rank
Q#53	The degree UNRWA news start as, informal rumors & informal (grip vine) news ?	3.36	67.12	5.38	0.000*	3
Q#54	The degree, UNRWA communications practice, rumors & grip vine methods?	2.89	57.89	0.00	0.138	4
Q#55	The degree, Your director prefers his own grip vine informal persons?	3.51	70.18	5.95	0.000*	1
Q#56	The degree, your director constructs his perceptions, from grip vine news?	3.42	68.49	5.55	0.000*	2
Q#57	The degree, you like to be a grip vine person, form and to the director during work?	1.68	33.65	-11.91	0.000*	5
	Total	2.97	59.47	0.00	1.000	

- The mean is significantly different from 3

<u>Second point:-</u> Communication and Mutual respect. (personnel & organizational)

Table (2):

No	Paragraph	Mean	Proportional Mean%	Test value	P-value (Sig.)	Rank
	(Q#58)The degree, UNRWA policy, practice mutual respect in its communications?	3.15	63.09	3.07	0.002*	4
	(Q# 59)The degree, HCP practice mutual respect during their communications?	3.55	71.08	9.17	0.000*	2
	(Q# 60)The degree; the director respect HCPs during his communication with them?	3.41	68.23	6.44	0.000*	3
	(Q# 61)The degree; you found that, mutual respect lies behind any effective communication?	4.31	86.26	14.05	0.000*	1

	Total	3.61	72.14	10.18	0.000*	

- The mean is significantly different from 3

<u>Third point:</u>- Communication and Transparency. (personal & organizational)

Table (3):

No	Paragraph	Mean	Proportional Mean%	Test value	P-value (Sig.)	Rank
1-	(Q#62) The degree, UNRWA communications are characterized by transparency e.g. during regular management team meeting (MTM)? (from your experiences)	3.17	63.38	2.92	0.003*	3
2-	(Q# 63) The degree, the director, was transparent during his communication with you e.g. as he transmit the results and message of regular MTM.	3.64	72.81	9.00	0.000*	1
3-	(Q# 64)The degree, transparent communications, improves work conditions	3.36	67.29	5.97	0.000*	2
	Total	3.39	67.81	6.60	0.000*	

- The mean is significantly different from 3

<u>Fourth point:-</u> Communication and Equity. (personal & organizational)

Table (4):

No	Paragraph	Mean	Proportional Mean%	Test value	P-value (Sig.)	Rank
1-	(Q# 65)The degree, UNRWA practices equity in gender in communication with HCPs?	3.29	65.78	5.30	0.000*	2
2-	(Q#66)The degree, communication with director through proper channels only, is sort of equity?	3.16	63.10	3.81	0.000*	3
3-	(Q# 67) The degree, you practice gender equity in your communication with HCPs?	3.52	70.43	8.16	0.000*	1

	Total	3.32	66.47	6.24	0.000*	

- The mean is significantly different from

<u>Fifth point:-</u> Communications and Openness. (personal & organizational)

Table (5):

No	Paragraph	Mean	Proportional Mean%	Test value	P-value(Sig.)	Rank
1-	(Q# 68)The degree, UNRWA practice openness in it's communications with all HCPs?	3.00	60.07	0.46	0.644	2
2-	(Q# 69)The degree, your colleague talks to you openly, if he had a medical mistake with patient?	3.07	61.44	1.76	0.078	1
	Total	3.04	60.76	0.07	0.946	

<u>Sixth point:-</u> Communications and Discrimination. (personal &organizational)

Table (6):

No	Paragraph	Mean	Proportional Mean%	Test value	P-value(Sig.)	Rank
1-	(Q# 70)The degree, UNRWA was far away from discrepancy in it's communications with HCPs?	3.00	60.00	0.30	0.765	2
2-	(Q# 71)The degree, director practices discrepancy between HCPs in his communications.?	3.01	60.14	0.00	1.000	1
3-	(Q#72)The degree, you are suffering from discrimination, when colleague communicate with you?	2.84	56.74	-2.02	0.043*	3
	Total	2.95	59.00	-1.09	0.275	

- The mean is significantly different from 3

Seventh point:- Communication and Competition OR Conflict. (personal & organizational)

Table (7):

