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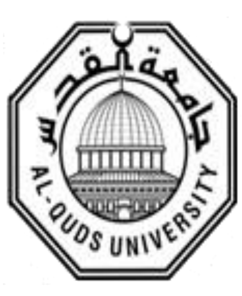


# Evaluation of the Family Health Team Approach Implemented at UNRWA Health Centers- Gaza Governorates

**Adham Khalil Safi**

**MPH Thesis**

**Jerusalem-Palestine**

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# Evaluation of the Family Health Team Approach Implemented at UNRWA Health Centers- Gaza Governorates


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## Thesis Approval

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**Jerusalem-Palestine**

**1439/2018**

## Dedication

I would like to express my deep sensation and admire to my father who gave me the strength and courage, and to the spirit of my mother who dreamed of the day that I will become a successful man.

To my lovely wife Samar who always supports me, helps me, and provides me with love and positive energy.

To my four inspiring sons"Khalil,Abdulla,Mohammed &Ahmed"

To all of my brothers and sisters who always encourage me.

To all of my friends who always support me

I dedicate the research for all of them

Adham Khalil Safi

## 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 higher degree to any other university or institution

## Signed

AdhamKh. Safi

Date: 18/8/2018

## Acknowledgement

With the feeling of proud and great the researcher is going to express his deep appreciation and respect to his honorable supervisor Dr. Khitam Abu HamadI would like to thank her for her unlimited support, patience and for everything she did to me especially sharing her experience and knowledge with me.

Great Thanks to DrGhada Al Gadba, the Chief of Health Program at UNRWA ,who supported and helped me to conduct this thesis and to collect data to complete this study, and deep appreciation for her experience sharing through the qualitative part in this study.

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Finally I would like to extend my deep appreciation and respect to my colleagues, staff and friends at the school of public health and UNRWA health department.

*With respect*

*AdhamKh. Safi*

## Abstract

*Family Health Teams are primary health care teams that include family physicians,nurse practitioners, registered nurses, social workers, clerks, and other professionals who work together to provide comprehensive health care services within primary health care settings. For any family health team to function effectively, several requirements need to be present, such requirements include electronic medical health record, skilled employees, organizational readiness, and space suitability to accommodate the provision of health services through family health teams.. After more than 5 years of UNRWA's adoption to the Family Health Teams as an approach to provide comprehensive health services in the Gaza Strip. It is highly important and highly needed to extensively evaluate outcomes of providing health services through Family Health Teams.*

*The design of this study is a mixed method that utilizes quantitative and qualitative data. The researcher collected quantitative data from beneficiaries of six UNRWA health centers across the Gaza Strip, and collected qualitative data from health service providers and key-informants. Quantitative data were collected from 400 clients attending UNRWA's health centers and have been utilizing health services through family health teams. The 400 clients were selected using simple random technique from the study settings. For the qualitative part, in total, four focus group discussions with health providers from study settings and three in-depth interviews with key informants of UNRWA Health Department were conducted. Analysis of the data was conducted using SPSS program. The analysis involved frequency distribution, chi-square and ANOVA tests.*

*The quantitative study findings have revealed that 86% of the study participant's preferred receiving health services through family health teams over the traditional approach of providing services, only 14% of participants prefer receiving health service through the traditional approach. The overall mean of perceived quality of health services provided through family health teams was 76.72%, and the overall mean satisfaction with health services provided through family health teams was 80.8%. From Clients' perspective, the overall mean of family health teams' appropriateness as a model to provide health services was 76.57%. The majority of the quantitative study participants would recommend the utilization of health services provided by family health teams to their relatives and friends, (93.5%). There was statistically significant relationship between the three domains-perceived quality, satisfaction, and appropriateness- and having chronic diseases, regular patient follow up. Additionally, perceived quality and satisfaction were statistically significant with clients' age. While having health insurance was statistically significant with the perceived quality of the provided services, satisfaction with the provision of health services through family health teams with and appropriateness of providing health services through family health teams.*

*Quality of the provided services through family health teams could be improved by reducing the clients waiting time and increasing the contact time, strengthening follow up for chronic patients as well as updating protocols. It is also recommended that UNRWA's strengthens its systematic monitoring to improve the quality of the provided services. Finally, conducting further comparative studies to assess the impact of providing health services through family health teams across the five locations of UNRWA's work and to deeply assess the long-term impact of providing health services through family health teams on improving health status of Palestinians are highly needed.*

**تقييم نهج فريق صحة العائلة المطبق في عيادات وكالة الغوث الدولية بمحافظات قطاع غزة**

**ملخص الدراسة**

فرق صحة الأسرة (ف.ص.أ) هم عبارة عن فرق من مقدمي الرعاية الصحية الأولية و تضم هذه الفرق فريقا من أطباء الأسرة, و ممرضين ممارسين, و ممرضين أو ممرضات المسجلين في نقابة التمريض, و أخصاء الاجتماعيين, و موظفين كتّاب, و غيرهم من الممتهنين المختصين و يعملون معا جميعا لتوفير خدمات الصحة الأساسية داخل المنشئات التي تقدم خدمات الرعاية الصحية الأولية. لأجل أن يعمل أي من فرق صحة الأسرة بشكل فعال, يجب تلبية العديد من المتطلبات الأساسية. هذه المتطلبات تتضمن: سجل (ملف) الصحة الالكتروني و أيضا مجموعة من الموظفين المختصين و المهرة. و يجب أيضا توافر ترتيبات داخلية داخل المراكز الصحية ليتم تمكين و استيعاب النهج المتبع الجديد في تقديم الخدمات الصحية و هو نظام فرق صحة الأسرة.

بعد أكثر من خمس سنوات من تطبيق نظام فرق صحة الأسرة, ظهرت حاجة ملحة الى تقييم نتائج اتباع النظام الجديد المتبع في المنشئات الصحية. و بالتالي, فإن هذه الدراسة تعتبر استجابة للحاجة إلى تقييم هذا النهج و النظام الجديد المتبع في العيادات و المراكز الصحية التابعة لوكالة الغوث (الأونروا).

أما بالنسبة لهيكلية الدراسة الكمية, فإنها دراسة وصفية و تحليلية شاملة تغطي مزيج من الجوانب المعنية بها الدراسة. قام الباحث بأخذ العينة المعلومات الكمية من المستفيدين المترددين الى ستة مراكز صحية موزعة على قطاع غزة, وقام ايضا بجمع البيانات النوعية من مقدمي الخدمة الصحية و المسؤولين بوكالة الغوث في قطاع غزة,المعلومات الكمية تم الحصول عليها من 399 مستفيد يحصلون على الخدمة من مراكز الصحة الاولية التابعة للأونروا ويستفيدون من خدمات نهج فريق صحة العائلة و بالنسبة لطريقة اختيار العينة التي بنيت عليها هذه الدراسة, فهي عن طريق جمع العينة العشوائية و تم تطبيقها في ستة مراكز صحية تابعة للأونروا داخل قطاع غزة. أما بالنسبة للجزء الذي يتعلق بالبيانات النوعية من الدراسة, قام الباحث بإجراء أربع مجموعات بؤرية مع مقدمي الخدمات الصحية من المراكز الصحية الستة التابعة للأونروا. و علاوة على ذلك, قام الباحث أيضا بإجراء ثلاث مقابلات فردية تضمنت أسئلة متعمقة مع كبار المسؤولين المعنين بالقضايا الصحية من موظفي وكالة الغوث في قطاع غزة. تم اتباع الاجراءات الرئيسة للإحصاء و الاختبارات ذات الطابع الأكاديمي المتبع مثل اختبار مربع كاي, و اختبار العلاقة, و اختبار تي و من ثم تم تطبيق مبدأ التبويب التقاطعي على نتائج الاختبارات. و تم أيضا اعتبار اختبار أنوفا أحادي الوجه أو الاتجاه قد كان من ضمن الطرق المتبعة للتحري في العلاقات بين المتغيرات المختلفة و العلاقات التي قد يحتمل ورودها بين المتغيرات فيما بينها.و كانت النتائج الرئيسية المترتبة على الدراسة كالتالي:

- نسبة 86% من المرضى يفضل نهج فرق صحة الأسرة على النظام التقليدي لتقديم الخدمات.
- نسبة 14% فقط من المشاركين قالوا بأنها يفضلون النظام التقليدي لتلقي الخدمات الصحية.
- بلغ متوسط نسبة جودة الخدمة المقدمة 76.72% بالنسبة لتقييم المشاركين للخدمات الصحية المقدمة عن طريق نظام فرق صحة الأسرة, و بينما كان متوسط نسبة رضاهم العام عن نهج فرق الأسرة في تقديم الخدمات الصحية 80.8%, و بلغ متوسط نسبة ملائمة نهج فرق صحة الأسرة 76.57% في تقديم الخدمات الصحية. أما نسبة المشاركين الذين أوصوا أقاربهم و أصدقائهم بتلقي الخدمات الصحية عن طريق نظام فرق صحة الأسرة كانت 93.5%. و تم رصد علاقة ذات دلالة احصائية بين النطاقات الآتية: (الجودة المدركة و ملائمة النظام في تقديم الخدمة و ايضا الرضا عن الخدمة بالنهج المتبع) مع (اصابة المريض بمرض مزمن و ايضا مدى انتظام المتابعة مع المركز الصحي). و تم أيضا رصد أن عامل السن كان له علاقة إحصائية مع الرضا عن تقديم الخدمة بالنظام المتبع, و الجودة المدركة للخدمة المقدمة أيضا. و بالسنبة لعامل امتلاك التأمين الصحي, فكان له علاقة في قياس الجودة المدركة, و ملائمة نظام فرق الصحة في تقديم الخدمات الصحية و أيضا الرضا عن النظام في الخدمات المقدمة.

في النهاية الباحث يقترح ان جودة الخدمات الصحة المقدمة من خلال نهج فريق صحة العائلة يمكن ان تتحسن من خلال تقليل وقت انتظار المرضى و زيادة مدة الحصول على الخدمة بشكل كافي. ايضا الباحث يقترح متابعة مرضى الامراض المزمنة بشكل كافي لتجنب المضاعفات التي قد تحصل لهم بدون متابعة و اهتمام و العمل على تحديث القوانين والضوابط المتعلقة بالخدمات الصحية, و ايضا تقوية نظام المراقبة للحصول على جودة عالية من خدمات الصحة.و أخيراً, فإن صاحب البحث يقترح بإجراء المزيد من الأبحاث لدراسة مقارنة تأثير اتباع نهج فرق صحة الأسرة على جودة الرعاية و الخدمات الصحية المقدمة لـلاجئينالفلسطينيين في اماكن تواجدهم بالأقاليم لخمسة و يرى الباحث أيضا أن هنالك حاجة لإجراء بحث يقيم مدى تطبيق نهج فرق صحة الأسرة في تقديم الخدمات الصحية إلى الفلسطينيين على المدى البعيد, واثره على تحسين الحالة الصحية من خلال منهاج فرق صحة الأسرة .

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## List of Abbreviations

| | |
|---|---|
| EMR | Electronic Medical Records |
| FHT | Family Health Team |
| GS | Gaza Strip |
| MCH | Mother and Child Health |
| MOH | Ministry of Health |
| NCD | Non Communicable Diseases |
| NGO | Non-governmental Organization |
| PA | Palestinian Authority |
| PCBS | Palestinian Central Bureau of Statistics |
| PHC | Primary Health Care |
| UNEP | United Nations Environment Program |
| UNRWA | United Nations Relief and Works Agency for Palestine Refugees in the Near East |
| WB | West Bank |
| WHO | World Health Organization |

# Chapter 1

## Introduction

### 1.1 Background

Family Health Teams (FHT) are primary health care providers that include a team of family physicians,nurse practitioners, registered nurses, social workers, clerks, and other professionals who work together to provide primary health care services within primary health care settings. For any FHT to function effectively, several basic requirements need to be presented. These requirements include electronic health records, skilled employees, and prepared internal arrangements inside the health centers to accommodate the provision of services through FHT. The extent to which these requirements are presented increases the chances of achieving good outcomesby the FHT(Hogan, 2007; Keen,2003). Previously, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) used to provide health service through traditional ways through different providers distributed in different places within health centers, thus, in each visit, patients consult different health care providers. Generally, the traditional provision of health services jeopardizes the provision of comprehensive patient-centric services (Zwane, 2005). The FHT focuses on the treatment of diseases and also helps families to adopt healthy lifestyle through understanding the common health risks that a family might face. FHT approach helps health care providers to provide comprehensive health service, prevent the spread of communicable disease, and controlling further epidemic diseases that could threatens families. Finally, FHTapproach is a good strategy to build a trust relationship between patient and health care providers which in turn achieve a high level of patient satisfaction with the provided services. With regard to UNRWA's health service, previously Non-Communicable Diseases (NCD) and Mother and Child Health (MCH) services were provided through the traditional way which means involving different providers in each visit. Currently, UNRWA has adopted the FHT approach to provide services in which each family is served by one team that is composed of one physician, one nurse, one midwife and one clerk (UNRWA, 2012). The new FHT approach was adopted as a model for service delivery in 2011. It aimed to provide services in a cost effective and efficient way, with the best attainable level of quality. It has been also adopted in the West Bank, Lebanon, Jordan, and Syria.

## 1.2 Study Significance

The FHT approach is a new a modern fairly new approach to deliver quality of health care. UNRWA's FHT is a client-centered approach which was introduced originally to improve the health status of Palestinians (UNRWA, 2016a). Within the context of the Gaza Strip, the FHT is expected to deliver highquality services, ensure the accessibility to comprehensive health services, and help in controlling and eliminating communicable and non-communicable diseases (UNRWA, 2015). Additionally, FHT approach is expected to fairly distribute the workload among the health care providers. Generally, after more than five years of adopting and implementing the FHT approach within UNRWA health centers, there is a need to evaluate the outcomes of FHT approach.

## 1.3 Study Justification

The number of Palestinian refugees has increased over the past years, thus, the demand for health services has been increased due to different factors, such as population growth, frequent wars, changes in the population structure. With the overall aim of improving the health status of Palestinians, UNRWA is committed to deliver health services that are considered of good quality, highly accessible, and affordable. To improve the health of the Palestinian population, UNRWA has been providing comprehensive package of primary, secondary, and tertiary services. The provision of services is free of charge. In response to the high demand of health services, UNRWA has initiated administrative reform which is the introduction of FHT. The FHT approach was introduced as a pilot study program in 2011 in two health centers. After the piloting stage, UNRWA has expanded the FHT to be implemented in its 22 centers after making sure of staff readiness, full functionality of the e-health system. After more than 5 years of implementing the FHT approach, there is a need to extensively evaluate outcome of the FHT. Thus, this study is a response to such need, the study will be the first one to evaluate this new approach within the UNRWA clinics. The study will propose recommendations that could be used by policy makers in UNRWA to improve the quality of the provided services. Additionally, findings of this study could be used by other health care providers such as the Ministry of Health (MoH) to reform the service provision.

## 1.4 Aim of the study

This study aims to evaluate the family health team approach implemented at UNRWA-health care centers in the Gaza Strip, in order to propose recommendations that could

improve outcomes of the FHT approach, and thus, improve the overall wellbeing of the Palestinians in the Gaza Strip.

## 1.5 Objectives of the study

1. To examine the appropriateness of FHT approach at UNRWA health centers
2. To assess the perceived quality of FHT, from patients'perspectives
3. To assess the patient satisfaction with the FHT approach at UNRWA health centers
4. To propose recommendations that could improve the outcomes of FHT

## 1.6 Context of the Study

### 1.6.1 Socio demographic context

Palestine is located in Southwest Asia in the southern part of the East coast of the Mediterranean Sea, and is located in the heart of the world, that makes it a bridge between the continents of Asia and Africa, and between the Mediterranean and the Red Sea (PIC, 2010). According to the Palestinian Central Bureau of Statistics (PCBS), in 2018, the total population who live in the Gaza Strip and West Bank was about 5 million, including about 2.1 million in the GS. Based on these estimates the urban population is accounted for 73.9% in 2016 and the percentage of the population living in the rural area is 16.6%, while in the refugee camps accounted for 9.5%. The Palestinian community in the GS residents' young more heavily than it is in the West Bank, estimated the proportion of individuals in the age group (0-14) in the middle of the year 2017 was 38.9% of the total population in Palestine, by 36.6% lived in reality in the West Bank and 42.6% in the Gaza Strip(PCBS,2018). The Gaza Strip is a very narrow piece of land along the Mediterranean Sea, a narrow section about 365 $Km^2$. It is approximately 41 km long and between 6–12 km wide (UNEP, 2009).

The GS comprises 7 towns, 10 villages and 8 refugee camps. It was occupied by Israeli army in 1967 until the Palestinian National Authority returned back after the Oslo Accord between Israel and Palestinians signed in 1993. But Israeli army and settlers' withdrawal completely occurred in August 2005, however military forces maintain existence,monitoring, and controlling of all GS borders and crossing points as well as the 40 km of cost line and air space of this narrow strip of land (MOH, 2009). According to the PCBS, the high population density in Palestine in general and especially in the GS is due to the concentration of about 2.1 million people in an area not exceeding 365 $km^2$. Those people are mostly Palestinian refugees who had to abandon their families to flee

from the occupied towns in 1948, in addition to high natural increase of the Gaza Strip population. In 2018 the estimated population density was 823 individual/$km^2$ in Palestine, 532 person/$km^2$ in the West Bank versus 5324 individual/$km^2$ in the GS (PCBS, 2018).

Economic conditions in the GS became worse due to the Israelblockadeof the GS and after the political segregation between the GS and the WB in June 2007. Israeli security imposed effective border control, this led to high unemployment and poverty rates.The Israeli military aggression in July 2014 has led to the further depression aid-dependent economy in the GS. The supporters donated to rebuild the destructed houses after the 2014 war, but Israeli restrictions complicated the post conflict needs, with almost 22,000 people remaining internally displaced as end of February 2018. The blockade on the sea, land and the air has remained since 2007, and three wars happened that increased the hardness of life in the GS. Before the blockade in 2005, Gaza was able to export 9,319 truckloads of goods (e.g. textiles, furniture, vegetables, etc.).This number fell to 113 truckloads (PCBS, 2015). The blockade has created very high aid dependency rates over 80 per cent of the people of GS depend on humanitarian assistance. According to PCBS, the unemployment rate stood at an average of 41% in2015 and for youth at 61 per cent. UNRWA works to address these issues through its regular operations by short-term employment opportunities. In 2015, the Agency created over 29,000 jobs, reducing unemployment by 6.2 per cent and the blockade created US 8.6$ million extra costs for UNRWA (UNRWA, 2016b).

### 1.6.2 Palestinian health care system

Ministry of health (MoH) is the main health care provider in the GS,and are struggling to provide a high quality of medical services to meet the high demand of health services.In the GS the health care providers are MoH ,UNRWA, NGOs,and private sector.The (MoH) provides primary ,secondary ,and tertiary services.The services for mother and child are free of charge. There are 54 primary health centers in the GS (MoH, 2013).

### 1.6.3 UNRWA Services

UNRWA was established by the UN General Assembly in 1949 and is mandated to provide assistance and protection forabout 5 million registered Palestinian refugees. Its mission is to help Palestinian refugees in Jordan, Lebanon, Syria, WB and GS to achieve their full potential in human development. UNRWA's services include education, health care, relief and social services, improvements of the infrastructure of the camp, microfinance and emergency assistance. UNRWA is funded almost entirely by voluntary contributions from all over the world (UNRWA, 2015). UNRWA's programs are classified

under the following departments: education, health, relief and social service, infrastructure and camp development (UNRWA, 2015).Through its 22 centers, UNRWA provides health-care services to the vast majority of over 1.2 million Palestine refugees in the GS. It also provides daily care and laboratory services at 22 centers and radiology services that are available at 7 centers, and dental services are available at 19centers. Across the GS, psychological trauma, poverty and environmental degradation have had a negative impact on resident's physical and mental health. This includes children who suffer from anxiety, distress and depression. UNRWA also provides psychosocial support through qualified counsellors to help Gaza's, particularly school students to overcome their difficulties and distresses. According to the latest report published by UNRWA, the total registered population accessing UNRWA health services was 1,372,440 (96.9%) (UNRWA, 2017). In 2017, the outpatient consultations for generalphysicians were 3,826,940 at the same time specialists' consultation were 31,557At each health center the average daily medical consultations decreased from 85 in 2016 to 78 in 2017 per physician (UNRWA, 2017).

## 1.7 Operational Definitions

### 1.7.1 Family Health Team

FHT consist of doctors, nurses, nurse practitioners, social workers, dietitians and other health care professionals who work collaboratively, each utilizing their experience and skills so that people can receive the best care, when you need it, as close to home as possible (Ontario Ministry of Health, 2016).

### 1.7.2 Perceived Quality

Perceived quality can be defined as the customer's perception of the overall quality or superiority of a product or service with respect to its intended purpose, relative to alternatives (Aaker, 1991).

### 1.7.3 Evaluation

This is a systematic way of learning from experience and using the lessons learnt to improve current activities and promote better planning by carefully selecting alternatives for future action (WHO, 1981).