No	Paragraph	Mean	Proportional Mean%	Test value	P-value(Sig.)	Rank
1-	(Q# 73)The degree, UNRWA communications cerate's positive competition between HCPs?	2.94	58.70	-0.15	0.883	3
2-	(Q# 74)The degree, UNRWA communications cerate's conflict situation between HCPs?	2.89	57.84	-1.51	0.132	4
3-	(Q# 75)HCP positive competition results in effective communications.	3.23	64.55	3.46	0.001*	1
4-	(Q# 76)HCP conflicts results in ineffective communication.	3.18	63.67	2.94	0.003*	2
	Total	3.06	61.21	2.52	0.012*	

- The mean is significantly different from 3

Eighth point:- Communication and Political balance. (personal & organizational)

Table (8):

No	Paragraph	Mean	Proportional Mean%	Test value	P-value (Sig.)	Rank
1-	(Q#77)The degree, UNRWA communications with others described as politically balanced.	3.22	64.40	3.43	0.001*	3
2-	(Q#78)UNRWA communications with other organizations, are far away from state division and separation between parties.	3.27	65.42	4.41	0.000*	2
3-	(Q#79)Communications of HCPs has negatively affected by situation of political closure.	3.46	69.24	7.08	0.000*	1
4-	(Q#80)Your communication with HCPs has negatively affected by situation of political closure.	3.15	63.02	2.20	0.028*	4

	Total	3.28	65.52	5.87	0.000*	

* The mean is significantly different from 3

Annex 13

Opinions of HCPs on communication improvements in Arabic

نتائج اراء مقدمي الخدمات لتحسين حالة الاتصال

<u>في الوضع العادي</u> :

1. التدريب على مهارات الاتصال الفظي وغير اللفظي .
2. إدخال موضوع الاتصال ضمن المناهج التعليمية لجميع المستويات الدراسية.
3. برنامج للتوعية المجتمعية عن دور الاتصال الفعال في بناء الصحة الجيدة.
4. تامين الميزانيات اللازمة وزيادة الاستثمار في تدريب مقدمي الخدمات الصحية.
5. تحسين البنية التحتية للاتصالات في المراكز التابعة للانروا.
6. زيادة فرق الصيانة المتحركة المخصصة للاتصالات.
7. تزويد المراكز بخط اتصال مجاني لخدمة المجتمع.
8. تحسين مجلة أخبار الاونروا بزيادة المواضيع الخاصة عن انجازات مقدمي الخدمات الصحية.
9. تحسين بيئة الاتصالات بالمركز لتكون خالية من التشويش.
10. تنشيط لجنة أصدقاء المركز الصحية الاجتماعية وزيادة التواصل بين مقدمي الخدمة.
11. تزويد المراكز بشاشات عرض وأدوات التوعية المناسبة.
12. تنفيذ تدريب خاص لمهارات الاستماع الجيد والتركيز أثناء التخاطب.
13. التحول إلى نظام التواصل عبر جميع القنوات.

14. الاهتمام بردود وطلبات المجتمع من خلال صناديق الشكاوي.

15. تخصيص ربع ساعة في الصباح وأخرى بنهاية الدوام للتواصل بين مقدمي الخدمات الصحية.

أثناء الطوارىء :

1. تكوين فريق للطوارئ ليكون جاهزا للعمل.
2. تزويد البنية التحتية بوسائل الاتصال اللاسلكية.
3. توفير زى طوارئ للعاملين الصحيين بالوكالة لحمايتهم وعدم استهدافهم.
4. توفير الحماية الدولية اللازمة للعاملين بالوكالة.
5. تامين المواصلات والتموين لأسر العاملين بالوكالة أثناء الحرب أو الكوارث .
6. تأمين خط هاتفي مجاني لاتصالات المجتمع.
7. إنشاء محطة إذاعية FM للبث للعاملين بالوكالة.
8. تجهيز مراكز الإيواء بوسائل الاتصال المناسبة .
9. تدريب مقدمي الخدمات الصحية على كيفية إرسال الرسائل الواضحة واستخدام اللاسلكي
10. إنشاء محطة اتصال بديلة خارج قطاع غزه لاستخدامها عند اللزوم.
11. الاهتمام بالتوثيق والتغذية الراجعة وتحديد الهدف من كل اتصال أثناء الطوارئ.
12. عمل مراجعة للأخطاء أثناء الحرب الأخيرة للاستفادة من هذه الدروس في تحسين الاتصالات.