### 1.7.4 Client Satisfaction

It is the degree to which individuals or community agrees with the nature, volume and quality of care services that delivered to their health needs and expectations (WHO, 2007)

# Chapter 2
# Conceptual Framework and Literature Review

## 2.1 Conceptual Framework

The conceptual framework represents the researcher synthesis of study. The conceptual framework sets the stage for the presentation of the particular research question that drives the study based on the formulation of the study problem. The “problem statement” of a thesis presents the context and the issues that motivated the researcher to conduct the study (McGaghie et al., 2001). Conceptual to evaluate the FHT approach, Donabedian’s model is applied. This model is universally accepted and widely used in the health service literature, especially in developing quality standards (Ibn El Haj et al., 2007). As shown in **Figure (1)** the proposed framework consists of the main factor that could be evaluated through patients-factors, providers-factors and process-factors.

### 2.1.1 Patient factors

The researcher investigated the effect of three factors that may affect the implementation of the FHT approachat UNRWA health centers which consist of the demographic factors, the socioeconomic factors and the medical profile factors. Demographic data includes the age and the marital status of the patient that could affect the implementation of the FHT approach, as well as the socioeconomic factor which includes the income of the family and its level of education. The health status or the medical profile of the patient can also affect the implementation of the FHT approach. The researcher also included the type of medical condition which led to the utilization of FHT services and the type of visit to the health center **Figure (1).**

### 2.1.2 Health care provider factors

This consists of four factors: knowledge and qualifications of the health care provider, as well as opinion and attitude that may affect the implementation of the FHT approach.The researcher think that the above factors will greatly affect the implementation and the provision of health services through FHT and the outcome of the provided services.

### 2.1.3 Process factors

The researcher will study the importance of six factors on the implementation of the FHT approach, as to know their role and effect through qualitative investigation. The researcher

will investigate the relationship between the process factors and their effect on provision the health services through FHT as shown in **Figure (1)**

**Factor 1: Staff Training**

Continuous staff training contributes to increase the skills of the staff, and it increases their ability to apply protocols. Training also help to change the staff's attitudes, behaviors, and performance by different methods like "on the job training", classroom training or even informal training (Carter, 1997).

**Factor 2: Workload**

The workload is defined as the amount of work that can be performed usually within a specific period of time. At UNRWA, the workload is an indicator of the daily journal of work and can help to estimate the needs of human resources and the population that centers can cover.

**Factor 3: Readiness of the staff**

It is the level to which the staff employed by UNWRA is qualified and ready to be trained to adapt to the changes associated with the new approach of service provision. Coaching is an important element that can increase staff readiness to implement the reform effectively and efficiently.

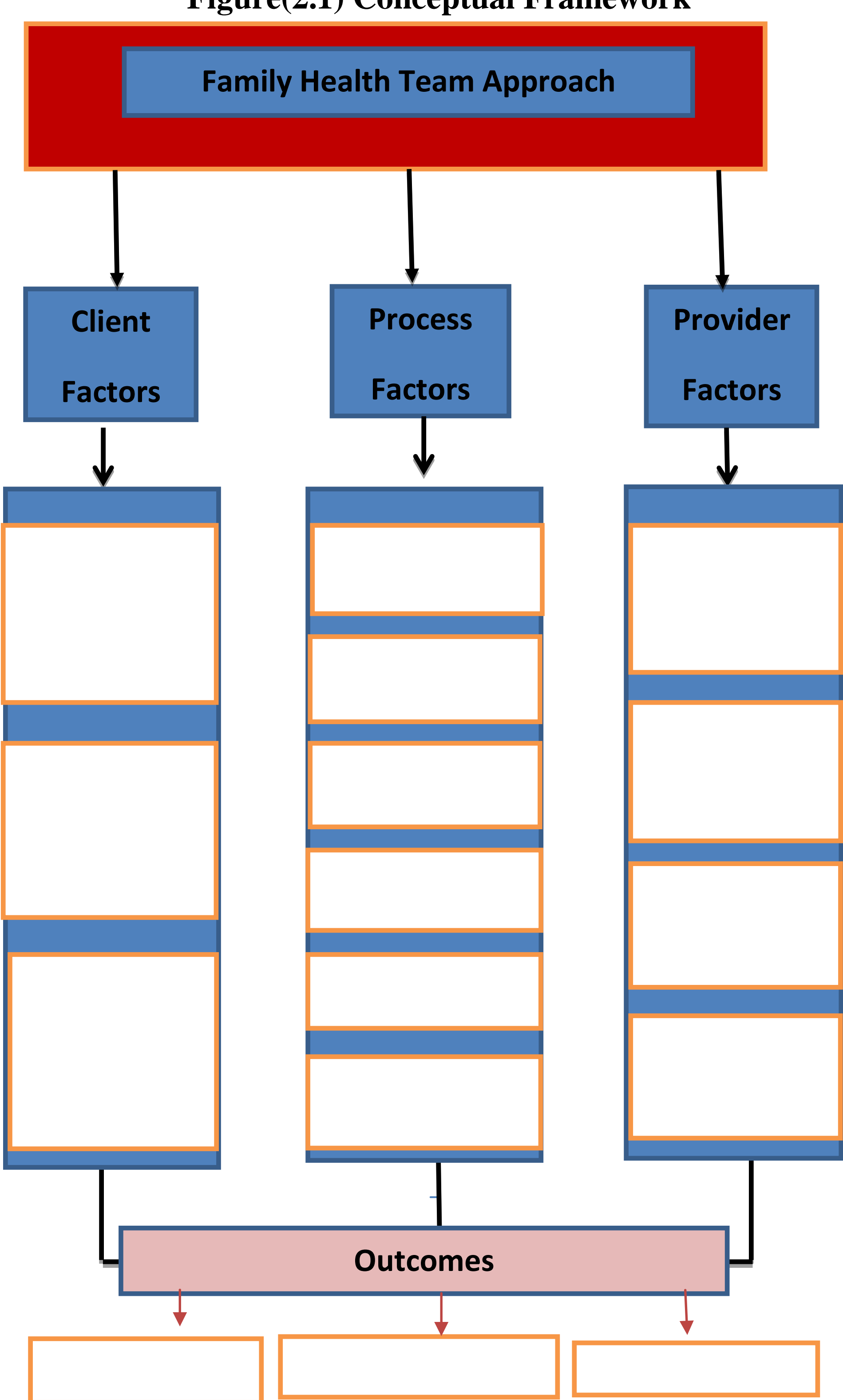
**Factor 4: Protocols**

UNRWA has guidelines and technical instructions "protocols" applied at UNRWA health centers. These protocols organize the work precisely and in accordance to World Health Organization (WHO) standards.

**Factor 5: Monitoring and Supervision**

The role of the supervisor is to coach the staff under his/her responsibility to get updated continuously about professional changes as well as to collect data and monitor the work process.Supervisors also guide their staff on how to react to errors, and to take the right decisions in accordance.

**Figure(2.1) Conceptual Framework**




**Factor 6: e-health system**

UNRWA's“e-health” was a major factor to implement the FHT approach. It assures that documented files will help the health care providers to deliver their services precisely. The researcher will investigate this factor and how it affects the implementation of the FHT approach.

## 2.2 Literature review

### 2.2.1 Family Health Team

The FHT is an approach designed to bring the health care providers to interact and work together, in order to provide a good quality care to the patients (WHO, 2008). FHT is composed of physicians, nurses, social workers and a dietitian, health care professionals who can coordinate with each other to provide quality health care (WHO, 2008). It is a new health reform and is patient-centered to obtain the best quality of primary public health care (Europa, 2015).

### 2.2.2 Team and Collaborative work

Teamwork involves sharing ideas to develop and address shared goals. Collaborative work yields effective benefits and its possibilities are expanded due to the existence of the internet and other online options. Through teamwork, problems can be more easily solved, knowledge better exchanged, and experiences shared. The health care team generally uses the terms 'multidisciplinary' or 'transdisciplinary' to describe the type of collaboration among team members. It was found by (Opie, 1997; Sands, 1993; Satin, 1994) that it is most useful to conceive of these terms as not distinct or opposing concepts, but as existing along a continuum from loose coordination, through interdependency, to role-blurring and synergistic teamwork. Two models of disciplinary relationships were applied. The first model was multidisciplinary, and the second was transdisciplinary, in which the team members collaborated without joint planning and or coordination, yet with good results.Campbell and Cole (1987) defined the multidisciplinary team as a team that is working together, that is interacting formally but working independently, while Jones (1997) defined the multidisciplinary group of professionals as a process of communication channels either verbal or written or both, involving the health care providers and patients with their families to coordinate for a common goal for the patient.

Studies indicate that effective collaboration leads to a synergy that can improve the care of the patients. Pike (1991) indicated that team members must trust and respect each other and develop strong relationships. While Cott (1998) indicated that teamwork functions promote cooperation and collaboration among professionals. Griffiths (1998) indicated that lower ranked team members sometimes use strategies to resist instructions coming from

the high level management and to avoid direct confrontation. Abramson & Mizrahi (1996) and Sands, and colleagues (1990) indicated that conflicts can decrease collaborative work among professionals.The size of the team can be considered as a factor, too. The bigger the team, the less civilized social behavior  and the result will be felt in the social behaviors of these individuals (Stahelski & Tsukuda, 1990).

### 2.2.3 Advantagesof providing health services thorough Family Health Team approach

Globally, the FHT was conceived and applied first in Canada (2003, 2004), and the policy priorities, and health accord were executed promising the Canadian to recognize health care into teams, and the most appropriate providers, in the most appropriate settings (Cote et al., 2008). The FHT can improve the continuity of care and as well as quality (Gaboury et al., 2009) and patients can have good accessibility to their health needs and to the right treatment at the same time (Herbert, 2005). It can also reduce errors in the treatment (Willison, 2008) and it improves the patients' health (Sargeant et al., 2008). The FHT approach was implemented also in Brazil through a constitutional change the right to health care in 1988. At that time the FHT program has shifted the health care strategy from a heavy hospital system to primary health care system in 1994 (Ling chi and Cashin, 2011). Countries like Canada, Australia and United States of America have adopted this approach. Like elsewhere, it improved the residents' health with lower costs associated with provision of health services.  This approach also improved the care for chronic and complex conditions (Russell et al., 2017). As part of the FHT approach, UNRWA has introduced operational changes to improve efficiency in the clinics. These include the reorganization of the staff to work in teams, the use of appointment systems, the introduction of e-Health – an electronic management system for patient files – and physical modifications in the clinics to facilitate patients' access (UNRWA, 2013). The FHT aims to improve the overallaccess to primary health care, and will include teams of different sizes that will work together in different sizes to fulfill the needs of the community it serves. For comprehensive health care the patient canbuild a strong and long lasting relationship with their health care providers.  The FHT will be able to address and control chronic diseases by treatment and monitoring (UNRWA, 2013). Improving the patient's general health will lower the need for emergency interventions (WHO, 2008). Knowledge and skills are shared between the physicians and the nurses who work together to create a positiveenvironment which will be beneficial for all (WHO, 2008). Soubhiand Colleagues

(2009) found that quality of the care improves when two or more professionals are willing to put together their specialty and knowledgein a way that benefit the patient. Other researchers, Suter et al. (2009) indicated that a team can be effective when working skills contribute to share plans and goalsand are willing to collaborate. Another study has suggested thata good relationship between nurses and physicians can improve the communication and interaction between the health care providers (O'Brien-Pallas et al., 2005).

### 2.2.4 Requirements to provide services through FHT

In order to properly implement the FHT, the clinics need enough physical spaces to accommodate all the team members and allow the services to go along effectively. Enough time spent with the patient plays an important role in quality of the provided care. Socially, this wasa difficult point to be considered according to Willison (2008). Inadequate communication and technology can be a barrier to the effective implementation of the FHT. Difference of competencies among team members due to lack of interprofessional education and training can play a role as a barrier in the implementation of the FHT. Inappropriate monitoring can be a strong barrier to the development of the FHT Approach (Canadian Conference Board, 2012) and fail to provide needed information about the adoption of the reform.

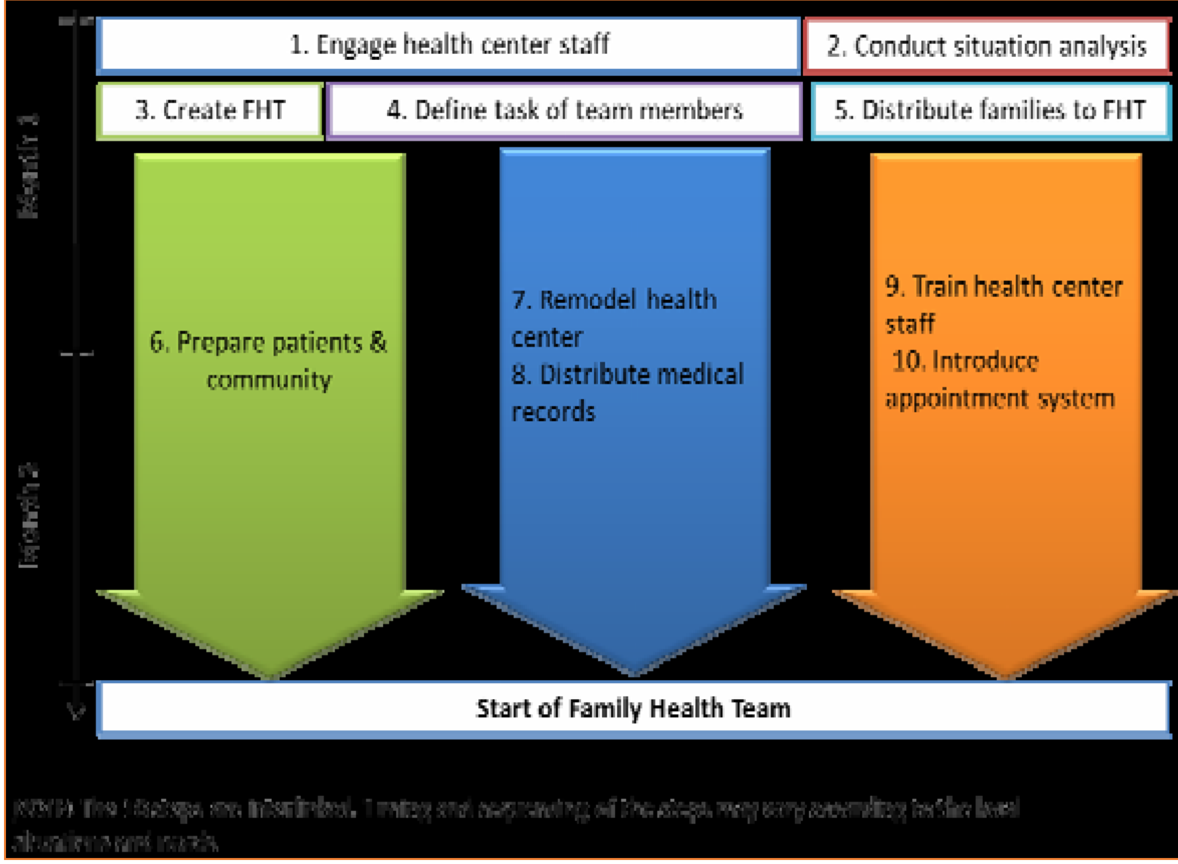
There are five fundamental building blocks that play an important role in the successful implementation of the FHT (Shahin, 2013).

- One of the main factors for implementing the FHT program is commitment to carry out the protocols. Its lack would be a barrier to the success of the FHT approach.
- Insufficient human resources like the lack of family doctors and other health professionals working together is a limitation to the effectiveness of the teams. The size of the team should be adapted according to the sizes of families and their needs. If not, the care will suffer.
- Accommodation and remodeling of the spaces available in the health centers is vital to accommodate the family and the teams.
- Lack of knowledge can be considered as a barrier to implement the FHT, too, as well as lack of communication between the family, the health care providers and the community.

- The provision of electronic medical record can be considered as a building block which greatly helps in the implementation of the FHT (Shahin, 2013).

## 2.3 UNRWA's Family Health Teams

In 2011 UNRWA started to implement a new major health service reformafter previously using the traditional way of providing health care, andwas based on a vertical approach between patient and health professionals. The traditional system is no longer adapted to the present health care needs (UNRWA, 2011a). It is a comprehensive interdisciplinary medical team formed especially to provide public health care to families within UNRWA centers. Each team is composed of one doctor, one nurse, one midwife and a clerk (Europa, 2015). UNRWA's FHT approach is patient-centered rather than disease centered. The patient is seen each time by the same team, which can focus on the comprehensive health needs of the person and the entire family. FHT maintain the relationship between the health care providers and their patients, and a continuity of care is obtained (UNRWA, 2011c). There was extensive consultation and preparationbefore the implementation of the FHT. Two health centers were chosen to house the pilot program in the Gaza strip and in Lebanon. UNRWA has adopted a learning-by-doing approach depending on the pilot experience. Based on UNRWA there were ten steps to be followed for the development of FHT in the health facilities as shown in **Figure (2.2)**. The ten steps are interlinked to implement the FHT according to timing and sequencing.



Source: UNRWA annual report, 2011

Positive reaction to the approach between the health care providers and the patients in the pilot health centers was observed until the end of 2011. The success of the pilot study generated great motivation in the healthcare professionals to start implementing the approach at their own center. Lessons learned from the pilot program expanded to the other health centers at UNRWA. After the adoption of the FHT approach and its implementation across the five fields as shown in **Annex (6)**,and after the five years succeeding the implementation the of FHT approach, The workload became equitable and the teamwork structure was one of the strong factors perceived by the staff. Professional satisfaction of the FHT resulted from having the responsibility for the comprehensive health care of the patients registered with them.

## 2.4 The difference between FHT and traditional way of service provision

Prior to the establishment of FHT, health care was provided by different units scattered in various places within the clinic. Patients had a different doctor to deal with at each visit. With this new system, patients will be dealing with all their family and during every visit by the same team of professionals: the same doctors, nurses and midwives. Each team is responsible for caring for families registered with them. The team's focus is on the

treatment of diseases, but will also help address the patients' life style issues to improve overall health. Thus ensuring that patients get a more comprehensive treatment by their FHT (Rosser et al., 2011).

## 2.5 Services provided by the FHT approach

### 2.5.1 Primary health services

Palestinian refugees have access to comprehensive health care provided by their FHT (UNRWA, 2015). It includes all outpatients, screening, mother and child care.

### 2.5.2 Maternal health care

Registered Palestinian refugee pregnant women can receive regular check-ups which are subsidized by the Agency (UNRWA, 2015) and which include the use of screenings, supplements to prevent congenital malformation, protection against micronutrient deficiencies, and high-risk hospital deliveries.

### 2.5.3 Infant and child care

The FHT approach provides mothers with health education and counseling on child care. Infants and children from birth to 5 years old receive a thorough medical examination in the clinics. The services include growth monitoring, immunization, screening for disabilities and child abuse, oral health, vitamin supplementation (UNRWA, 2016a).

### 2.5.4 Adolescent and adult care

Palestinian adults can use the preventive and curative services within the UNRWA health centers. These services include screening for breast cancer, family planning, community mental health and psycho-social support, gender-based violence screening and counseling, outpatient services, health education and nutrition awareness, dental health services, diagnostic services, and physical rehabilitation(UNRWA, 2015).

### 2.5.5 Active aging and the burden of chronic disease

UNRWA focused on chronic diseases, particularly hypertension and diabetes mellitus, because of being common condition among Palestinians, and the morbidity numbers, went down, but a rise occurred of cases of cardiovascular diseases and cancer, so UNRWA started several screening programs to minimize and detect these diseases (UNRWA, 2015).

### 2.5.6 Support services

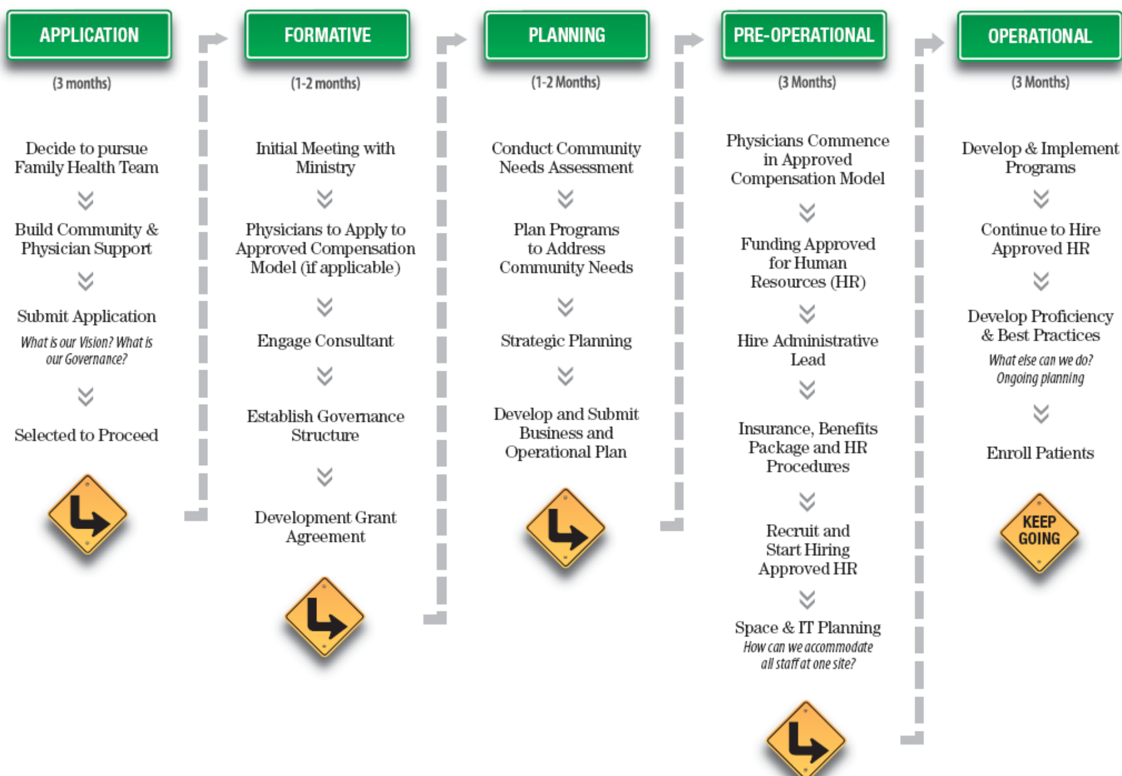
UNRWA introduced an electronic patient record system referred as 'e-health'. The current patient record system is based on hard-copy folders. As a complement to the FHT approach, e-health ensures that FHT can readily follow and offer curative or preventive

services as result of having consolidated information about the patient's health (UNRWA, 2015).

## 2.6 Stages of Development and Associated Activity:

After the initial building of the FHT approach, its completion should be submitted to the Ministry of Health, so that team requirements to provide services are obtained, as well as the decision about the program to be continued in the future.The second step should be the definition of a management structure to set the responsibilities and duties inside the FHT. Financial management should be present in order to provide funding and to ensure accountability and reporting by the ministry, with regard to the strategic and the FHT planning approach. Long term objectives should be applied, also procedures and plans to be set to achieve the objectives. It will help to know about the people's health needs, and if they are met. So the FHT will have a mission, a vision and goals to ensure that every staff member understands and works to reach the desired goal of the FHT. Also demographics can be defined for the development plan to become fully operational to improve the health outcome. According to business plans and funding stage and in order to build the FHT, the plan should be set to acquire resources, refine program needs, and be required to develop a business plan for the FHT and to develop a staff plan. An early implementation should be considered before the completion of the business plan to find the funding necessary to start delivering some programs and services to identify the needs of the patients.Regarding the preoperational stage in building FHT resources, ~~and~~ spaces should be made available to implement the FHT and to carry out the activities for making the team operational.Family Health Teams need appropriate spaces to accommodate the health teams and staffing complements to complete a detailed capital improvement planning process. Finally, regarding the operational stage in building FHT, this stage will complete the building of a collaborative team to meet the patients' needs through developed programs in order to assess and adjust the programs, as well as to ensure service delivery through the EMR to adjust the services to the general public.

**Figure(2.3) Family Health Implementation Road Map**




**Advancing Family Health Care, July 2009 - Version 2.0**

## 2.7 Patients factors affecting the implementation of the FHT

In this study, patients' factors include demographic, socioeconomic and medical profiles that can help in the implementation of the FHT.

### 2.7.1 Socio-demographic factors

Literature generally indicates that demographic and socio-economic factors have an effect on the implementation of the FHT and the use of health services. Several studies found that the demographic profile of a patient (age, marital status) and the socioeconomic profile (income, educational level) had an effect on the perception of health care and the satisfaction of the patient (Alrubaiee and Alkaa'ida, 2011).

Another study conducted in the United States found that socio-economic factors such as low income are a barrier to receive timely and appropriate health care, even when the patient was under health insurance coverage (Escarce and Kapur, 2006). Another study that was conducted in Al Bahrain found that the demographic factor (age, marital status) and the socioeconomic factor affected the perceived health care of women (Mukhaimer, 2010).

## 2.8 Process factors affecting the implementation of the FHT

There are six factors that can play a major role and affect the implementation of the FHT approach, and the researcher is going to mention them and their importance.

### 2.8.1Staff Training

When staff is lacking access to adequate training it is a barrier for the implementation of the FHT. The staff will be lacking skills and confidence to do the assigned work (Eassom et al., 2014). Staff training for any implementation of a program became more important than ever. Staff training not only increases competitively but supports the organizational goal, so good training and developing new approaches will help the organization grow and retain the best staff members and achieve better outcomes (Allen, 2017). Training and support to the staff don't end, even after the staff gets back to work, and continued support is required to make the initial training stick. Investment in the training of the staff will lead to organizational benefits on the long run. The staff member is the most valuable asset to the organization and to increase job satisfaction is to help the organization get the most of its investments (Queensland, 2018). Changes in work conditions requires also training offers. When UNWRA started to implement the FHT approach, health centers were given two to four weeks on the job training by peers during the preparation phase, to firmly introduce the new health reform, and to be ready for task shifting procedures. For example, nurses can now prescribe iron for an anemic child, when previously by only doctors could prescribe it, and clerks can accomplish tasks that before were performed only by a professional nurse (UNRWA, 2011b).

### 2.8.2 Workload

The workload is always defined as the amount of work that can be performed usually within a specific period of time. At UNRWA, the workload is an indicator of the daily journal of work and can help to estimate the needs that can cover the clinics. Doctors at an UNRWA health facility see an average of 85 cases in one single day during the first two hours of the working day (UNRWA, 2011a). To obtain a high quality of work, there should be good contact time with the patient, and the waiting time should be not too long. Overcrowding should be minimized (UNRWA, 2011b). The strategy of the FHT was to manage the workload by addressing two challenges, the appointment system and the triage system, as well as task shifting to make better use of the specific skills of the staff. Appointments avoided the staff the pressure of crowdedness and lead to an increase in quality of care, and therefore will present the comprehensive needs of the patients (UNRWA, 2011b). The congestion in the health centers will be relieved and because of scheduled appointments the waiting time of the patient will be reduced. Patients who come

to the health center without appointment can undergo triage system, to distinguish if they need urgent response, or can be given appointments. For whatever reason patients come to the health center to seek medical treatment, they should be seen by the doctor or the nurse. To minimize the workload of the health care providers, the triage system will be useful, and through the FHT, task shifting enables the staff members make use of their skills and provide services that previously could only be done by the doctors. Practical nurses and midwives can now perform some of these tasks to minimize the workload, and the controlled chronic disease patients can receive their medication periodically after the regular check up by the NCD nurse (UNRWA, 2011a). A study conducted by Sébastien Fournier and Colleagues (2011) to identify the workload factors that have an impact on health and safety found that burn-out from workload places a greater demand on their cognitive, psychological and physical abilities of the staff (Hamon-Cholet & Rougerie, 2000). Over the last decade, a return of certain work-related health and safety problems has been noted in various sectors of the working world (Askenazy & Gianella, 2000). Overall, a common denominator in the psychological and physical consequences observed in workers is undoubtedly the workload, or more specifically, work overload. Burn-out and its consequences affect the external and internal resources available to workers and management for coping with work constraints. This can lead to a downward spiral for workers health and safety in their workplace. Another study in Brazil (Albuquerque et al., 2016) found that there are seven research works that approach the workloads of the Family Health Team. From the set of studies it was concluded that working in the family health strategy exposes the nurses to different types of workload that can be divided into psychological, physiological, biological and mechanical loads, butno chemical load.

### 2.8.3 Staff Readiness

It is the level to which the staff employed by UNWRA is qualified or ready to be trained to adapt to the changes associated with the new approach. Any organizational change will make the staff and health teams shift the way they are working, and any change needs resource allocations and new technology (Schneider, Brief & Guzzo, 1996). Through previous research it has been shown that there is a positive relationship between people's support for implementing a new approach and the organizational capabilities to implement the change. There should be overall orientation or staff readiness to go through the change like in health reform. One study described the orientation and staff readiness (called "service climate") as a strategic effort to improve the patient service (Ray et al., 2004). Successful change at any health reform requires organizational resources and policy shifts,

and the staff should be prepared and ready to go through implementing the new reform (Ortenzio, 2012). Any attempt to do any organizational implementation of a new policy often fails because leaders don't give enough time for preparation or staff readiness (Shea et al., 2014). Any organizational shift should be prepared and ready in a behavioral and psychological manner to go through an implementation of the change. Members can show consistent efforts and more cooperative behavior, and staff can initiate more change when the readiness for organizational change is high. Conversely, if the organizational readiness is low, the staff members will look to the change or reform as undesirable step, and they will not show interest to change the process, but rather to deteriorate it (Shea et al., 2014). At UNRWA, during the preparation phase of the FHT approach, staff members were given two to four weeks to be ready for implementation and prepared for the task shifting for the new services that the staff might have to provide, and tasks performed previously by physicians would be provided by nurses (UNRWA, 2011b).

### 2.8.4 Protocols

At UNRWA there are guidelines and technical instructions ("protocols") applied to be used at UNRWA health centers. These protocols organize the work precisely and in discipline way according to WHO standards. Technical guidelines are always important for health aspects involving managing several conditions, to ensure efficiency according to international technical standards and should be updated to maintain technical soundness (UNRWA, 2011b). To implement the FHT approach, certain measures should be achieved like task shifting, and official regulation should be taken harmonized with MOH. Doctors and nurses should be trained to match the revised new technical guidelines, on the management of common medical conditions, as well as person centered patient management approach (UNRWA, 2011a). The protocols are issued and used by UNRWA to make the actions of its staff members or divisions are predictable, and presumably of higher quality. At the preparation phase, both technical preparation and teamwork are needed before the reorganization of the services can begin (UNRWA, 2011b). A previous study by Steven H. and Colleagues (1999) have found that protocols and guidelines offer patients benefits, and clinical guidelines are one of the options to improve quality of care. It is also considered as a magic solution for health care problems. The greatest benefits that can be achieved by guidelines are to improve health outcomes (Entwistle et al., 1999). Teams function better when they have a clear purpose and implement protocols and procedures (Canadian Health Services, 2006).

### 2.8.5 Monitoring and Supervision

The role of the supervisor is to coach the staff under his responsibility to get updated continuously about professional changes as well as to collect data and monitor the work process. The supervisor will also guide the staff on how to react to errors, and to take the right decisions in accordance. In most countries supervision systems have a long history, and are generally called inspectorate (UNESCO, 2004). However many countries changed this term to be called supervision. Both terms are considered to be the same and they are widely used in companies and offices, they are synonyms of each other. Supervisor is more in contact with the work process, but has some limitations. The monitor has fewer limitations and boundaries compared to the supervisor, and the monitor doesn’t have to be close to the work process (Ezaz, 2017). The supervisor’s main role is to report the work progress to the management at a higher level, and he is responsible for employees' action. He offers support, removes obstacles and can coach the staff if needed (Ezaz, 2017). Monitoring is a broad word and can be considered as a sub-type of supervision. Monitoring is for checking progress, as well as to react to the opportunities and can address issues (Ezaz, 2017). Monitoring doesn’t need to be in the workplace, while a supervisor’s main site is the work place (Ezaz, 2017). Recent studies (Marshal & Fehringer, 2013) proved that supportive supervision was successful for data quality and data collection, and monitoring during supportive supervision contributes to increase staff capacity, and to make decisions to strengthen the health system reform(Marshal & Fehringer, 2013).

### 2.8.6 System Readiness - e-health

UNRWA introduced “e-health” as a major factor to implement the FHT approach. It assures that documented files will help the health care providers to deliver their services precisely. The question here is if this system is effective all the time? Can it run the information of patients without delay or rupture? The researcher will cover this factor and how it affects the implementation of the FHT approach.In order to promote any health facility based on data management, and to implement e-health, health centers must be provided with computers, and the staff requires training to start using the system (UNRWA, 2011a). E-health replaces paper medical record by electronic patient files, and makes life easier for both the patient and the provider. The old filing system was frustrating to the patient when he arrived at the health center, the clerk could search his file for 15 minutes. Now, doctors can locate patient file in seconds. E-health forms part of the

Family Health Team approach to improve the efficiency of the UNRWA health services and the quality of care to the Palestinian refugees (UNRWA, 2013). The e-health system helped in reducing the workload of the health care providers, and has subsequently improved the quality of health services by avoiding mistakes like a wrong entry or the entry of incomplete data, and it provides proper monitoring. It also helped to reduce the waiting time and to increase the doctor-patient contact time, thereby realizing the quality of evidence-based planning and management. The essential component of the health reform is e-health. The spaces in the health center were well arranged and the printed forms used minimally. Staff that used to print papers before were relieved from their paperwork. E-health is a joint product with other departments in UNRWA, particularly the Information Systems Division (ISD) at the headquarters, and in all fields. Other countries have been the key supporters for e-health as well as the FHT reform since it started. But aside from e-health benefits, there are some physicians who reported that they stopped the use of EMR, because hunting for menus and buttons disrupts the clinical encounter (Ludwic et al., 2009). In 2011, e-health was operational in five UNRWA clinics in Jordan and had been introduced in 29 clinics in Lebanon. E-health has streamlined service delivery and data management in UNRWA clinics. After introducing a module, all clinical information is managed electronically. Routine service data are available through automated reporting functions, reducing the time spent on reporting tasks. E-health has also enhanced capacity for data analysis. For example, by using e-health, UNRWA was able to introduce an innovative system of cohort analysis for routinely monitoring the care of patients with non-contagious diseases. Before the introduction of e-health, such analyses were feasible only for a limited number of patients and even then required time-consuming hard-copy record reviews. But the introduction of an electronic medical record system into a clinical practice is a complex task (UNRWA, 2011).

## 2.9 Health care Providers factors

The FHT approach broadens the knowledge and skill of the health care provider (Taddle & Creek, 2018). The FHT will work with educational institutions to expand the qualifications of the health care providers, and to enhance learning for team members (Soklaridis, 2007). UNRWA now offers a one year diploma of family medicine provided by Rila Institute from Britain affiliated with Al Azhar University (UNRWA, 2015). The Family Health Team approach is an important part of changing the way people think about health care, and the health care provider's attitude, as well as family physicians. Through their

education and training, health care providers and family physicians possess exclusive attitudes, skills and knowledge, which provide them with a high qualification that can help in providing a comprehensive medical care for the members of the family (Mosadeghrad, 2014). No single practitioner can handle, absorb and use all this information, and the need for specific knowledge in specialized areas of care by different team members has become a necessity. Now, more than ever, there is an obligation to strive for perfection in the science and practice of Interprofessional team-based health care. Each clinician relies upon information and action from other team members. Yet, without explicit acknowledgment and purposeful cultivation of the team, systemic inefficiencies and errors cannot be addressed and prevented (Babike et al., 2014). Team care required shifts in the attitudes of providers and the organizations that represent them. At the individual level, this shift was found most difficult by physicians who deeply held beliefs that primary care doctoring was based on a strong, trusting relationship between a patient and a physician, and bringing others into that relationship threatened what was special about their relationship with clients. As such, this shift required not only a change in roles of both physician and staff, but also substantial changes in the way physicians thought about themselves.This translated into the perspectives of professional organizations (Russell et al., 2017).

## 2.10 Cost and quality of care

UNRWA plays a role in providing primary health care for Palestinian refugees to minimize the increased expenses on health according to the current reports and provides quality services by the implementation of the FHT approach that was introduced a changing environment of increasing health care needs, particularly with the increase of chronic non-communicable diseases (UNRWA, 2012), to improve the quality and accessibility of the primary health care services it delivers to Palestine refugees**.**Health care services costs raised and the financial resources became limited, which is why UNRWA responded effectively to the emergent needs of Palestine refugees (UNRWA, 2012). The introduction of the FHT was to re-adjust the primary health care in order to use the existing limited resources, and each doctor became responsible for all types of services instead of one type of service, in order to promote efficiency. Through the implementation of the FHT, each team treats the same family members, and the workload can be equalized by redistributing the daily tasks.The FHT allows to reduce the average daily consultations of repeated visits.

This was enforced by the appointment system, that led to reduce the crowdedness generated from the repeated visits, and patients seeking physicians' signatures can go directly to the pharmacy to collect their medication if their medical condition is controlled (Shahin, 2013).

As the funding for UNRWA has not increased, while at the same time the health requirements increased and the global financial crisis influenced the availability of support to UNRWA. Non communicable diseases are the largest expense compared to other services provided by the health department, like maternal and child care. It was a challenge for the agency to implement the FHT in order to cope up with the health needs of the patients (UNRWA, 2013).

To assess and to have information about the quality of care

There are three factors that can lead to good service delivery:

- Structure through resources and administration,
- Process through culture and professional cooperation
- The outcome presented by goal achievement and competence development.

To understand quality of care and how to measure it and how to improve and influence it was indicated by Steinwachs and Hughes (2008). Quality of care can be achieved efficiently through the implementation of the FHT approach by facilitating easy access to the service through physical reconstruction of the health centers, and the formation of an appointment system together with the provision of the electronic health record. As part of its ongoing efforts to improve the quality and accessibility of the primary health care services it delivers to Palestinian refugees, UNRWA has introduced the Family Health Team approach. In a changing environment of increasing health care needs – particularly with the increase of chronic non communicable diseases, rising health care costs and limited financial resources.It has become imperative to find and adopt new strategies to respond effectively to the emergent needs of the Palestinian refugee population (UNRWA, 2012). The FHT is a new, person-centered approach, devoted to improving the quality and delivery of public primary health care for Palestine refugees. The reform has introduced a shift in focus. Previously, care was provided to treat specific ailments without taking into consideration the comprehensive health status or the family history of an individual. Now care is delivered by multidisciplinary medical teams, who provide comprehensive, continuous care to the patients and families registered with them. Each FHT is made up of at least one doctor, a nurse and a clerk. Each team manages approximately the same number of family files, which has improved patient flow in the clinic and equalized the

workload among staff. As part of the FHT approach, UNRWA has introduced operational changes to improve efficiency in the clinics. These include the reorganization of the staff work in teams, the use of appointment systems, the introduction of e-health(an electronic management system for patient files)and physical modifications in the clinics to facilitate patients' access.

## 2.11 Perceived Quality

It is defined as the overall perception of quality of the service to be delivered to the patient with respect to the alternates and the main purpose of the service, it is considered as a different concept. People differ in their personalities, needs and preferences, so everyone look to the feature through his preference, but not objectively (Aaker, 1991). A study conducted in Tanzania used findings obtained with a mixed method found that there are benefits by both quantitative and qualitative methods, and the results were similar. 46% of the reported participants in in-depth interviews are harassed or with disrespectful care, and 38% reported being ignored (Tancred, 2016). Another cross-sectional study conducted by (Dahrouge et al., 2016) found that increasing physician care comes with a small decrease in cancer screening. Another study conducted by Carrroll and Colleagues (2016) found that 75.3% of the participants were satisfied with their access to the health care program. Dansereau and colleagues (2015) conducted a study in Zambia and found that perceived quality is an important driver of patient satisfaction and health service delivery. Bonger and Colleagues (2015) found that Medicare beneficiaries at higher stage of activity limitations although not necessarily the highest stage of activity limitations reported less satisfied with medical care. Seita and Colleagues (2014) used a mixed method to study the effect of FHT on the quality of health care of Palestinian infants in Jordan, found that the FHT approach has the potential to improve infant care in terms of growth monitoring and anemia treatment.

## 2.12 Dimensions of perceived quality (Service delivery).

There are five dimensions of perceived quality according to (Aaker, 1991) that could be able to measure the perceived quality of any service or product ,which are:

**Tangibles**

It means that the appearance of the product or service imply quality, and the facilities or equipments show the same outlook.

**Reliability**

Meaning to say about work performed dependably and accurately regarding FHT implementation .

**Competence**

It is the staff knowledge and skills to do the things right while implementing the FHT approach, and it is the relation of trust to patients, as well as the confidentiality of the performing staff .

**Responsiveness**

This dimension measures the service delivery according to patients' requests and needs. At UNRWA the services are delivered day by day, and the expectations patients have towards the FHT made a change on their daily needs .

**Empathy**

This is the process of sharing patients with other members of the staff with mutual respect, so that patients can feel better. After the implementation of the FHT program, care can be delivered exclusively in order to obtain a high community engagement and special attention .

## 2.13 Patient Satisfaction

Patient satisfaction is not just an appropriate set of behaviors. It is the way the concepts can be found, and the experience of patients' care is a very important aspect (Worthington, 2004). The response to care is improved when the patients' satisfaction is important from a clinical point (Oman, 2014). That point alone is enough to justify the implementation and the commitment to a customer satisfaction program. There are, however, other compelling reasons. Customer satisfaction has profound ramifications for the financial status of the institution and for its professional reputation in the community (Mavrinac and Siesfeld, 1998). The caregivers who participated in a system of good customer satisfaction experienced fewer malpractice suits than their counterparts (Worthington, 2004). They also enjoy a work environment that is more stable and pleasant than that of other institutions. The implementation of a meaningful customer service program is a huge task. It is a fundamental culture change that requires vision, long-term commitment, and constant surveillance.The most critical factor in the successful implementation of a program is leadership (Ejimabo, 2015). The leadership must set the stage, create the atmosphere, demand that staff meet expectations, reward success, provide an example and shape the new culture (Worthington, 2004). Without strong leadership, any customer service initiative will be simply an institution-wide exercise, and those staff members who harbor a

cynical viewpoint will be proved right in the end. One major difference between a successful customer service initiative and an unsuccessful one is the level of sincerity in the institution. Its staff has to express care for their patients. If the whole process is merely an exercise to improve scores, the success will be limited and without deep roots. If the push is to establish an atmosphere of genuine care and interest for patients, however, the results are more meaningful, longer lasting, and more appreciated by patients and staff (Worthington, 2004). At UNRWA, the health service staff is sometimes influenced by the overload of work, stress and pressure due to several circumstances: It was mentioned previously the economic situation and that most of the Palestinian refugees utilize UNRWA health centers abuse the services. To obtain the level of patient satisfaction there is a need to prepare a system that can serve the patient and satisfy his needs, and the staff should adapt to the system so that they can provide complete health service with collaborative work (UNRWA, 2010). To reach the quality of care at UNRWA, it was a new reform to start implementing the FHT approach in order to increase patient satisfaction, to rationalize the use of drugs and to arrange the scattered work by applying the appointment system. Families enjoy the ever-ended criteria that take care of Palestinian families' health. There is a good evidence that there is a positive effect on the users' satisfaction (Willison, 2008). Patient satisfaction became the most common indicator to measure the quality of care, and became an effective indicator for the doctors' success (Oman, 2014). Literature view studies indicated that the satisfaction of family team members are commonly related to the success of their family business (Handler, 1991) and (Ivancevich et al., 2005) and (Sharma, 2004) and (Venter, 2003). Also the studies of Campion and Colleagues (1996), Doolen and Colleagues (2006), and Howard and Colleagues (2005) indicated that satisfaction of the team members is the measure of team effectiveness in organizations. Team effectiveness can be considered when the team members have the willingness to continue their efforts (Kreitner & Kinicki, 1995). Four other studies about patient satisfaction with the care received conducted by (Corser, 1998) and (Fields et al., 1999) and (Wiggins, 2008) and by (Gittell et al., 2000) speak about improving collaboration to improve the quality of care and patient outcome.