Annex .14

Research Recommendations in Arabic

التوصيات لتحسين الاتصال بين مقدمي الخدمات الصحية في المراكز التابعة للانروا في محافظات غزة

1 -برنامج للتدريب على الاتصال اللفظي وغير اللفظي ومهارات الاتصال.

2- أدراج موضوع الاتصال ضمن البرامج التعليمية في كل المستويات .

3- تحسين بيئة العمل لتكون هادئة وخالية من التشويش.

4- تجهيز الأماكن المخصصة للإيواء بالبنية التحتية المناسبة للاتصالات.

5- تدريب ميداني على الاتصال باستخدام الأدوات المتاحة.

6- مراجعة للدروس المستفادة من الحرب الأخيرة على غزه.

Annex. 15 Abstract in Arabic

الخلاصة

" (حالة) واقع الاتصال والتواصل بين مقدمي الخدمات ألصحية في المراكز الصحية التابعة لوكالة غوث وتشغيل اللاجئين الفلسطينيين (الاونروا) في محافظات غزة"

ألاتصال والتواصل قضية مهمة في أي مكان يقدم الرعاية الصحية. تهدف هذه الدراسة إلى استكشاف وضع الاتصال بين مقدمي ألخدمات الصحية العاملين في المراكز الصحية التابعة لوكالة غوث وتشغيل لاجئي فلسطين(الاونروا) في محافظات غزه. استخدم في هذا البحث التصميم الوصفي التحليلي. وقد شملت الدراسة جميع مقدمي الخدمات الصحية العاملين في المراكز الرئيسية الخمسة بواقع مركز صحي من كل محافظة. وزع الاستبيان الذي صممه الباحث على جمي ع الأفراد اللذين شملتهم الدراسة. وقد بلغت نسبة الاستجابة95.5 %. استخدم في تحليل البيانات البرنامج الإحصائيِ SPSS 15 في تحليل البيانات.

أظهرت النتائج أن الاتصالات اللفظية هي الأكثر استخداما من قبل الفرق الصحية بنسب ة 67%. كذلك أوضحت أن الاتصال بالتحدث وجها لوجه هي الأكثر تفضيلا بنسبة بلغت 84.1% ، الهاتف بنسبة 6.4%، الرسائل المكتوبة بنسبة 2.8%، البريد الاليكتروني بنسبة 2.1%، الانتركوم بنسبة 1.4%. كذلك أظهرت النتائج أن 26.3% فقط من مقدمي الخدمات الصحية قد درسوا موضوع الاتصالات قبل تأهيلهم الجامعي ، وأن 19.1% قد حصلوا على دورات تدريبية عن الاتصالات. ومن خلال حساب جميع النقاط المتعلقة بالمعرفة وجد أن 25.3% فقط من مقدمي الخدمات الصحية لديهم المعرفة الكافية عن الاتصال والتواصل, ة وأن 87.3% من مقدمي الخدمات الصحية لديهم المفاهيم الواضحة عن الاتصال والتواصل. هذا ويعتبر89.5% من مقدمي الخدمات الصحية أن الاتصالات هامة وحيوية للمريض. كما أفادت الدراسة أن 62.8% من مقدمي الخدمة لديهم ألخبره في الاتصال والتواصل. وكان ترتيب الصفات وخصائص الاتصال التي يتمتع بها مقدمي الخدمات الصحية على النحو التالي : ألاحترام المتبادل بنسبة 72.1%، الشفافية 67.8%، المساواة 66.4%، التوازن السياسي 63%، التنافس الايجابي 61.2%. أظهر البحث أن هناك فروقا ذات دلالة احصائيه تتعلق بالمهنة والمستوى التعليمي ومكان الدراسة العليا.

هذا وقد أوصى البحث لتحسين الاتصال بين مقدمي الخدمات الصحية في الانروا من خلال التغلب على الازدحام، و تنفيذ برنامج تدريبي عن مهارات الاتصال وتدعيم البنية التحتية للاتصالات.

قال ابن العماد:

لا يكتب الإنسان كتابا في يومه إلا

قال في غده

لو زيد هذا لكان أحسن ولو

انقص هذا لكان

يستحسن ولو تغير هذا لكان أجمل

وهذا من أعظم العبر وهو دليل على استيلاء النقص على جملة البشر

تم بحمد الله

وآخر دعوانا أن الحمد لله رب العالمين