## 2.14 Types of Evaluation

### 2.14.1 Formative Evaluation

This type of evaluation was conducted during the course of the program to know about strengths and weaknesses in order to improve the quality and effectiveness of the program

(CDC, 2012). It ensures the suitability and feasibility of the program and acceptance before the complete implementation of the program. The usual conduction of this kind of evaluation when the program is newly adopted or implemented (CDC, 2016).

#### 2.14.2 Summative Evaluation

It takes place during the project implementation, but in most cases it is performed at the end of the project, it is sometimes recommended for both quantitative and qualitative methods to attain good assessments. It is important to distinguish the outcome from the output (Fitzpatrick et al., 2011). This type of evaluation is conducted at the end of any program in order to know the future of the programs and to help decision makers to decide about the continuity of the program (Pell Institute, 2017).

#### 2.14.3 Process Evaluation

Process evaluation can be determined during program activity and after implementation to know the output results. Process evaluation can be done periodicallyduring the conduction and implementation of a program and the results can help to improve and strengthen the ability of the program as well as to monitor how program is working and to obtain any warning for any problem may occur.(CDC, 1999).

# Chapter 3

## Methodology

### 3.1 Introduction

This chapter describes the methodology used to conduct this study; it includes the study design, study settings, study population, study sample, data collection process, data cleaning and analysis, and ethical considerations. The chapter also provides a description of the instruments of data collection that were used to collect data, finally, this chapter is concluded by the limitations of this study and the ethical considerations

### 3.2 Design of the study

The design of this study is a mixed methods that entailed collecting quantitative and qualitative data. The design of the quantitative study is a descriptive analytical cross-sectional study. Mixed method studies enable researchers to investigate the research

questions through using different tools of data collection, thus, the validity and depth of collected data and findings are generally high. Mixed method research studies also increase the chance of controlling the threats that may affect the validity of the results. The researcher can be more confident and the outcome bias is minimized (Creswell, 2013).Cross-sectional design is an appropriate design due to its advantages such as time factors and required financial resources. Cross-sectional studies are less expensive than other designs and direct researchers to meet the objectives in a short period of time (Michigan, 2009). For the quantitative data, the Researcher is going to study the three main factors that could evaluate the FHT implemented at UNRWA health centers in GS. Which are the demographic data, socioeconomic data, and the medical profile. The in-depth interviews with providers will be conducted. In-depth interviews generate rich data at the same time save time and financial resources.

## 3.3 Settings of the study

The study was conducted in six UNRWA health care centers that have been providing health services through FHT since 2012. Out of the 22 UNRWA health centers operate in the Gaza Strip, six health centers were selected through Simple Random technique. The six health centers are distributed across the Gaza Strip, one center in each governorate, except two centers are located in Rafah governorate.

## 3.4 Duration of the study

The study has started after having the university approval of the proposal, and after obtaining the ethical approval from Helsinki committee in August, 2017, as shown in **Annex (8).** The study started in Jan 2017 and completed in August 2018. Pilot study was conducted in Nov 2017, then data collection was completed in January 2018. Data entry and cleaning were conducted in March 2018. Coding and analysis of data were conducted in April 2018.The study final report was complete in July 2018. **Annex (11)** describes the study steps and the duration of each activity.

## 3.5 Study Population

The data were collected from two groups of participants: the clients who have been utilizing health services through FHT. In 2016, a total of 1,224,383 clients have utilized health services through the FHT, and the second group of participants were the key-informants and health care providers working for UNRWA.In total, there are 1,016 health professionals that are distributed across the 22 health centers.

### 3.5.1 Sample size -Quantitative part-

As shown in **Annex (2)**, the required sample size was 385, but it was increased to 400 to cover non-respondents. The researcher used the following parameters for sample calculation

- Maximum acceptable percentage points for error 5%
- Confidence level 95%
- Total Population (1224383).

The 400 participants were randomly selected from the study settings, **Annex (3)** shows the proportional distribution of the study participants by health centers. Of the total 400, 399 agreed to participate in the study, with a response rate of 99.7%.

### 3.5.2 Sample size - Qualitative part

For the qualitative part, the researcher conducted interviews with four focus groups of health care providers from the study settings, and conducted 3 in-depth interviews with key informants from UNRWA's staff. The selection of participants was done purposefully in order to collect rich data and to have diversity in views.

## 3.6 Eligibility Criteria—quantitative part

### 3.6.1 Inclusion

- Patients from clinics that have been providing health services through FHT in the past five years.
- Patients who have been utilizing services provided by FHT.

### 3.6.2 Exclusion

- Patients who use the daily care services and dental patients, as these two departments were not part of FHT

## 3.7 Eligibility Criteria—qualitative part

### 3.7.1 Inclusion

- The health care providers include physicians, nurses, midwifes and senior medical officers working in study locations and been part of FHT
- Key-informants from UNRWA Headquarters and Area Officers

### 3.7.2 Exclusion

- Health care providers who are not part of FHT such as dentists

## 3.8 Instruments/Tools

### 3.8.1 Quantitative study: Questionnaire

The questionnaire was designed in order to collect all the needed data as in the study objectives and study research questions. It was solely based on its conceptual framework. Most questions therefore were closed ended questions. The following areas were included in the questionnaire:

- Socio-demographic and economic characteristics of the patients utilizing the FHT approach.
- Effectiveness of the FHT services.
- Patient's satisfaction by the new FHT approach.
- Safety measures that may affect the implementation of the FHT services.
- Accessibility of the health centers and time-factors that may affects the application of the FHT approach.

### 3.8.2 Qualitative Study: Guiding questions

Guiding questions for the in-depth interview were developed to complement the quantitative data in order to address the study objectives and questions, as in **Annex (5).** The Guiding questions covered different issues as of the following:

- Received training on Family Health Team approach
- System readiness- e health
- Availability of monitoring tools
- The current workload
- Availability of protocols and technical guidelines
- Knowledge and qualifications of the health care providers
- Attitude and opinion of the health care providers

## 3.9 Scientific rigor

### 3.9.1 Reliability

To help in collecting the data, the researcher hired an assistant. The assistant was trained by the researcher to ensure collecting reliable data, and the assistant was trained of how to select the participants, and how to ask questions, and how to fill the questionnaires. The researcher used to check and review each questionnaire that were completed by the assistant day by day. The researcher re-entered 5% of the collected data. Data were

checked for internal consistency of its domains to demonstrate the appropriate clustering of items. Each domain was individually assessed using Cronbach's alpha, the standard statistical technique for assessing the coherency of each item within each domain.

**Table (3.1) Cronbach alpha coefficient for perceived quality, satisfaction and appropriateness domains**

| Items | Number of items | Cronbach alpha |
|---|---|---|
| Perceived Quality | 26 | 0.930 |
| Satisfaction | 21 | 0.832 |
| Appropriateness | 15 | 0.930 |

### 3.9.2 Face validity

It refers to the transparency or relevance to the tool in collecting the needed data. The questionnaire was structured in an organized way to allow easy smooth data collection and data entry. During the validation process, the questionnaire lay out was reviewed and reformed for several times until the final version of the questionnaire looked suitable.

### 3.9.3 Content validity

It addresses the development of the items that can be operational to provide adequate and representative sample of all items that might measure the construct of interest (Kimberlin and Wintersten, 2008). There is no statistical test to determine and cover the content area. Content validity usually depends on the judgment of experts in the field so, eleven experts with different backgrounds have evaluated the questionnaire and the interview questions **(Annex7).**The evaluation purpose was to assess the relevance of each domain. Additionally the researcher considers all experts feedback and comments, so the final version developed, and the interview questions matched all experts' feedback. Finally the research assistant was trained well to ensure accuracy of data collection.

## 3.10 Pilot Study

To assess the appropriateness of questionnaire, a pilot study for 30 patients was carried out. The researcher has modified the questionnaire based on the outcomes of the pilot study. Data collected through the pilot study were included in the study sample.

## 3.11 Data Collection

Data were collected by the researcher and his assistant, and it took almost two months to do that. Each month, about 200 questionnaires were completed. At the same time the

assistant was trained on how to select the sample and how to ask the questions. The researcher conducted all the in-depth interviews.

## 3.12 Data entry and data analysis

### 3.12.1 Quantitative part

The researcher has used the Statistical Package for Social Sciences (SPSS) program version 20 for quantitative data entry and data analysis, and the researcher followed different steps.

- Data entry was conducted immediately after collecting the data
- The variable from the questionnaire was coded and entered into SPSS by the Researcher and a Statistician
- Data cleaning was conducted after finishing the data entry.
- Frequency distribution was done.

Cross tabulation for the main finding and bi-variate statistical tests such as Chi square test was used, and correlation and t- tests, or one way ANOVA to investigate the relationships between the different variables and the different relationship between them.

### 3.12.2 Qualitative part

Through the focus group, the researcher used the open coding thematic analysis, and took notes during and after each focus group, then developed a data entry model that involves data cleaning, categorization and coding. Coding is an interpretative technique in a quantitative method. Most coding needs to be demarcated via themes. Each theme is labeled with a code. After completion of coding, the researcher prepared a summary of relationships between the codes. The quantitative and qualitative findings were then compared and integrated to validate the findings and create rich information.

## 3.13 Ethical and managerial consideration

- An academic approval was provided through Al Quds University.
- An ethical approval was received by Helsinki committee, as in **Annex (8)**
- An administrative approval was given by the Chief Field Health Program (at UNRWA), as in **Annex (9)**
- Informed consent for patients was developed to ensure confidentiality. The purpose of the study was explained to the participants and participants were made aware of the voluntary and confidential nature of their involvement, **Annex (10)**
- The Senior Medical Officers and the health care providers were asked for their permission to record in-depth interviews.

### 3.14 Limitation of the study

- Limited resources including funds and facilities for data collection and data entry
- Time limitations
- Limited literature resources, such as books and journals
- Limited working hours at UNRWA health centers
- Frequent power shortage

# Chapter 4

## Results and Discussion

### 4.1 Introduction

This chapter presents the results of the statistical analysis of the quantitative and qualitative data as well as contextualized interpretation and analysis of the results. The descriptive quantitative analysis highlights the demographic characteristics of the participants as such

as residence, age, marital status, education level and income. In this Chapter, variety of statistical tests were used to analyze quantitative data and open thematic analysis was used to analyze qualitative data.

## 1. Clients Factors

### 4.1.1 Distribution of the study participants by selected demographic variables

The quantitative data were collected from 399 beneficiaries attending UNRWA clinics.**Table (4.1)** shows that the majority of the participants were from Khanyounis governorate (40.1%), followed by participants from Deir Al-balah governorate (22.6%), others from Gaza governorate (18.3%) as well as beneficiaries from North Gaza governorate (11.5%), and finally another minority from Rafah (7.5%). The distribution of the quantitative sample was consistent with the utilization of UNRWA health services per governorate (UNRWA, 2017). Table **(4.1)** also shows that more than two-thirds of the participants were mostly females (82.8%). While, less than one-quarter were males (17.2%). These findings also line up with the current rates of utilization of UNRWSA's services, in 2017, 60% of UNRWA'sbeneficiaries were females compared to 40%of male beneficiaries.

Regarding the age of the study participants, the mean age was 32.37 years with (SD 11.6), the majority of the study participants were from the age group 25-39 years old with a percentage of 45.1 %. The group which had participants with ages less than 25 years had a percentage of 31.6%. As for the group with ages between 40-59 years old, it had a percentage of 19.9%. The study participants whose ages were above 60 years had a percentage of 3.4% of the overall participants of the study. According to UNRWA (2017), the age group percentagedistribution were also in line with the beneficiaries attending to the health centers at UNRWA.

Concerning the marital status of the participants, findings of study showed that the majority of the study participants were married (a percentage of 81.1% of overall participants) while unmarried participants constitute less than one-quarter (a percentage of 18.2% of the study sample).

The mean of years of schooling for the participants was 12.15 years, with (SD 3.55). **Table (4.1)** shows that more than two-third of study participants had 12 years of schooling or more (73.8% of participants). On the other hand, less than one-third of the study

participants had less than 12 years of schooling. The findings are also consistent with the findings of the PCBS (PCBS indicated a mean of 11.08 years of schooling for Gaza refugees at the year 2016).

Regarding the work status of the study participants, **Table (4.1)** shows that the vast majority of participants were not working with (82.1%), only 15.4% of study sample were working and 2.5% were retired. The findings of this study are consistent with the findings of the PCBS as the current unemployment rate is about 78% for female (PCBS, 2017). In this study the unemployment rate is very high due to the fact that more than 80% of the study participants were females, in the Gaza Strip, female participation rate in the labor market is very low at19%,according to PCBS (2017).

With regards to the occupation of the study participants, **Table (4.1)** reveals that more than one third of the working study participants were having professional jobs (43.3% of participants) and others working as clerks, sales and service workers with a percentage of 21.7%. Additionally, about 20% of working participants had managerial positions. Finally, skilled workers constitute 15% of the study working participants.

**Table (4.1) Distribution of the study participants by selecteddemographic variables**

| Demographic Data | Number | % |
|---|---|---|
| **Governorate** | | |
| North Gaza | 46 | 11.5 |
| Gaza | 73 | 18.3 |
| Deir Al balah | 90 | 22.6 |
| Khanyounis | 160 | 40.1 |
| Rafah | 30 | 7.5 |
| **Total** | **399** | **100.0** |
| **Age** | | |
| Less than 25 years | 122 | 31.6 |
| From 25 to 39 years | 174 | 45.1 |
| From 40 to 59 years | 77 | 19.9 |
| 60 years and more | 13 | 3.4 |
| **Total** | **386** | **100.0** |
| **Mean= 32.37, SD= 11.76** | | |
| **Gender** | | |
| Male | 68 | 17.2 |
| Female | 327 | 82.8 |
| **Total** | **395** | **100.0** |
| **Marital Status** | | |
| Married | 324 | 81.8 |
| Unmarried | 72 | 18.2 |
| **Total** | **396** | **100.0** |
| **Years of education** | | |
| 11 Years and less | 98 | 26.2 |
| 12 Years | 139 | 37.2 |
| 13 Years and above | 137 | 36.6 |
| **Total** | **374** | **100.0** |

| Demographic Data | Number | % |
|---|---|---|
| Mean= 12.15, SD= 3.55 | | |
| **Working status** | | |
| Yes | 61 | 15.4 |
| No | 326 | 82.1 |
| Retired | 10 | 2.5 |
| **Total** | **397** | **100.0** |
| **Type of Work—only for participants who work*** | | |
| Managerial positions | 12 | 20.0 |
| Professional jobs | 26 | 43.3 |
| Clerks, sales and service workers | 13 | 21.7 |
| Skilled workers | 9 | 15.0 |
| **Total** | **60** | **100.0** |
| **Having health insurance** | | |
| Yes | 360 | 90.2 |
| No | 39 | 9.8 |
| **Total** | **399** | **100.0** |
| **Average monthly income** | | |
| Under poverty line | 309 | 88.3 |
| Above poverty line | 41 | 11.7 |
| **Total** | **350** | **100.0** |
| **Mean= 934.0NIS, SD= 784.72** | | |

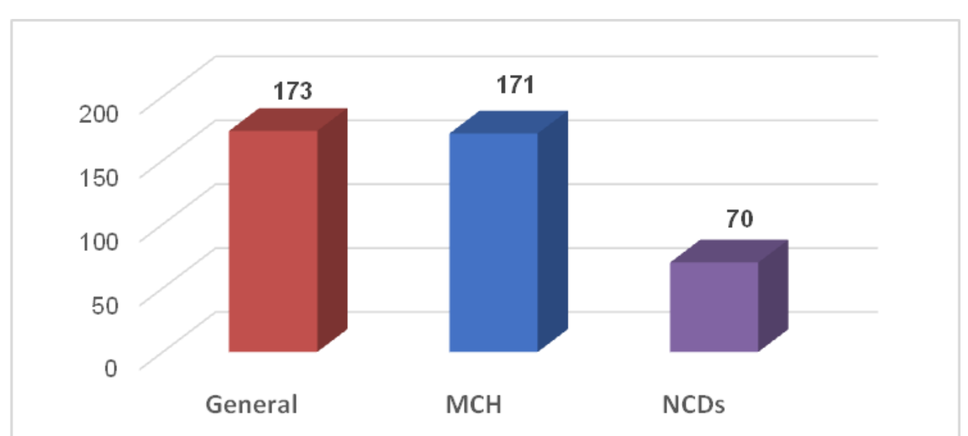
Regarding the ownership of health insurance, **Table (4.1)** shows that the vast majority of the participants have health insurance with a percentage of 90.2%, and the participants who don't have health insurance constitute9.8% of the study participants. As a reminder, utilization of UNRWA services does not require having health insurance, as the only criteria to receive services is to be a refugee. Thus, a conclusion to be drawn here is that majority of refugees have health insurance to benefit from secondary health servicesprovided by MoH hospitals.

**Table (4.1)** shows that the monthly average income of the study participants was 934.0 ILS, with (SD=784.72). The vast majority of the study participants have income that is considered to be under poverty line as articulated by PCBS with a percentage of 88.3%, while the participants who have income above poverty line constitutesonly 11.7% of the study sample. This finding is consistent with the general deterioration and collapse in Gaza economy. It is also consistent with the current high rate of poverty (53%) as reported by PCBS (PCBS, 2018).

### 4.2 Distribution of the study participants according to their medical profile

**Figure (4.1)** shows more than 40% of the study participants visit health centers to utilize general clinic services with (41.7%). Additionally, 41.3% visit the centers to utilize MCH services. Finally, less than 20% of study participants attend the clinic to utilize NCD services, with (16.9%).

**Figure (4.1) Distribution of the study participants by service utilized**




The results of the study findings are consistent with the utilization rates of UNRWA health centers. In 2016,according to UNRWA health report (2016a), the number of the consultation visits to the medical offices constituted almost 50% of the patients utilizing medical services from the health centers. The number of patients utilizing the MCH services was about 35% of the total patients coming to utilize the services at the health centers. Finally the number of NCDs patients utilizing health service was about 15.0% of the total number of the patients utilizing health services at the health centers.

### 4.2.1 Utilization of main services

**Table (4.2)** shows that almost half (49.7%) of theparticipants attended the general clinics due to different reasons such as headache, influenza, low back pain with a percentage of 49.7% of total participants. Interestingly, about one third of the participants visited the general clinic complaining from upper respiratory tract infection with a percentage of 32.9%, followed by urinary tract diseases with a percentage of 7.5%. Also, about 6% of the study participants visited the general clinic to receive treatment for skin diseases. Finally, the percentage of participants who attended the health centers to be treated for gastro intestinal tract and sexual diseases were 2.9% and 1.2%, respectively.Concerning the participants who visited the centers to utilize MCH services, more than one third of the participants were utilizing preconception care with a percentage of 40.9%, followed by the postnatal care clinic with a percentage of 18.7%. Additionally, 12.9% of participants visited the health centers to utilize antenatal care and a percentage of 12.9% were visiting the centers to monitor the growth and development of their children. Finally, of the total participants who attended MCH services, 9.4% and 5.3% did visit the centers to utilize family planning and immunization services, respectively.

Regarding the participants who visited centers to utilize NCD services, **Table (4.2)** shows that almost half of the participants had diabetes mellitus, with 47.1%, and 20% had diabetes mellitusand hypertension. Additionally, 15.7% of participants did visit to receive treatment of elevated blood pressure, and 7.1% attended the centers to receive treatment for different cardiac issues.

**Table (4.2) Distribution of the study participants according to their medical profile**

| Item | Number | % |
|---|---|---|
| **General daily services as the main purpose of the visit** | | |
| Upper respiratory tract infection | 57 | 32.9 |
| Skin diseases | 10 | 5.8 |
| Gastrointestinal diseases | 5 | 2.9 |
| Urinary tract diseases | 13 | 7.5 |
| Sexual and reproductive diseases | 2 | 1.2 |
| Others | 86 | 49.7 |
| **Total** | **173** | **100.0** |
| **MCH services** | | |
| Immunization | 9 | 5.3 |
| Postnatal Care | 32 | 18.7 |
| Antenatal Care | 22 | 12.9 |
| Preconception Care | 70 | 40.9 |
| Family Planning | 16 | 9.4 |
| Growth Monitoring | 22 | 12.9 |
| **Total** | **171** | **100.0** |
| **NCDs** | | |
| Hypertension | 11 | 15.7 |
| Diabetes Mellitus | 33 | 47.1 |
| Hypertension and Diabetes Mellitus | 14 | 20.0 |
| Cardiac problems | 5 | 7.1 |
| Other | 7 | 10.0 |
| **Total** | **70** | **100.0** |

## 4.3 Distribution of study participants by medical history

By asking the study participants if they suffer from any chronic diseases, **Table (4.3)** shows that most (78.4%) of the study participants do not have any chronic diseases, while 21.6% of the study participants reported having chronic diseases. **Table (4.3)** shows quantitative distribution of participants as follows: chronic diseases with a percentage of 14.0% who had hypertension, and the percentage of diabetic patients was 61.6%, while the participants who had both hypertensive and diabetes mellitus percentage was 20.9%, while the participants with cardiac,renal, and others constituted a percentage of 27.9% of the

study sample.By asking the study participants who have chronic diseaseabout the period since being diagnosed, **Table (4.3)** shows that 27.9% of participants who had chronic diseases were diagnosed since two years. While 24.4% were diagnosed over the past 3 to 5 years. Additionally, 25.6% the participants were diagnosed over the past 6 to 10 years. Finally 22.1% of participants were diagnosed since more than 10 years. The overall mean of diagnosing chronic diseases was 7.02 (SD 6.3). By asking the study participants who have another chronic diseaseabout the period since being diagnosed, **Table(4.3)** shows that 32%of the participants were diagnosed since two years. While 32% of the participants were diagnosed over the past 3 to 5 years. Additionally,12% of the participants were diagnosed over the past 6 to 10 years. Finally 24% of participants were diagnosed since more than 10 years. The overall mean of diagnosing of having another chronic disease was 7.23 (SD7.51).

**Table (4.3): Distribution of the study participants according to their medical history**

| **Item** | **Number** | **%** |
|---|---|---|
| **Suffer from any chronic diseases** | | |
| Yes | 86 | 21.6 |
| No | 313 | 78.4 |
| **Total** | **399** | **100.0** |
| **Type of chronic Diseases** | | |
| Hypertension | 12 | 14.0 |
| Diabetes Mellitus | 53 | 61.6 |
| Hypertension and Diabetes Mellitus | 18 | 20.9 |
| Cardiac diseases | 2 | 2.3 |
| Renal diseases | 5 | 5.8 |
| Chronic Obstructive Lung Diseases | 5 | 5.8 |
| Other | 12 | 14.0 |
| **How many years since were your diagnosis with disease 1** | | |
| 2 years and less | 24 | 27.9 |
| From 3 to 5 years | 21 | 24.4 |
| From 6 to 10 years | 22 | 25.6 |
| More than 10 years | 19 | 22.1 |
| **Total** | **86** | **100.0** |
| **Mean = 7.02 , SD = 6.33** | | |
| **How many years since were your diagnosis with disease 2** | | |
| 2 years and less | 8 | 32.0 |
| From 3 to 5 years | 8 | 32.0 |
| From 6 to 10 years | 3 | 12.0 |
| More than 10 years | 6 | 24.0 |
| **Total** | **25** | **100.0** |
| **Mean = 7.23 , SD = 7.51** | | |

## 4.4. Distribution of study participants for regular follow up.

The results of quantitative research regarding the commitment to follow ups with clinics are represented in **Table (4.4)** which shows that more than half of participants who had chronic diseases did commit to regular follow ups (a percentage of 53.9% of participants). While 46.1% of participants who had chronic diseases reported committing to regular follow ups. For participants who had chronic diseases and do not conduct regular follow up, they were asked if they were approached by the health care providers; the results showed that more than two thirds of the participants answered no with a percentage of 76.6% while about 23.4% affirmed being approached by health care providers to commit to follow up regularly. According to UNRWA(2016a), in total, 26% among the NCD patients are not coming regularly for their service utilization as well as 12% of those patients come with late complications. All of these factors or indicators could be the reason for health care providers to assert necessity of having patients committing to regular follow ups and required taking a step which involved approaching the clients by the health care providers to avoid unfortunate complications.

By asking the participants if they receive health services from other providers, **Table (4.4)** shows that less than half of the participants answered yes to having utilized services from other providers, with a percentage of 41.4% of total participants. On the other hand, about 60% of participants have not reported utilizing services from other providers. According to UNRWA (2016a), it was reported that the quality of health care is the main reason of implementing FHT, aside of distributing 22 health centers through GS which made the accessibility of the health centers increase. At the same time UNRWA is offering medical treatment that is free of charge since it was evident that the affordability of health services played a major role for the patients to utilize the medical treatment by UNRWA since the utilization of health services from health care providers other than UNRWA is not free of charge. By asking the participants who have reported utilizing services from other providers about provider of the of other services, **Table (4.4)** shows that 60.6% of them receive services from MoH, and 29.7% of participants receive health services from private providers and 7.8% from Military Medical Services, and finally, 1.8% receive services from NGOs. These results reflect that there is a duplication of services offered by other providers like the MoH, and private providers.

**Table (4.4): Distribution of study participants by selected utilization factors**

| Item | Number | % |
|---|---|---|
| **Conducting regular follow up** | | |
| Yes | 184 | 46.1 |

| | | |
|---|---|---|
| No | 215 | 53.9 |
| **Total** | **399** | **100.0** |
| **Approached by provider to conducting regular follow up** | | |
| Yes | 43 | 23.4 |
| No | 141 | 76.6 |
| **Total** | **184** | **100.0** |
| **Receive health services from other service providers** | | |
| Yes | 165 | 41.4 |
| No | 234 | 58.6 |
| **Total** | **399** | **100.0** |
| **The other service providers** | | |
| Governmental clinic | 100 | 60.6 |
| Non-governmental organization clinic | 3 | 1.8 |
| Private clinic | 49 | 29.7 |
| Military Medical Services and others | 13 | 7.9 |
| **Total** | **165** | **100.0** |
| **Reasons of seeking services from other organizations** | | |
| Have more services | 91 | 55.2 |
| Better quality of services | 77 | 46.7 |
| Have staff that is very qualified | 30 | 18.2 |
| More convenient working hours | 23 | 13.9 |
| Maintain my privacy | 8 | 4.8 |
| Closer to home | 15 | 9.1 |
| Other | 9 | 5.5 |
| **Years of receiving services from other organizations** | | |
| Less than 5 years | 46 | 32.4 |
| From 5 to 10 years | 50 | 35.2 |
| Above 10 years | 46 | 32.4 |
| **Total** | **142** | **100.0** |
| **Mean = 9.43 , SD = 7.60** | | |

**Table (4.4)** shows the main reasons of utilizing health services from other organizations. The reasons are listed as following: (1). More availability of services as reported by 55.2% of participants. (2). Better quality of services as reported by 46.7% of participants, (3). More qualified staff as reported by 18.2% of participants. (4). More convenience when it comes to working hours as reported by 13.9% of participants. (5). Distance to/from providers as reported by 9.1% of participants. (6). Privacy, as reported by 4.8% of participants.

By asking the participants about the number of years they have been utilizing health services from their health center, 32.4% of participants have been utilizing the services since less than 5 years, while 35.2% of participants have been receiving service from the other providers from 5 to 10 years. Finally, 32.4% of participants have been receiving services for more than 10 years. This reflects that more than two thirds of the participants received health service from their UNRWA health centers for more than 5 years with a

percentage of 67.6% of total participants. The overall mean of utilizing health services from other providers was 9.43 years with (SD=7.60).

### 4.5 Study participants' perspectives on traditional and FHT approach of providing services

**Table (4.5)** reveals that 80.5% of participants had received services through the traditional approach while 19.5% of participants did not receive health services through the traditional system. By asking participants who have utilized services through the two approaches, 86% of them preferred the family health team approach over the traditional approach of providing services and only 14% of participants prefer receiving health service through the traditional approach. By asking the study participants about the gender of their physician preference, most of the participants (73.2%) prefer female physician, while a percentage of 26.8% of participants prefer male physicians. Concerning gender of the nurse preference, Table **(4.5)** showed that a 79.7% prefer a female nurse, while 20.3% prefer a male nurses.

Regarding the service provision through the provider gender, more than two third of the study participants indicated that gender does not affect their utilization of services (62.2%), while about 40% indicated that gender of providers does affect their utilization of services. By asking the study participants if they felt embarrassed when they were treated by other gender provider than the participant gender, 74.4% of participants indicated that this issue is not important to them, however, 25.6% of participants indicated that this issue is important to them and it does embarrass them to be treated by a provider of not of their gender.

Concerning the quality of service the participants received, **Table(4.5)** showed that a 38.7% received a high quality service but more than half of the study participants indicated that received a reasonable/median quality with a percentage of 55.9% of total participants and 5.3% of them have indicated that they received services of low quality.

**Table (4.5):Participants' perspectives on traditional and FHT approach of service provision**

| Items | Number | % |
|---|---|---|
| **Received services through the old traditional system** | | |
| Yes | 321 | 80.5 |
| No | 78 | 19.5 |
| **Total** | **399** | **100.0** |
| **Approach clients prefer** | | |
| Family team approach | 276 | 86.0 |
| Traditional approach | 45 | 14.0 |

| Total | 321 | 100.0 |
|---|---|---|
| **Prefer your physician to be** | | |
| Male | 107 | 26.8 |
| Female | 292 | 73.2 |
| **Total** | **399** | **100.0** |
| **Prefer your nurse to be** | | |
| Male | 81 | 20.3 |
| Female | 318 | 79.7 |
| **Total** | **399** | **100.0** |
| **Gender of your provider affects the service provision** | | |
| Yes | 151 | 37.8 |
| No | 248 | 62.2 |
| **Total** | **399** | **100.0** |
| **Felt embarrassed to be treated by a different gender, other than yours** | | |
| Yes | 102 | 25.6 |
| No | 297 | 74.4 |
| **Total** | **399** | **100.0** |
| **Describe the quality of the services that you received** | | |
| Of high quality | 153 | 38.7 |
| Reasonable quality | 221 | 55.9 |
| Low quality | 21 | 5.3 |
| **Total** | **395** | **100** |
| **Describe your health status after receiving services from this center** | | |
| Good | 249 | 85.9 |
| No improvement | 26 | 9.0 |
| Getting well | 3 | 1.0 |
| I don't know | 12 | 4.1 |
| **Total** | **290** | **100.0** |

According to UNRWA, (2016), the goal of the new health provision strategy, after the reform in health service provision through FHT, was to support initiatives that enhance the quality and efficiency of services provided. UNRWA health department always conduct workshops and meetings to elevate the level of quality of its services. According to WHO standards, UNRWA was able to implement policies in which the standards services quality are met by staff capacity building, accessible health centers, and so on to match the goals the new FHT approach is meant to meet. **Table (4.5**) showed that the majority of study participants (85.9%) described their health status as “improved” after receiving health services from UNRWA's health center. Conversely, 9.0% of the study participants have reported no improvement in their health status and 1 % have reported deterioration in their health status.

## 2. Process factors

## 2.1 Staff training and readiness before shifting from traditional services provision approach to FHT Approach

Staff training is the essence of success for any workplace. An effective training with emphasis on following safety measures serves as a catalyst for the development and growth of an employee skills. Results of focus group discussions with participants revealed in that the health staffs has acquired proper training and believe in their readiness to switch to following the FHT approach. Conversely, one-third of the four focus groups have indicated that the training they received prior to implementing FHT was short and not sufficient. They also added that it did not cover all the needed topics to allow them to operate at their fullest potential. On one hand, nurses and midwifes perspectives, the training was good enough. They linked that to having more experience in working within teams than physicians. On the other hand, most physician participants indicated that the training would be more effective if more time was allocated to it. From physicians' perspective, the training was crucial as they used to focus on treating diseases without having a holistic perceptive when dealing with cases. The adoption of FHT approach required from physicians to deal with more cases they used to deal with such as NCD, and women health. Such diversity in cases was a challenge for physicians, thus, the training program, from physicians' perspective, was not enough.

In-depth interviews with the decision makers revealed that training and staff readiness to introduce FHT approach was well-planned and well- organized. The introduction of FHT approach was done through phases and it was piloted before being implemented in all health centers. From key-informants point of view, the piloting was a good practice that enabled UNRWA to implement a reformed system across its 22health centers in the GS. During the piloting, most senior medical officers have visited the piloted centers and then all of them expressed the need of their centers to adopt FHT. One participant stated that *"Change will not happen if someone says I am prepared to it without, indeed, implementing it. During the implementation, you realize that your needs are changed and you even can have new ideas to implement that enhance effective implementation."* [51 years old, female Key- informant]

From the eyes of key-informants, trainings was more of in-service training as it was done in all health centers. One key-informant stated *"Training was conducted in all health centers with the involvement of all staff. The allocated time was enough. The main*

*challenge was to train staff on the use of E-health system.*" [61 year-old male, Key-informants].

In regards to the staffs' readiness, from health care providers perspectives, they were informed previously that a major reform will be taking place in which the FHT approach will replace the traditional approach when it comes to the provision of health services. From participants' perspective, physicians were the main target to be trained and prepared for this major reform. The FHT approach required from physicians to provide comprehensive services to families instead of specialized services. One physician did say "*Before adopting the family health team approach, we used to have specialists who deal with different cases, right now, we treat all cases*" [46 years old, male physician].

From decision makers' perspectives, the implementation of FHT approach required high level of cooperation among teams. The cooperation was a basis to divide tasks across team members, mainly among midwifes, nurses, and physicians. The implementation of FHT also required high level of flexibility from all staff members, starting from the top management to the front-line workers. Finally, while the new reform represented a change of the way physicians conducted their practices, to the nurses and midwives it was seen as a pure empowerment and an integrated training program. The FHT has introduced new skill sets and increased the capacity of the nurses and midwives to operate at higher level of potential where nurses learned to do their work more efficiently as a complementary team not a group of workers. A senior Key-informant stated *"Empowerment of nurses is one of the main learnt lessons through preparing the staff to implement FHT"* [51, female key-informants].

### 2.2 Protocols for implementing FHT

All participants in the four focus groups mentioned that there is no designated protocols for FHT, however, each service delivered at UNRWA has its own technical instructions that are consistent with WHO recommendations and guidelines. The adoption of FHT was a challenge to service providers, particularly physicians as services providers, because they were no longer focusing on one area. Instead the scope of their work was widened and the specialization aspect of work diminished with the new system. Thus, providers were

required to familiarize themselves with different protocols such as NCD which was a tiresome deal for some of them. One physician stated *“At the beginning, I got tired of knowing all protocols of the different services, it took me two weeks to study the protocols in order to become a physician working within FHT”*[37 years old, female physician].

From the in-depth interview with the key-informants perspective, it was evident that there are no protocols to be followed for FHT. Instead, FHT was viewed as a new integrated model for service delivery. Currently, and consistent with what participants of focus groups stated, most diseases such as NCD have specialized protocols. The presence of such protocol was a great tool that significantly helped service providers to provide a comprehensive package of services to their clients. Interestingly, UNRWA keeps updating its protocol and share their updates with staff through emails. *A key-informant stated" the service should be provided based on clients need, in general, every five years the UNRWA updates its protocols according to the internationally implemented guidelines. Recently, UNRWA introduced preconception care -for example- and it has its own protocol”*[61 years old, Key informant].

Most of the participants indicated that healthcare practitioners have been trained on how to use the available protocols prior to the implementation of FHT and have received hard copies of the protocols and also received the updated protocols. This finding was consistent across all study participants.

### 2.3 Monitoring and supervision

From participants' perspective, UNRWA has a good system of supervision and monitoring. Indeed, participants stated that the current success of FHT implementation was an outcome of commitment made by top management through the manifestation of continuous monitoring. In health centers, monitoring is not only a duty of the senior managers, but also a duty of every member of the team. The FHT proposes performance indicators that all teams are required to match. The performance indicators created organizational change in which each member within the team is responsible for and committed to achieving the outcome indicators. One nurse stated*“All teams monitor and follow up their work thoroughly, somehow, we now do more of self-monitoring”*[57 years old, staff nurse]. UNRWA's has introduced statistical monitoring measures such as antibiotic use rate, client satisfaction, and check lists about each service provision properly. The implementation of FHT did help in achieving good outcomes such as decreasing the use of antibiotic. One

provider stated *"After implementing FHT, the antibiotic use rate has decreased, and drug rationalization is becoming more and more achievable*." [39 years old, female Key-informants]. Additionally, key informants stated that UNRWA has timetable that is used to track the progress of performance of each center. In addition to receiving special course in monitoring, E-health system has enabled Senior Medical Officers to actively monitor the performance of center as stated by key informant *"We have trained all staff on monitoring performance of FHT and we trained senior medical officers in monitoring as well*."[51 years old, Key-informants]. The FHT serves as a comprehensive monitoring platform in which self-mentorship was introduced to healthcare staffs and emphasized on by top management.The FHT set criteria and provided a benchmark for goals attainability within a health center, all while taking mentorship to a new level, thus, applying the element of control to the actual end results to the goals and criteria set in advance.

### 2.4 Workload after implementing FHT

Results of the focus groups discussion and in-depth interviews revealed that there is a decrease in the workload after FHT has been implemented at UNRWA and this is due to improved work efficiency. After the implementation of FHT management was able to do workforce analysis in order to improve the labor efficiency and cope up with the requirements of the several services now facilitated by FHT. The analysis was made in order to ensure that each employee is not being overworked or underworked, thus, the concept of task shifting was introduced to exchange efforts between the health care providers and improve cooperation while increasing human resources efficacy. Over the course of the past ten years, it is well known the population of GS has been drastically increasing. Unluckily, UNRWA did not increase the health service providing centers mainly due to the financial crisis that the UNRWA is facing. Additionally, the utilization rates of UNRWA services are high due to the accessibility and affordability of the services. The high demand on UNRWA's service was one of the main reasons to adopt FHT. Since the financial budget of UNRWA was tight, it had to consider a more efficient way in which services are effectively and sufficiently delivered while maintaining an equitable distribution the workload among healthcare staff members. Before implementing FHT, on a daily basis, each physician used to treat 100 cases. After the implementation of FHT, the ratio of cases treated to physicians has decreased to 80 patients per a physician each day. UNRWA aims to distribute the workload to be about 70 cases per FHT each day. The current workload is not far from the target, as stated by a key informant"*FHT can provide*

*health services to 110 cases per day, however, sometimes they provide services to 40 cases. On average, each FHT provide services to 70 cases per day."* [39 years old, Key informants].

Focus group discussions revealed that the human resources are not distributed fairly across health centers and some physicians have very limited ability to enjoy their annual leaves. The focus group discussion also revealed that staff are loaded with additional tasks required from them such as screening services. One staff nurse stated *"The introduction of screening services to the provided services increased our workload. Each day, at least 18 cases should be screened for NCDs, it doesn't matter for the administration them. The current workload may lead sometimes to a burnout." Key informants agrees that there is a need to recruit more staff, however, the current financial crisis limited UNRWA's ability to hire more staff.* Key-informants stated *"At the beginning it was difficult to adopt FHT, but through needed analysis, like manpower analysis, we were able to pass up the need of recruiting 20 new staff members while providing required services thanks to adopting the FHT Approach*" [51 years old, Key-informants].

**2.5 System readiness (E-health) for the implemented FHT**

Findings from focus group discussions and in-depth interviews with key informants revealed that some of health centers started to implement the FHT approach by the old health family cards (hard copy) while other health centers were able to start with the usage of E-health system. After the internal structure was prepared and the internet were provided to replace the old system, the E- health team members at UNRWA were able to train the staff members at each health centers so that they can use the system properly. At first, the health centers were provided by private intranet connection (HIS). Then UNRWA coordinated with other professionals from other countries and applied a management system, E-health version 5, to the database that is full of information about the patient profile, medical condition, recent medications, and other queries applied to the mentioned tables. When they find any gap or needed modification according to the health care providers' recommendation to with stand the needs of their clients, E-health team members can do the needed change.

Based on the discussion with the focus groups, each family was categorized based on their registration numbers and were distributed fairly among family health teams. Using the new E-health system affiliated with FHT, numbers of clients are adjusted according to the

workload. By the provision health services through the new E-health system, a specialized crew started training the medical staff. It would take them from six to eight weeks to complete the training. There was also a close follow up from the SMOS, AHO on this important step while it was being implemented. According to the discussion with the key-informants, they stated that medical history of the patient is protected by the provision of E-health. In addition to that, any history of drug abuse became evident and monitored through E-health. The system maintained confidentiality of the patient health file.

## 3-Providers Factors

### 3.1 Staff qualifications and knowledge needed to implement FHT

In-depth interviews and focus group discussions have revealed that medical staffs were qualified enough to start providing services. Additionally, the in-services training before implementing FHT increased the level of staff knowledge. Participants of focus group discussions agreed that they were qualified enough to start implementing FHT and adhering to the system protocols within the clinics, particularly nurses and midwives. However, for physicians, it was a must that they update their knowledge regarding the other types of services that they used to provide. The main change in knowledge required from them was to shift the scope of their work from traditional service provider to a family physician. A 47 year-old male physician stated that: *"At the beginning stage of the FHT implementation, it was unclear and difficult to adopt the new approach, but now after experience on working as family doctor several things became easy and prominent."* And according to the health care providers' perceptions, that past experiences played a good role in implementing the new approach and to be delivered in a suitable way.

Regarding the perception of the decision makers on needed knowledge, in-depth interview with key-informants revealed a shift even in the process of recruiting employers who are involved in the selection process for recruiting doctors who have experience as family doctors .Key-informants mentioned that they *"select the best of the best among the nominees to match the new approach standards*" [61years old, key-informants]. When it comes to training of staff and capacity building, the health department has shifted its requirements. Instead of hiring master of public health holders, into family health diploma holders by minimal expenses. And the donors can support the family medicine diploma after they are convinced that we had implemented the FHT like in the developed countries, and donors always donate to the successful project or programs .They have done the first

cohort and now they are doing the second cohort of family diploma, so that the new health services can be delivered appropriately, key informants stated*" We have trained the staff not only once ,or even for several times to higher the their qualifications in the different categories"*[51 years old, female key-informants].

### 3.2 Opinion of the health care providers regarding FHT implementation

The provision of the high quality health services is the ultimate goal for the new approach. During the interviews and focus groups, the participants have expressed the differences between the two systems in the way of health services are delivered. The successful outcomes from the implementation of FHT were: (1) the patients became able to recognize their patients, and patients became familiar with their doctors. (2) Quality of service became better than it was during the period of the traditional system.(3)Trust between the health care provider increased with their patients.(4) care became comprehensive rather than fragmented(5) The waiting time according to the appointment time was reduced to fit the clients convenience. (6) The contact time with the beneficiary became almost three minutes for each curative case. (7) There are no wasted resources like before and the labor is more efficiently employed. (8) Drugs rationalization and antibiotic rate is maintained average of 25% of the total number of drugs prescribed. (9) Doctors are working comfortably and checking their patients through a family history and became more able to control the drug collectors. (10) Now the services are more capable of maintaining respect and confidentiality.

With regard to the in-depth interview with the decision makers, it revealed that they are concentrating on providing the best possible services to the patients. Key-informants stated that *"the difference between the traditional system and the new FHT system is like the difference between hell and heaven"* [39 years old, key-informants]. There was a huge waste of the resources. For example, when different members of the same family need to see different doctors, there would be no connectedness of family related cases, thus a big chunk of time would be wasted (an example from the focus group: when a women wanted to be treated by MCH doctor and her kids needed to be treated in the general clinic, and her mother needed to be seen by her NCD doctor, there was no connection between them and it resulted in a huge waste of time). Conversely, when following the new FHT approach, patients of the same family will be served by one team that covers all of their needs. In the past (2013), there was an outbreak of mumps, and it was easily discovered in one day,

because the same doctor treated 7 cases belonging to one family. Now the FHT approach is person centered and family centered, and there is a good communication between the health care provider and the clients. The provider can ask about the medical condition of the clients' relatives, it is the new way of respect the dignity of the clients. One time a satisfaction survey/interview was done to hear from the clients about the FHT and the services they provided. The results were that more than 85% of the interviewed beneficiaries were satisfied and say that the service is good and hoped for the service to keep going on the same direction. Key-informants stated *"Words can express stronger than numbers, prior to FHT was an era and now it is a new era. Previously the services were fragmented, now it is holistic and comprehensive*" [51years old, female key-informants].

### 3.3 Attitude change from both clients and health care providers after FHT implementation

Focus group discussion with the health care providers and in-depth interviews with the key-informants revealed a significant change in clients' attitude towards the delivered health services post to the FHT approach implementation. Patients became familiar with their service providers and they now cooperate with them in several issues, even ones related to the community engagement, and feedback so that they can gain appropriate services. Trust became stronger between the clients and the healthcare services' providing teams. Patient became more cooperative and are more encouraged not to hide any information regarding his medical condition, and say the truth to his/ her healthcare provider. Moreover, clients developed a sense of gratitude to the family health teams because of the protocol of doctor-patient confidentiality. Health care providers stated: *"Now FHT is better, because we are able to know more about our people and familiarize ourselves with their life aspects. People also knew us better than before"*[37 years old, female midwife].

The interviewees and practitioners have also expressed their satisfaction about the change in attitude when encountered with their clients. They mentioned that they felt proud that the patients knew the name of their doctors, and the patient feel comfortable when they come to utilize health services. Clients feel that they are coming to their private clinic, patients now come to clinic of the doctors and treated better than visiting several doctors outside UNRWA health centers, Key-informants stated *"One time I heard the patient that*

*he is going to get consultation through Dr.XY, and he is my private physician*".[51 years old, female key-informants]. The relationship between doctors and their patients previously was limited, and it doesn't go beyond asking certain questions. However, after FHT was implemented, the patients' attitude towards their providers has changed to the best. The patients used to complain about their physicians and health service provided and now that has been deceased a lot and the patient's attitude is much better. A 51-year old, key-informants stated that: *"Surprisingly, while I was passing in the beach health center, one female patient stopped me, and I thought that she is complaining about staff member, but she expressed her respect and thanks to the FHT who served her. I say that this is the best evaluation to the success of our FHT approach implementation".* Having discovered that from the key-informant, this suggests that one of the main reasons of the reformed system has been attained which is that each patient treated at UNRWA health center is treated with respect and dignity without being looked down upon for seeking free healthcare services. The FHT approach has achieved several goals like, (1) Trust building between the health care provider and their clients.(2) The community became more engaged with the health care providers through providing a proactive feedback which contributed to producing comfortable services.(3) Health service became comprehensive ,and not disease oriented. (4) The FHT implemented a successful use of database management systems in the field of health. Finally, on the several aspects related to the implementation of FHT, participants from both focus groups and in-depth interviews expressed their satisfaction and appropriateness for the new reform and their quality perception is better than the traditional way of delivering the health services and improving the doctor-patient relationship.

## 4. Outcomes

### 4.1 Perceived quality of health services from study participants' point view

Patient perceptions of service quality have become an important component in measuring the quality of care and healthcare services. The SERVPERF model of measurement for customer perception was used to measure the quality of services provided through the FHT approach. The five dimensions considered were tangibles, reliability, responsiveness, empathy, and assurance.

Regarding Tangiblefindings, **Table (4.6)** reveals that more than two-thirds of study participants (78.4%) found it easy to adapt to receiving health services through FHT. While less than 10 % of the study participants found it not easy to adapt the new way of healthcare services' provision through FHT. Also, 76.2% of the study participants indicated that FHT has positively improved the quality of services they received. On the contrary, 7.8% of the study participants indicated that FHT Approach didn't improve the quality of services they received. A percentage of 16.0% of the study participants were not sure whether the FHT has improved the quality of services they have received or not. The mean percentage was 76.8%. Finally, 83.7% of the study participants have indicated that FHT approach has enabled providers toprovide them with good healthcare. It is worth mentioning that the study findings are consistent with the results of the study done by Steinwachs and Hughes (2008).A percentage of 4.8% of the study participants indicated that FHT approach did not enable providers to provide them with good care. It is interesting to mention that 11.5% of the study participants were unable to judge if the FHT has enabled providers provide them with good care or not. The mean percentage was 79.0%.

Concerning responsiveness of health services to clients' needs, on one hand, a total of 76% of the study participants have indicated that FHT approach ensures providing them with health services at the right time. On the other hand, 9.8% of the study participants have indicated that FHT approach did not ensure providing them with health services at the right time and 14.3% of study participants were not sure if the provision of health services through FHT was different from the traditional way of providing services in guaranteeing the provision of health services at the right time.

Additionally, a percentage of 83.7% of the study participants indicated that FHT approach helps in maintaining continuity of care while a percentage of 6.8% of the study participants have indicated that FHT approach did not help in maintaining continuity of care. The findings of this part of study is consistent with the study findings of (Gaboury et al., 2009). FHT approach helps in maintaining continuity of care. The mean percentage was 78.4%.

Regarding clients perception about whether the provision of service through FHT has promoted receiving comprehensive health care service, more than two-thirds of the study participants have agreed that FHT approach has promoted comprehensiveness of care and only 6.8% of the study participants indicated that FHT approach did not promote

comprehensiveness of care. The mean percentage was 78.4%.The study findings are consistent with the study conducted by Seita (Seita et al., 2014).

As for the measurement of the services compellability with beneficiaries' needs, when asking the study participants if FHT promotes receiving services matching their needs, only 74.2% of the study participants have agreed that the provided services were matching their needs while 5.8% of the study participants indicated that the FHT services were not based upon their needs. Additionally, more than 20% of the study participants were not sure if the services received are compliable with their needs. The mean percentage was 76.4%. The findings were consistent with an UNRWA report which discussed how providing the services with regards to the needs of the patients was one of the main challenges for the agency (UNRWA, 2013). The study findings also emphasized the achievement of this main goal (which is to have services that are compatible with the needs of beneficiaries) and highlight the urgency of addressing that challenge. According to Herbert (2005), a scholar in the field, it is very important that the patients can have good accessibility to their health services that are compatible with their needs and by the right professionals at the same time (Herbert, 2005). The findings of this study do a good job evaluating the FHT approach in terms providing services more compatible to the customer's needs and by a team of specialized professionals when compared to the traditional way of provision of health services which suffered a lot from satisfying that need and tackling that obstacle.

**Table (4.6) Perceived quality from study participants point view**

| Items | | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | Weighted Mean % |
|---|---|---|---|---|---|---|---|
| **Tangibles** | | | | | | | |
| It was easy to adapt to receiving health services through FHT | **No.** | 8 | 22 | 56 | 243 | 70 | 77.2 |
| | **%** | 2.0 | 5.5 | 14.0 | 60.9 | 17.5 | |
| FHT approach has improved the quality of services you received | **No.** | 7 | 24 | 64 | 233 | 71 | 76.8 |
| | **%** | 1.8 | 6.0 | 16.0 | 58.4 | 17.8 | |
| FHT approach enabled | **No.** | 6 | 13 | 46 | 262 | 72 | 79.0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| providers to provide you with good care | % | 1.5 | 3.3 | 11.5 | 65.7 | 18.0 | |
| **Responsiveness** | | | | | | | |
| FHT approach ensures providing health services at the right time | No. | 11 | 28 | 57 | 242 | 61 | 75.8 |
| | % | 2.8 | 7.0 | 14.3 | 60.7 | 15.3 | |
| FHT approach helps in maintaining continuity of care | No. | 10 | 17 | 38 | 265 | 69 | 78.4 |
| | % | 2.5 | 4.3 | 9.5 | 66.4 | 17.3 | |
| FHT approach promotes providing comprehensive care | No. | 8 | 19 | 58 | 224 | 90 | 78.4 |
| | % | 2.0 | 4.8 | 14.5 | 56.1 | 22.6 | |
| FHT services provided based upon your needs | No. | 6 | 17 | 80 | 237 | 59 | 76.4 |
| | % | 1.5 | 4.3 | 20.1 | 59.4 | 14.8 | |
| FHT approach promotes courteous and polite providers' behavior towards clients | No. | 15 | 19 | 59 | 194 | 112 | 78.4 |
| | % | 3.8 | 4.8 | 14.8 | 48.6 | 28.1 | |
| FHT approach enabled providers to understand the specific needs of clients | No. | 10 | 29 | 70 | 246 | 44 | 74.2 |
| | % | 2.5 | 7.3 | 17.5 | 61.7 | 11.0 | |
| **Competence** | | | | | | | |
| FHT approach promotes good performance of staff | No. | 9 | 25 | 74 | 217 | 74 | 76.2 |
| | % | 2.3 | 6.3 | 18.5 | 54.4 | 18.5 | |
| FHT staff members were knowledgeable regarding to your health conditions | No. | 9 | 53 | 61 | 212 | 64 | 73.4 |
| | % | 2.3 | 13.3 | 15.3 | 53.1 | 16.0 | |
| FHT staff members have all the required skills to provide you with the needed services | No. | 8 | 32 | 91 | 201 | 67 | 74.4 |
| | % | 2.0 | 8.0 | 22.8 | 50.4 | 16.8 | |
| FHT approach helps you in building trust with the health care provider | No. | 8 | 36 | 57 | 238 | 60 | 75.4 |
| | % | 2.0 | 9.0 | 14.3 | 59.6 | 15.0 | |
| **Items** | | **Strongly Disagree** | **Disagree** | **Neutral** | **Agree** | **Strongly Agree** | **Weighted Mean %** |
| FHT approach maintain and respect confidentiality of health records | No. | 6 | 7 | 40 | 263 | 83 | 80.6 |
| | % | 1.5 | 1.8 | 10.0 | 65.9 | 20.8 | |
| FHT approach gives health care providers the chance of being in close contact with their clients | No. | 7 | 27 | 50 | 229 | 86 | 78.0 |
| | % | 1.8 | 6.8 | 12.5 | 57.4 | 21.6 | |
| FHT approach has improved the provider's willingness to help. | No. | 6 | 17 | 57 | 252 | 67 | 77.8 |
| | % | 1.5 | 4.3 | 14.3 | 63.2 | 16.8 | |
| **Empathy** | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| FHT approach ensures the commitment of the health care providers towards their clients | **N** | 8 | 16 | 52 | 247 | 76 | 78.4 |
| | **%** | 2.0 | 4.0 | 13.0 | 61.9 | 19.0 | |
| FHT gives the staff the feeling of trust in providing health care to clients | **N** | 6 | 21 | 53 | 249 | 70 | 77.8 |
| | **%** | 1.5 | 5.3 | 13.3 | 62.4 | 17.5 | |
| FHT gives the clients comfortable feeling in receiving health care and communication with staff | **N** | 11 | 23 | 67 | 218 | 80 | 76.6 |
| | **%** | 2.8 | 5.8 | 16.8 | 54.6 | 20.1 | |
| FHT approach makes health care providers more accessible | **N** | 5 | 10 | 49 | 228 | 107 | 81.2 |
| | **%** | 1.3 | 2.5 | 12.3 | 57.1 | 26.8 | |
| FHT approach enabled providers to provide you with good care | **N** | 6 | 13 | 46 | 262 | 72 | 79.0 |
| | **%** | 1.5 | 3.3 | 11.5 | 65.7 | 18.0 | |
| FHT approach focus more on you as a whole person(not only as a case) | **N** | 23 | 134 | 53 | 150 | 39 | 62.4 |
| | **%** | 5.8 | 33.6 | 13.3 | 37.6 | 9.8 | |
| Overall FHT approach improved the communication between patients and providers | **N** | 8 | 16 | 54 | 261 | 60 | 77.4 |
| | **%** | 2.0 | 4.0 | 13.5 | 65.4 | 15.0 | |
| FHT approach has helped providers to maintain the best interest of the clients | **N** | 11 | 18 | 57 | 258 | 55 | 76.4 |
| | **%** | 2.8 | 4.5 | 14.3 | 64.7 | 13.8 | |
| **Reliability** | | | | | | | |
| The FHT approach ensures providing health services that are appropriate | N | 7 | 13 | 63 | 250 | 66 | 77.8 |
| | % | 1.8 | 3.3 | 15.8 | 62.7 | 16.5 | |
| FHT approach provides the appropriate atmosphere for communicating with health staff and receiving care | **N** | 9 | 22 | 56 | 238 | 74 | 77.4 |
| | **%** | 2.3 | 5.5 | 14.0 | 59.6 | 18.5 | |
| **Over all Mean of Perceived Quality = 76.72, SD= 13.10** | | | | | | | |

One of the most common complaints of beneficiaries of health services is the way the treating physicians treat them because they receive services that are free of charge which discourages the patients or clients from committing to follow ups or even going to UNRWA clinics in the first place. The study draws a correlation between the implementation of the FHT approach and the promotion courteous and polite provider behavior towards clients and highlight the importance of the aspect. Interestingly, 63.4% of the study participants indicated that provision of health services through FHT approach has promoted good providers' behavior towards their clients such as being polite with them and manage to relate FHT approach with more polite manner of service providers. In the other hand, a percentage of 8.6% of the study participants have indicated that FHT approach did not promote good providers' behaviors or failed to see a connection between good health

care provider’s manner and the implementation of the FHT approach. The mean percentage was 78.4%. The findings of the study are consistent with the study made by (Russell et al., 2017). Finally, 72.7% of the study participants have indicated that FHT approach enabled providers to understand their specific needs, while, less than 10% of the study participants have indicated that the provision of health services through FHT did not increase providers' understanding of their specific needs and 17.5% of the study participants could not judge if the provision of health services have improved providers’ understanding to their needs. The study findings expressed the new change attributed to the implementation of FHT and expressed how it is better than the traditional system which was previously adopted in that regards.

The third domain of the SERVPERF modelwas competences of health care providers. As in **Table (4.6),** about two-thirds (72.9%) of the study participants have indicated that FHT approach has promoted the health care providers’ competence and resulted in a better staff performance. Interestingly, about 20% of study participants were not sure of the provision of services through FHT has promoted good staff performance and even 8.6% of the study participants do not agree that provision of health services through FHT promoted good performance of staff.

With regards to staff members knowledge about patient health conditions, 15.6% of the study participants have indicated that health staff members were not knowledgeable about their health conditions, while 59.1% of the study participants have indicated that staff members were knowledgeable about their health conditions. The mean percentage was 73.4%. From the researcher point of view the findings express that the health care providers should spend more effort and time to be knowledgeable about the clients’ health condition and to concentrate more on the medical file of the client.

When participants were asked if they think that the staff have all the required skills to provide them with the needed services, only 67.2% of the participants indicated that staff members do have the required skills to provide them a proper care. A total of 10% of the study participants have indicated that the staff members don’t have the required skills to deliver the needed health services and 22.8% of the study participants could not judge if the staff has the required skills to deal with their health needs. The mean percentage was 74.4%.

Regarding building trust between the health care provider and patients, a small portion (11%) of the study participants have indicated that receiving health services through FHT approach did not help in building trust with health care providers, while 74.6% indicated it did help in building trust with the health care provider. A total of 14.3% were neutral. The mean percentage was 75.4%.

Regarding to confidentiality of the health records, a percentage of only 3.3% of the study participants have indicated that the provision of health services through FHT did maintain and respect the confidentiality of the health records, while 86.7% of the participants indicated it did maintain and respect confidentiality of the health records. A total of 10% of the study participants were neutral. The mean percentage was 80.6%. The findings were consistent with the findings of Shahin (2013), who emphasized on the importance of shifting to record keeping through E-health instead of the formal way of paper registration (Shahin, 2013).

Regarding the chance of increasing the duration of contact time between beneficiaries and their health care providers, only 8.6% of the study participants indicated that FHT approach did not increase the contact time of the health care provider with the clients, while 69.9% of the participants indicated that FHT approach did increase the session duration with their providers. A total of 12.5% of the study participants were neutral. The mean percentage was 78.0%. This study emphasized the need to increase the contact time found out the FHT approach contributed that positive change of outcomes. The results of the study in that regards go hand in hand with the a study done by UNRWA emphasizing that in order to obtain a high quality outcomes, there should be good contact time between patients with the clients and the study addressed that parameter (UNRWA,2016a).

Finally, it is worthwhile for this study to mention that 80% of the participants have indicated that FHT approach has improved the providers' willingness to help them rather than just helping because it is a part of provider’s job. In the other hand, 5.8% of the study participants have indicated that FHT approach did not improve providers' willingness to help them. A total of 14.3% of the study participants were neutral. The mean percentage was 77.8%. The findings of the study was consistent with researcher findings (Suter et al. 2009). Concerning commitment of the health care provider towards their clients, 6% of the study participants have indicated that FHT approach did not ensure commitment of the health care providers to their clients, while 74.9% of the study participants indicated that

FHT approach have ensured commitment of the health care providers towards their clients. A total of 13% were neutral. The mean percentage was 78.4%.

As to whether FHT gives the medical staff the feeling of trust in providing health care to their clients, 6.8% of the study participants indicated that FHT did give the providers the feeling in providing health care to their clients, while 79.9% of the study participants have indicated that FHT approach gives the staff the feeling of trust in providing health care to them. A total of 13.3% of the study participants were neutral .The mean percentage was 77.8%. The findings of the study are consistent with the study done by Pike (1991) who also indicated that feeling of trust can also lead to strong relationship between the health care providers and the clients (pike, 1991).

As to measuring the clients' comfort about received health care services and ability to communicate with staff, a percentage of 8.6% of the study participants indicated that FHT did not give the clients feelings of comfort while receiving healthcare and allowed communication with the staff, while 74.7% of the participants indicated that FHT gives the clients comfortable feeling in receiving health care and communication with staff. A total of 16.8% of the study participants were neutral. The mean percentage was 76.6%.

Regarding the evolution of accessibility to services by health care providers, 3.8% of the study participants indicated that FHT approach did not make the health care providers more accessible while 83.9% of the participants indicated that FHT approach did make health care providers more accessible and easier to communicate with. A total of 12.3% of the study participants were neutral. The mean percentage was 81.2%. The study findings are consistent with the findings of Herbert (2008) who also indicated that patients could have good accessibility to health care through the provision of family health team (Herbert, 2005). With regards to the provision of health services with good care, 4.8% of the study participants indicated that FHT approach did not enable providers to provide services of good care, while 83.7% of the participants indicated that FHT approach did enable the providers to provide services with a good care. A total of 11.5% of the study participants were neutral. The mean percentage was 79.0%. The study also took into consideration the measurement of individual attention given to clients by providers, 39.4%of the study participants have indicated that FHT approach did not feel getting individual attention from their providers, while 47.4% of the study participants have indicated that FHT approach helps providers in dealing with client as a with individual attention. A total of 13.3% of the study participants were neutral. The mean percentage was 62.4%. The findings of the study

are consistent with a similar study by Europa (2015) who indicated that the health reform is person centered and attains better quality of delivering primary health care than traditional system (Europa, 2015). Concerning the communication between patients and health care providers, 6.0% of the study participants indicated that overall FHT approach did not improve the communication between patients and providers, while 78.9% of the participants indicated that FHT approach improved the communication between patients and providers. A total of 13.5% of the study participants were neutral. The mean percentage was 77.4%. With regards to evaluating whether health services were provided to the clients to their best interest, 7.3% of the study participants indicated that FHT approach hasn't helped the providers to maintain the best interest of their clients, while 78.5% of the clients indicated that FHT approach has helped the providers to maintain the best interest of the clients. A total of 14.3% of the study participants were neutral.The mean percentage was 76.4%. Finally the overall mean of the perceived quality of the study participants was 76.72 with (SD=13.10). Finally, the last domain of SERVPERF model was Reliability. Findings in **Table (4.6)** showed that 79.2% of the study participants indicated that services they received through their FHT approach were appropriate and reliable, while 5.1% of the study participants have indicated that services they received through their FHT were inappropriate. A total of 15.8%of the study participants were neutral. The mean percentage was 77.8%. Finally, the study findings is consistent with the study of Cote and Colleagues (2008).

The study also focused on addressing whether FHT approach provides the appropriate atmosphere for communicating with health staff and receiving care, 8.6% of the study participants indicated that FHT approach did create appropriate atmosphere for communicating with health care providers and receiving care, while 78.1 % of the study participants have indicated that FHT approach did create appropriate atmosphere for communicating with health care providers and receiving care. A total of 14.0% of the study participants were neutral.The mean percentage was 77.4%.

The overall mean of perceived quality of health services provided through FHT was 76.2%. The study findings is consistent with (Tancred, 2016; Dahrouge et al., 2016) as well as (Carrroll et al.,2016) where it is pointed out that the overall perception of the quality of the service to be delivered to the clients is measurable to the respect of the atmosphere, alternates and the main purposes of the service.

## 4.2 Satisfaction with the provided services

By asking the study participants if they are satisfied with the provision of health services through FHT approach, **Table (4.7)** showed that 6.8% of the study participants are unsatisfied because they do not feel they could obtain services with ease from the health center through the FHT approach. On the other hand, 77.2% of the study participants were satisfied with the ease of obtaining services from the health center through the FHT Approach. Finally A total of 16.0% of the study participants were neutral. The mean of satisfaction measure was 77.0%.

Regarding the satisfaction with the waiting time in the health center, 37.1% of the study participants were dissatisfied about the waiting time in the health center, while 34.1% were satisfied with the waiting time they spent waiting to receive health services. A total of 28.8% of the study participants were neutral. The overall mean satisfaction level was 58.8%.

Regarding the ease and appropriateness of the appointment system and making appointment for follow up visits, 6.8% of the study participants were unsatisfied of the appointment system, while 79.2% of the study participants were satisfied with ease of booking appointment system for follow up visits. A total of 14.0% of the study participants were neutral, and overall mean satisfaction level 77.6%.

By asking the study participants if they were satisfied with the performance of FHT in general, about a total of 6.0% of the study participants were dissatisfied the performance of FHT. However, 81.7% of the study participants expressed satisfaction with the performance of FHT in that regards. The overall mean satisfaction level was 78.0%. By asking the study participants if they are satisfied with the explanation they have received about their health condition, 5.6% of the study participants have expressed their dissatisfaction, while 79.7% of the participants expressed that they are satisfied with the explanation they have received from their providers about their health conditions. The overall mean satisfaction level was 78.0%. This study findings are consistent with (Worthington, 2004). And according to (UNRWA, 2010) the new health reform of FHT was to reach the quality of service and to satisfy the needs of the patients.

With regards to clients' satisfaction of providers respect to their privacy, a total of %11 of the study participants were not satisfied, meanwhile, 86.5% of the study participants

expressed satisfied with the providers' respect to their privacy. The overall mean of clients' satisfaction level about their providers' respect of their privacy is 80.8%.

**Table (4.7)** illustrates that 6.3% of the study participants were unsatisfied with physical environment allocated to their FHT. In contrary, a total of 76.9% of the study participants were satisfied with the physical environment allocated to their FHT in the health center. A total of 16.8% of the study participants were neutral. The overall mean satisfaction level was 76.0%.

By asking the study participants if they were satisfied with the providers responses to their questions, only 7.0% of the participants were unsatisfied with the answers they receive from health care providers, while 75.5%of the study participants were satisfied with the answers they receive from their FHT.

The overall mean satisfaction level was 77.8%.With regards to the health education materials received regularly from FHT, 5.3% of the study participants were unsatisfied about the health education materials that they receive from their FHT, meanwhile79.2% of the study participants were satisfied about the health education materials they received through their FHT staff. A total of 15.5% of the study participants were neutral. The overall mean satisfaction level was77.4%.Regarding the health counselling received by the clients from FHT.

**Table (4.7**) shows that 6.3% of the study participants were unsatisfied with the health counselling while, 77.5% of the study participants were satisfied about health counselling received from clients FHT staff. About 16.3% of study participants were neutral. The overall mean satisfaction level was 76.8%. By asking the study participants if they are satisfied with the contact with their FHT, 18% of the participants were unsatisfied about the contact time, while 54.4% of the study participants were satisfied about the contact time, about 27.6% were neutral. The overall mean satisfaction levelwith the contact time was 68.2%.

By asking the study participants if they are satisfied with the overall length of their visits from the first moment they enter the health center until the moment they leave the health center, 26.4% of the participants were unsatisfied about the length of their visits, while 43.3% of the study participants expressed satisfaction with the overall length of their visits. About 30.3% of the study participants were neutral. The overall mean satisfaction levelwith the contact time was 63.8%. From the researcher point of view, the findings of

the study showed low percentage of participants' satisfaction about the contact time, and this important aspect should be emphasized and improved through close monitoring to the time spent with the patients, and further steps could improve such point like appointment system.

**Table (4.7) Distribution of the study participants according to their Satisfaction**

| Items | | Disagree | Disagree | Neutral | Agree | S. Agree | Weighted Mean |
|---|---|---|---|---|---|---|---|
| The ease of obtaining service from the health center through the FHT | N | 12 | 15 | 64 | 237 | 71 | 77.0 |
| | % | 3.0 | 3.8 | 16.0 | 59.4 | 17.8 | |
| The waiting time in the health center | N | 40 | 108 | 115 | 106 | 30 | 58.8 |
| | % | 10.0 | 27.1 | 28.8 | 26.6 | 7.5 | |
| Making appointment for follow up visits | N | 7 | 20 | 56 | 248 | 68 | 77.6 |
| | % | 1.8 | 5.0 | 14.0 | 62.2 | 17.0 | |
| The performance of the FHT all in all is good | N | 8 | 16 | 49 | 258 | 68 | 78.2 |
| | % | 2.0 | 4.0 | 12.3 | 64.7 | 17.0 | |
| The services providers' explanations about your health condition/s | N | 5 | 17 | 59 | 251 | 67 | 78.0 |
| | % | 1.3 | 4.3 | 14.8 | 62.9 | 16.8 | |
| The services providers' respect of your privacy | N | 3 | 12 | 39 | 259 | 86 | 80.8 |
| | % | 0.8 | 3.0 | 9.8 | 64.9 | 21.6 | |
| The physical environment allocated to my FHT in the health center | N | 7 | 18 | 67 | 263 | 44 | 76.0 |
| | % | 1.8 | 4.5 | 16.8 | 65.9 | 11.0 | |
| The services providers answers to your questions. | N | 8 | 20 | 70 | 211 | 90 | 77.8 |
| | % | 2.0 | 5.0 | 17.5 | 52.9 | 22.6 | |
| The health education materials that I receive regularly from my FHT staff | N | 9 | 12 | 62 | 255 | 61 | 77.4 |
| | % | 2.3 | 3.0 | 15.5 | 63.9 | 15.3 | |
| Health counselling you received from your FHT staff | N | 7 | 18 | 65 | 252 | 57 | 76.8 |
| | % | 1.8 | 4.5 | 16.3 | 63.2 | 14.3 | |
| The contact time with the FHT health care provider | N | 16 | 56 | 110 | 184 | 33 | 68.2 |
| | % | 4.0 | 14.0 | 27.6 | 46.1 | 8.3 | |
| The length of your visits (from the moment where you entered until the moment you left the center) | N | 23 | 82 | 121 | 143 | 30 | 63.8 |
| | % | 5.8 | 20.6 | 30.3 | 35.8 | 7.5 | |
| Opening file for registration | N | 11 | 15 | 68 | 257 | 48 | 75.8 |
| | % | 2.8 | 3.8 | 17.0 | 64.4 | 12.0 | |
| Generally, you are | N | 11 | 12 | 69 | 258 | 49 | 76.2 |

| Items | | Disagree | Disagree | Neutral | Agree | S. Agree | Weighted Mean |
|---|---|---|---|---|---|---|---|
| satisfied with the performance of the FHT staff | % | 2.8 | 3.0 | 17.3 | 64.7 | 12.3 | |
| Welcoming and greeting of service providers. | N | 11 | 30 | 77 | 221 | 60 | 74.4 |
| | % | 2.8 | 7.5 | 19.3 | 55.4 | 15.0 | |
| The time that FHT team gives you to explain your complaints | N | 11 | 26 | 79 | 235 | 48 | 74.2 |
| | % | 2.8 | 6.5 | 19.8 | 58.9 | 12.0 | |
| FHT respects patient's appointments | N | 8 | 16 | 55 | 267 | 53 | 77.0 |
| | % | 2.0 | 4.0 | 13.8 | 66.9 | 13.3 | |
| The willingness of FHT to help their patients. | N | 5 | 14 | 60 | 268 | 52 | 77.4 |
| | % | 1.3 | 3.5 | 15.0 | 67.2 | 13.0 | |
| The response of FHT to your questions and requests | N | 8 | 16 | 73 | 250 | 52 | 76.2 |
| | % | 2.0 | 4.0 | 18.3 | 62.7 | 13.0 | |
| The ability of FHT to promote your self-confidence | N | 13 | 27 | 56 | 261 | 42 | 74.6 |
| | % | 3.3 | 6.8 | 14.0 | 65.4 | 10.5 | |
| FHT providers make you feel safe | N | 14 | 26 | 58 | 253 | 48 | 74.8 |
| | % | 3.5 | 6.5 | 14.5 | 63.4 | 12.0 | |
| **Mean = 74.80 , SD = 12.69** | | | | | | | |

The study also addresses the degree of ease when opening a file for registration to benefit from UNRWA services (one is required to open a file to benefit from health services in Gaza), 6.6% of the study participants indicated that they were not satisfied with the ease of opening file for registration, while 76.4% of the study participants were satisfied about the ease of opening registration file. 17.0% of the study participants were neutral. The overall mean satisfaction levelwith opening file for registration is 75.8%.

Regarding the satisfaction with staff performance of FHT, 5.8% of the study participants were not satisfied about overall performance of the staff. Conversely, the majority (77% of the study participants) were satisfied with the performance of the FHT staff. A total of 17.3% of the participants were neutral. The overall general satisfaction with the performance of FHT staff is 76.2%. The findings of the study are consistent with (Gittell, Fairfield et al. 2000).which indicated that to improve the quality of care and patient outcome, good staff performance should be obtained.

Concerning the welcoming and greeting by the health care providers (once sessions started)**, Table (4.7)** showed that 10.3% of the study participants were unsatisfied with the greeting of the health care providers, meanwhile 70.4%of the study participants were satisfied with the welcoming and greeting of the service providers to them. A total of

19.3% of the study participants were neutral. The overall general satisfaction with providers welcoming and greeting from service providers was 74.4%.

Regarding to participants' satisfaction of the time that FHT gives to them to express their health complaints, 9.3% of the study participants were unsatisfied, while 70.9% of study participants were satisfied with the time that FHT staff allowed for the clients to state their complaints. A total of 19.8% of the study participants were neutral. The overall satisfaction with the time that FHT spent explaining their complaints was 74.2%.

By asking the patients about the commitment of FHT staff to their patients’ appointment, **Table (4.7)** shows that 6.0% of the study participants were unsatisfied the providers respect to a patient's appointments. While, 80.2% of clients have expressed their satisfaction with the providers commitment to their patients’ appointments. The overall satisfaction with the FHT respects to patient's appointments was 77.0%.

With regards to the willingness of FHT staff members to offer further help to their patients, 4.8% of the study participants were unsatisfied with providers' willingness to offer further help, while 80.2% of the study participants express satisfied with the willingness of FHT staff members to offer extra help. A total of 15.0% of the study participants were neutral. The overall satisfaction with the FHT respects to patient's appointments was 77.0%.77.4%.

Concerning the responsiveness of FHT staff members to the questions and requests of their clients, 6.0% of the study participants were not satisfied about the responses of FHT staff to their requests and questions while 75.2% showed satisfaction with the response of FHT staff to their questions and requests, and 18.3% were neutral. The overall satisfaction with provider’s responses to clients’ questions was 76.2%.

With regards to the ability of FHT to promote patients confidence, **Table(4.7)** showed that 10.1% of the study participants were not satisfied about the providers ability of FHT to promote clients self-confidence. In the other hand, 75.9%of the study participants were satisfied with the way providers promote self-confidence for their patients. A percentage of 14.0% were neutral participants. The overall satisfaction with providers’ ability to promote self-confidence was74.6%.

**Table (4.7)** illustrates that 10% of the study participant were not satisfied and don’t agree that they feel safe when dealing FHT, moreover 75.4% were satisfied that FHT providers

made clients feel safe. Neutral participants were 14.5%. The overall satisfaction with providers' ability to make their clients feel safe was74.80%.

The overall mean of satisfaction with the provision of health services through FHT was 74.80.

## 4.3 Appropriateness of health services provided by FHT

By asking the participants about the appropriateness of FHT approach implemented at UNRWA, **Table (4.8)** showed that 6.1% of the study participants disagree that FHT enables clients to receive health care in an easy manner. On the other hand 76.9% of the study participants agree that FHT enabled clients to receive health care service in an easy manner, and 17.0% of the participants were neutral. The overall mean of clients who feel enabled to receive health services in an easier fashion was 76.4%.

With regards to the FHT approach in helping health care providers to provide an appropriate follow ups, 5.3% of the study participants disagree that FHT helps their health care providers to provide appropriate follow up of care, meanwhile 78.7% of the study participantsagree that FHT had helped their health care providers to provide an appropriate follow up of care. A total of 16.0% of the study participant were neutral. The overall mean of helping providers to provide an appropriate follow up of carewas 77.4%.

In regards to receiving sufficient information regarding treatment, 7.1%of the study participants stated that through FHT, they did not feel like there were not provided with sufficient information about treatment. On the other hand, 75.7% of the study participants agreed that through FHT, providers were able to provide their clients with sufficient information regarding treatment. A total of 17.3% of the study participants could not judge if FHT has enabled the providers to provide them with sufficient information about their treatment. The overall mean of the effectiveness of FHT in providing sufficient information regarding treatment was 76.2%.

**Table (4.8) Distribution of the study participants according to their Appropriateness**

| Items | | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | Weighted Mean |
|---|---|---|---|---|---|---|---|
| FHT enables clients to receive health care services in an easy manner | N | 9 | 15 | 68 | 253 | 54 | 76.4 |
| | % | 2.3 | 3.8 | 17.0 | 63.4 | 13.5 | |

| Items | | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | Weighted Mean |
|---|---|---|---|---|---|---|---|
| FHT helps health care provider to provide an appropriate follow up of care | N | 6 | 15 | 64 | 252 | 62 | 77.4 |
| | % | 1.5 | 3.8 | 16.0 | 63.2 | 15.5 | |
| Through the FHT you have received sufficient information regarding treatment | N | 5 | 23 | 69 | 248 | 54 | 76.2 |
| | % | 1.3 | 5.8 | 17.3 | 62.2 | 13.5 | |
| Through the FHT you have received sufficient information regarding choices made available to you. | N | 5 | 16 | 93 | 250 | 35 | 74.8 |
| | % | 1.3 | 4.0 | 23.3 | 62.7 | 8.8 | |
| FHT approach meets your health needs. | N | 10 | 25 | 81 | 231 | 52 | 74.6 |
| | % | 2.5 | 6.3 | 20.3 | 57.9 | 13.0 | |
| The health care provider in the FHT you belong to gives enough time to address with you your concerns . | N | 9 | 28 | 73 | 232 | 57 | 75.0 |
| | % | 2.3 | 7.0 | 18.3 | 58.1 | 14.3 | |
| The family health team members provide services in a professional way | N | 11 | 11 | 65 | 267 | 45 | 76.2 |
| | % | 2.8 | 2.8 | 16.3 | 66.9 | 11.3 | |
| The health care providers of your FHT showed interest to your questions | N | 9 | 18 | 77 | 205 | 90 | 77.4 |
| | % | 2.3 | 4.5 | 19.3 | 51.4 | 22.6 | |
| FHT approach has changed positively the way of providing health services—more person centric | N | 8 | 14 | 62 | 244 | 71 | 77.8 |
| | % | 2.0 | 3.5 | 15.5 | 61.2 | 17.8 | |
| FHT provides enough cooperation's between different services at the health center. | N | 8 | 15 | 51 | 278 | 47 | 77.0 |
| | % | 2.0 | 3.8 | 12.8 | 69.7 | 11.8 | |
| FHT has facilitated your communication with all the FHT | N | 7 | 16 | 57 | 263 | 56 | 77.2 |
| | % | 1.8 | 4.0 | 14.3 | 65.9 | 14.0 | |

| Items | | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | Weighted Mean |
|---|---|---|---|---|---|---|---|
| members | | | | | | | |
| FHT approach ensures comprehensiveness of provided health care | N | 7 | 34 | 61 | 212 | 85 | 76.8 |
| | % | 1.8 | 8.5 | 15.3 | 53.1 | 21.3 | |
| FHT approach provides opportunity to decrease the spread of certain diseases | N | 8 | 14 | 56 | 217 | 104 | 79.8 |
| | % | 2.0 | 3.5 | 14.0 | 54.4 | 26.1 | |
| FHT approach helps providers to better understand your health conditions | N | 7 | 15 | 49 | 271 | 57 | 77.8 |
| | % | 1.8 | 3.8 | 12.3 | 67.9 | 14.3 | |
| FHT effectively engages my family in my health issues | N | 9 | 27 | 80 | 245 | 38 | 73.8 |
| | % | 2.3 | 6.8 | 20.1 | 61.4 | 9.5 | |
| **Mean = 76.57, SD = 13.07** | | | | | | | |

The **Table(4.8)** shows that 71.5% of the study participants agree that through FHT the clients received sufficient information regarding the range of choices offered to them about their treatment by their providers. On the other hand, 5.3% of the study participants do not agree that FHT help their providers in providing them with sufficient information regarding choices available to them. Interestingly, 23.3% of clients were unable to agree or disagree with the effectiveness of FHT in helping their clients to provide them with sufficient information regarding range of choices about treatment from which they can choose. The overall mean of the effectiveness of FHT in providing sufficient information regarding choices available to their clients was 76.2%.

By asking the participants about FHT and whether it matched their health needs, 8.9% of the study participants disagreed that FHT did not help them in meeting their health needs while 70.9% of the study participants agree that FHT appropriate did help them to meet their health needs. The overall mean of FHT approach in meeting clients' needs was 74.6%.

**Table (4.8)** showed that 72.4% of the study participants have agreed that FHT approach has enabled health care providers to give enough time to their clients to address their concerns. While, 9.3% of the study participants disagreed that FHT approach did not enable their health care providers to allocate time to address clients concerns. The overall

mean of FHT gives their clients enough time to address concerns was 75.0%.Concerning the professionalism of FHT members, 5.6% of the study participants disagree that the family health team provides service in a professional way, while 78.2% of the participants agree that the members of FHT provide services in a professional way. A total of 16.3% of the study participants were neutral, and the overall of FHT ability to provide services in a professional way was 76.2%.

Regarding the providers interest to answering clients' questions, **Table(4.8)** showed that 6.8% of the study participants disagreed that the health care providers of clients FHT showed interest to answering clients' questions. At the same time, 74.0% of the study participants agree that FHT health care providers showed interest to clients' questions. The overall mean of health care providers showed interest to clients' questions was 77.4%.

The beneficiaries from health services were also asked if FHT approach has changed positively the way of providing health services to become more person-centered, a percentage of 5.5% of the study participants disagree that FHT changed positively the way of providing health service to become more person-centered. While, 79.0% of the study participants strongly agreed that FHT had changed positively the way of delivering the health services to become more of patient-centered The overall mean of FHT enabling providers to provide more patient-centered services was 77.8%.

When asking clients whether FHT approach provides enough cooperation's between different services within a health center, **Table (4.8)** shows that 5.8% of the study participants disagree that FHT provides enough cooperation's between the different services in the health center and 81.5% of the study participants agree about FHT creates more cooperation between the different services within a health center. The all mean of FHT approach as enabling cooperation between different services was 77.0%.

Regarding the ability of FHT in facilitating reliable patient-doctor communication with all FHT members, 5.8% of the study participants disagree that FHT facilitated better clients' communication with the members of FHT staff while 79.9% of the participants agree that FHT has facilitated better patient-doctor communication. The overall mean of FHT approach in facilitating communication with all FHT members was 77.2%.

Concerning the comprehensiveness of provided health care by FHT, 10.3% of the study participants disagree that FHT approach ensures comprehensiveness of the provided health care. At the same time,74.4% of the participants agree that FHT approach ensures

comprehensiveness of the provided health care. The overall mean of FHT approach in ensuring comprehensive services was 76.8%

With regards to the perceived contribution of FHT in limiting the spread of certain diseases, 5.5% of the study participants disagree that FHT approach provides opportunity to decrease the spread of certain diseases, furthermore 80.5% of the study participants agreed that FHT approach provides opportunity to decrease the spread of certain diseases. The overall mean of FHT approach in providing opportunity to decrease the spread of certain diseases was 79.8%.

Participants were asked if FHT has enabled their providers to better understand their health conditions, 5.6% of the study participants disagree that FHT enabled providers to understand their clients' health condition while, in the other hand, 82.2% of the study participants agree that FHT approach helps providers to better understand their clients health conditions. The overall mean of FHT approach ability to help health care providers in understanding health conditions was 82.2%. The overall mean of FHT ability to improve providers to better understand their health conditions was 77.8%. With regards to FHT effectiveness in engaging family members in clients health issues, 5.6% of the study participants disagree that FHT effectively engages clients' family with his/her issues. Furthermore 70.9% of the participants agree that FHT effectively engages the family with clients' issues. The overall mean of the FHT effectiveness in engaging family members with clients' issues was 73.8%Finally the overall mean of FHT appropriateness was 76.57%

**4.4 Satisfaction with and utilization of FHT services**

**Table (4.9**) illustrates that 93.5% of the study participants recommend the use of health services provided by FHT approach to their relatives and friends, and only 6.5% of the study participants are not in favor of recommending the utilization of services provided by FHT. By asking the participants if they would like to come to the health center regularly ,as shown in **Table(4.9),** more than half (51.6%) of the participants mentioned that they prefer to come regularly while 44.6% of the participants preferred to come when necessary. About 3.8% of participants don't feel that they will come to the center again.

By asking the study participants about the health services received by whether FHT met their expectations**, Table (4.9)** showed that more than half(62.7%) of the participants indicated that FHT health services met their expectations while less than a third of them

(29.1%) expressed that their expectations were met to some extent. About 8.3% of the study participants reported that their expectations were not met at all.

By asking the participants about their overall satisfaction with services delivered through FHT **Table (4.9)** showed that more than half of the study participants (56.6%) were moderately satisfied, about (39.6%) of the study participants were highly satisfied , while (3.8%) of the participants were unsatisfied with the health services provided by FHT approach.

**Table (4.9) Distribution of the study participants according to Other Questions**

| Items | Number | % |
|---|---|---|
| **Will you recommend the use of health services through FHT approach to any of your relatives and friends?** | | |
| Yes | 373 | 93.5 |
| No | 26 | 6.5 |
| **Total** | **399** | **100.0** |
| **You would like to come to the center for follow-up?** | | |
| Regularly | 206 | 51.6 |
| When necessary | 178 | 44.6 |
| I don't feel will become her again | 15 | 3.8 |
| **Total** | **399** | **100.0** |
| **Have the health services you received through FHT met your expectation?** | | |
| Yes | 250 | 62.7 |
| No | 33 | 8.3 |
| Some extent | 116 | 29.1 |
| **Total** | **399** | **100.0** |
| **How satisfied are you with the services received** | | |
| Moderate | 226 | 56.6 |
| To high extent | 158 | 39.6 |
| Unsatisfied | 15 | 3.8 |
| **Total** | **399** | **100.0** |

## 4.5 Inferential Statistics

### 4.5.1Differences perceived quality, satisfaction, appropriateness and age groups

With regards to difference in the scores of perceived quality and age groups, **Table (4.10)** shows that there is a statistical significance in relationship between age groups of the participants and overall score of perceived quality of the services provided by FHT, with (F=3.467,P=0.016). One way ANOVA reveals that participants who are less than 25 years

old and whose age range is from 25 to 39 years had the lowest mean score of perceived quality of the provided services, with (74.72), and (77.94) respectively. Bonferroni post-Hoc test revealed that the participants of age group 60 years and older had higher score of perceived quality about the provided services than the participants with ages less than 25 years by (8.06). The difference was statistically significant, but statistics are not shown. **Table (4.10)** shows that there is a statistical significant relationship between age groups of the participants and overall satisfaction score of the provided services with (F=4.306,P=0.005). One way ANOVA reveals that participants of age group less than 25 years and of age group between 25 and 39 years old had the lowest mean score of satisfaction with (72.95), and (75.44), respectively. Bonferroni post-Hoc test revealed that the participants aged 60 years and older had higher satisfaction level than participants aged less than 25 years by (8.44).The difference was statistically significant, statistics are not shown. The findings of this study is consistent with a study was conducted in China revealed that the significance of older people and satisfaction with regards to health service provision (Sor et al., 2017).

**Table (4.10)** shows that there is no statistical significant relationship between age groups of the participants and overall appropriateness of provided services through FHT, with (F=1.907,P=0.128).

Regarding thedifference in the overall level of perceived quality and years of schooling, **Table (4.10)** shows that there is no statistically significance differences between participants years of schooling and the overall level of perceived quality, with (F= 2.179,P=0.115).

Concerning thedifference of participants years schooling and overall satisfaction level, **Table (4.10)** shows that there is statistically significance relationship between participants years of schooling and overall satisfaction level participants with (F= 3.366,P=0.036). One way ANOVA reveals that participants with 11 years of schooling or less and participants with more than 12 years of schooling had the lowest mean score with (73.62), and (74.79), respectively. Bonferroni post-Hoc test revealed that the participants with years 11 years and less had higher satisfaction than the participants with more than 12 years of schooling by (4.16).The difference was statistically significant, statistics are not shown.

With Regards to measurement of appropriateness of the provided services through FHT in relation to the participants years of schooling, **Table (4.10)** shows that there is a marginally

statistically significance relationship between participants years of schooling and overall appropriateness of services provided by FHT, with(F=3.006,P=0.051). ANOVA reveals that participants with schooling duration of 12 years or above had the lowest mean score with (75.56), and (76.46) respectively. Bonferroni post-Hoc test revealed that the participants with 11 years of schooling and less had higher impression about FHT services appropriateness than the participants with more than 12 years by (3.91).The difference was statistically significant ,statistics are not shown

Regarding the duration of health service provision to participants in relationship with the overall level of perceived quality, satisfaction level, and appropriateness level, **Table (4.10)** shows no statistical significance difference between perceived quality, satisfaction level, and appropriateness and years of receiving health services.

**Table (4.10) Differences in the all over scores of perceived quality, satisfaction, and appropriateness with and selected variables**

| Domain | Categories | N | Mean | Std | F | Sig. |
|---|---|---|---|---|---|---|
| **Age groups** | | | | | | |
| **Perceived Quality score** | Less than 25 Years | 122 | 74.72 | 12.74 | 3.467 | 0.016 |
| | From 25 to 39 years | 174 | 77.94 | 11.62 | | |
| | From 40 to 59 years | 77 | 79.06 | 11.91 | | |
| | 60 Years and more | 13 | 82.78 | 11.99 | | |
| | **Total** | 386 | 77.31 | 12.17 | | |
| **Satisfaction score** | Less than 25 Years | 122 | 72.95 | 12.26 | 4.306 | 0.005 |
| | From 25 to 39 years | 174 | 75.44 | 11.81 | | |
| | From 40 to 59 years | 77 | 78.13 | 10.42 | | |
| | 60 Years and more | 13 | 81.39 | 12.51 | | |
| | **Total** | 386 | 75.39 | 11.87 | | |
| **Appropriateness score** | Less than 25 Years | 122 | 75.49 | 12.94 | 1.907 | 0.128 |
| | From 25 to 39 years | 174 | 77.39 | 11.92 | | |
| | From 40 to 59 years | 77 | 78.60 | 10.44 | | |
| | 60 Years and more | 13 | 82.05 | 11.92 | | |
| | **Total** | 386 | 77.19 | 12.02 | | |
| **Years of schooling** | | | | | | |
| **Perceived Quality score** | 11 years and less | 98 | 79.22 | 13.25 | 2.179 | 0.115 |
| | 12 years | 139 | 76.61 | 13.83 | | |
| | More than 12 Years | 137 | 75.81 | 10.77 | | |
| | **Total** | 374 | 77.00 | 12.67 | | |
| **Satisfaction score** | 11 years and less | 98 | 77.78 | 13.18 | 3.366 | 0.036 |
| | 12 years | 139 | 74.79 | 13.16 | | |
| | More than 12 Years | 137 | 73.62 | 10.66 | | |
| | **Total** | 374 | 75.14 | 12.39 | | |
| **Appropriateness** | 11 years and less | 98 | 79.47 | 12.82 | | |

| Domain | Categories | N | Mean | Std | F | Sig. |
|---|---|---|---|---|---|---|
| score | 12 years | 139 | 76.46 | 13.46 | 3.006 | 0.051 |
| | More than 12 Years | 137 | 75.56 | 10.77 | | |
| | **Total** | 374 | 76.92 | 12.43 | | |
| **Years of utilizing services** | | | | | | |
| **Perceived Quality score** | Less than 5 years | 46 | 75.43 | 11.53 | 2.598 | 0.078 |
| | From 5 to 10 years | 50 | 72.72 | 15.93 | | |
| | Above 10 years | 46 | 78.88 | 11.46 | | |
| | **Total** | 142 | 75.60 | 13.38 | | |
| **Satisfaction score** | Less than 5 years | 46 | 72.63 | 10.93 | 2.837 | 0.062 |
| | From 5 to 10 years | 50 | 72.17 | 15.60 | | |
| | Above 10 years | 46 | 77.89 | 11.40 | | |
| | **Total** | 142 | 74.17 | 13.07 | | |
| **Appropriateness score** | Less than 5 years | 46 | 74.70 | 10.64 | 1.824 | 0.165 |
| | From 5 to 10 years | 50 | 72.77 | 16.70 | | |
| | Above 10 years | 46 | 77.97 | 11.82 | | |

### 4.5.2Relationship between perceived quality, satisfaction level, and appropriateness and selected variables

Concerning the relationship between gender and perceived quality, **Table (4.11)** shows that there is no statistical significant relationship between gender of the participants and perceived quality with (T=-1.163,P=0.246). With regards to the relationship between gender and satisfaction ,**Table (4.11)** shows that there is no statistical significant relationship between gender of the participants and satisfaction with(T=-0.509,P=0.611).Regarding the relationship between gender of the participants and appropriateness, **Table (4.11)** shows that there is no statistical significant relationship between gender of the participants and appropriateness with (T=-0.960,P=0.337).

Concerning the relationship between health insurance and overall perceived quality of provided services, **Table (4.11)** shows that there is a statistical significant relationship between having health insurance and perceived quality with (T=-2.415,P=0.016). The participants with health insurance had higher mean score of perceived quality than participants without health insurance by (5.31), and the difference was statistically significant, with (T=2.41,P=0.01). Available literature of health insurance and perceived quality of care could be found on several studies which indicated that there is positive significant relationship between them and improved quality of care (Debra et al., 2009). The findings of this studywere consistent with study conducted by Abuosi and Colleagues (2016).

Regarding the relationship between the ownership of health insurance and overall satisfaction level with the provided services, **Table (4.11)** shows that there is a statistical significant difference in overall satisfaction level with the provided services between participants who have health insurance and participants who do not have health insurance, with (T=2.034,P=0.043). Participants with health insurance had higher mean score of satisfaction compared to participants who do not have health insurance by (4.33), and the difference was statistically significant. The study findings of significant relationship between health insurance and satisfaction revealed that having medical insurance increased the overall satisfaction about service provision. The study findings were consistent with a study findings done in China resulted that satisfaction is strongly associated with having medical insurance (Munro, 2015).

With regards to the relationship between having health insurance and appropriateness of the provided services through FHT, **Table (411)** shows that there is no statistical significant relationship between having health insurance participants appropriateness of the provided services through FHT, with (T=-1.720,P=0.086).From the researcher point of view, having health insurance doesn't guarantee the appropriateness of the health service provision. The role of having a health insurance is exempted since services provided by FHT approach are free of charge which means that the finding was not significant in measuring the appropriateness of services provided.

With regards to the relationship between overall level of perceived quality of the services provided through FHT and having chronic diseases, **Table (4.11)** shows that there is a strong statistically significant relationship overall perceived quality level and having chronic diseases, with (T= 3.219,P=0.001). The participants who have chronic diseases had higher mean score of perceived quality of the provided services through FHT than participants who do not have chronic diseases by (5.08). The difference was statistically significant. The findings about this study were consistent with so many studies all over the world especially in the point stating that the chronic disease patients come to have regular service from the health center, and can distinguish the difference between the traditional system and the new FHT approach (UNRWA, 2013). A health service provision researcher, Megari, studied the perception about the service quality provided to the chronic patients, and the study findings were consistent with the findings of this study (Megari.K, 2013). Additionally, participants suffering from chronic diseases are more satisfied with the provided services than participants who do not have chronic diseases, with (T= 3.727,

P=0.000). The participants suffering from chronic diseases had higher mean score of satisfaction than participants who do not have chronic diseases by (5.67); the difference was statistically significant. The study findings were consistent with the finding of another researcher in the field, Carlin and Colleagues (2012). Both findingsindicated that chronic disease patients were more satisfied about the services provided than patients who do not suffer any chronic diseases (Carlin et al.,2012). The findings of this study as well as studies of the formerly mentioned scholars 'emphasize the importance of the FHT approach to the treatment of patients with chronic diseases.

Concerning the relationship between participantssuffering from chronic diseases and appropriateness of services provided by FHT, **Table (4.11)** shows that there is a marginally statistically significant relationship between participants suffering from chronic diseases and overall appropriateness of services provided by FHT, with (T= 1.905,P=0.057). Participants who have chronic diseases had higher mean score appropriateness of services provided by FHT than participants who do not have from chronic diseases by (3.03), and the difference was marginally statistically significant.

Regarding the relationship Between having regular follow upand overall level of perceived quality provided through FHT, **Table (4.11)** shows that there is a statistical significant difference in the perceived quality level between participants who do regular follow ups and participants who do not commit to regular follow ups, with (T= 2.702,P=0.007). The participants who commit to regular follow ups had higher mean score of perceived quality than participants who do not conduct regular follow ups by (3.52), and this difference is statistically significant .The study findings highlight the significant relationship between perceived quality and patient regular follow ups. The findings of the study about this relationship is consistent with the study findings of other studies such as (Haddad. & Roberge, 2000).

Concerning the relationship between having regular follow ups and overall level of satisfaction with the provided through FHT, **Table (4.11)** shows that there is a statistical significant relationship in the overall level of satisfaction between participants who conduct regular follow up and participants who do not, with (T= 2.378 ,P=0.018). The participants who conduct regular follow up had higher mean score of satisfaction than participants who do not conduct regular follow up by (3.01), the difference was statistically significant. With regards to the relationship of having regular follow upand overall level of appropriateness the provided services through FHT, **Table (4.11)** shows that there is a

statistical significant relationship between participants who conduct regular follow ups and overall appropriateness of services provided by FHT, with (T= 3.344,P=0.001). Participants who conduct regular follow ups had higher mean score of appropriateness of services provided through FHT than participants who do not conduct regular follow up by (4.33), and the difference was statistically significant. The findings

of this study were consistent with the findings of the research paper by Freeman. G and Hughes which concluded that regular follow up and continuity and commitment to follow ups is more desirable with the health provision appropriateness (Freeman et al., 2010). All other variables in the Table (4.10) were statistically not significant.

**Table (4.11) Relationship between perceived quality, satisfaction level, and appropriateness and selected variables**

| | Variable/ category | N | Mean | Std | T | Sig. |
|---|---|---|---|---|---|---|
| | **Gender** | | | | | |
| **Perceived Quality** | Male | 68 | 74.98 | 14.45 | -1.163 | 0.246 |
| | Female | 327 | 77.01 | 12.83 | | |
| **Satisfaction** | Male | 68 | 74.05 | 14.32 | -0.509 | 0.611 |
| | Female | 327 | 74.91 | 12.34 | | |
| **Appropriateness** | Male | 68 | 75.16 | 15.27 | -0.960 | 0.337 |
| | Female | 327 | 76.83 | 12.59 | | |
| | **Health insurance** | | | | | |
| **Perceived Quality** | Yes | 360 | 77.24 | 12.57 | 2.415 | 0.016 |
| | No | 39 | 71.93 | 16.68 | | |
| **Satisfaction** | Yes | 360 | 75.22 | 12.21 | 2.034 | 0.043 |
| | No | 39 | 70.89 | 16.12 | | |
| **Appropriateness** | Yes | 360 | 76.94 | 12.63 | 1.720 | 0.086 |
| | No | 39 | 73.16 | 16.42 | | |
| | **Income** | | | | | |
| **Perceived Quality** | Under Poverty line | 68 | 74.98 | 14.45 | -1.163 | 0.246 |
| | Above Poverty line | 327 | 77.01 | 12.83 | | |
| **Satisfaction** | Under Poverty line | 68 | 74.05 | 14.32 | -0.509 | 0.611 |
| | Above Poverty line | 327 | 74.91 | 12.34 | | |
| **Appropriateness** | Under Poverty line | 68 | 75.16 | 15.27 | -0.96 | 0.337 |
| | Above Poverty line | 327 | 76.83 | 12.59 | | |
| | **Having chronic diseases** | | | | | |
| **Perceived Quality** | Yes | 86 | 80.70 | 12.59 | 3.219 | 0.001 |
| | No | 313 | 75.62 | 13.05 | | |
| **Satisfaction** | Yes | 86 | 79.25 | 12.12 | 3.727 | 0.000 |
| | No | 313 | 73.58 | 12.59 | | |
| **Appropriateness** | Yes | 86 | 78.95 | 12.24 | 1.905 | 0.057 |
| | No | 313 | 75.92 | 13.24 | | |
| | **Regular follow up** | | | | | |
| **Perceived Quality** | Yes | 184 | 74.82 | 14.38 | -2.702 | 0.007 |
| | No | 215 | 78.34 | 11.69 | | |
| **Satisfaction** | Yes | 184 | 73.18 | 14.18 | -2.378 | 0.018 |
| | No | 215 | 76.19 | 11.10 | | |
| **Appropriateness** | Yes | 184 | 74.24 | 14.73 | -3.344 | 0.001 |

| | Variable/ category | N | Mean | Std | T | Sig. |
|---|---|---|---|---|---|---|
| | No | 215 | 78.57 | 11.11 | | |
| **Receiving services from other places** | | | | | | |
| **Perceived Quality** | Yes | 165 | 75.83 | 13.06 | -1.133 | 0.258 |
| | No | 234 | 77.34 | 13.12 | | |
| **Satisfaction** | Yes | 165 | 74.09 | 12.72 | -0.941 | 0.347 |
| | No | 234 | 75.30 | 12.67 | | |
| **Appropriateness** | Yes | 165 | 75.33 | 13.44 | -1.601 | 0.110 |
| | No | 234 | 77.45 | 12.76 | | |

### 4.5.3 Main strength points of providing services through FHT Approach.

Through focus group discussion and in-depth interview, it was evident that the perception about FHT strength points were (1) Strong relationship between the health care provider and the client.(2) Treatment could be obtained easily.(3) Trust between the team and the clients is increased.(4) contact time with clients has increased compared to traditional way of service provision.(5) Waiting time has been reduced in comparison with the traditional system.(6) Follow up for the referred cases is being conducted in a more organized and effective manner. (7) FHT approach is person centered and disease centered.(8)more effective and efficient service provision s(9)Respect to the dignity of the refugees.(10) Familiarity about appointment system by the society.(11) Satisfaction results about the service provision by FHT.

### 4.5.4Main weaknesses of providing services through FHT Approach.

In regards to the weakness points of providing FHT services as understood from the discussion with the participants at the focus groups and the in-depth interviews, weaknesses are: (1) Number of patients relying on UNRWA clinics have increased due to the economic crisis.(2) Number of health care providers is not increased to match the increasing demand on health services due to limited ability to recruit new staff.(3) Job creation program doctors needs to be oriented about FHT approach to cover the shortage of permanent doctors during their annual vacations.(4)Workload over one nurse to do the duty of two stations like vaccination and NCD.(5) Capacity Building and insufficient training (6)Lack of motivation and good incentive system (7)Skills improvement like doing the role of Obstetrician and gynecologist (8)Relation abuse between the health care provider and the client may lead to conflict of interest.

# Chapter 5

# Conclusion and Recommendations

## 5.1 Conclusion

Provision of health services through FHT is considered as a major reform in the provision of health services and has been implemented at UNRWA since 2011. This new way of service delivery was initiated to improve the quality of health care to Palestinian refugees

registered with UNRWA on the five fields, including the Gaza Strip. In the Gaza Strip, it was a newly experienced approach of service delivery compared to the traditional system of service provision which was previously practiced. In the Gaza Strip, no studies were conducted to comprehensively evaluate the outcomes of new FHT approach. Thus, the need for that study was of necessity to evaluate outcomes of the system, compare the differences between FHT and traditional systems, and come up with evidence that could be used to enhance and promote the quality of services provided and possibly contribute in developing new policies or enhancing already existing ones to improve overall efficiency and effectiveness of service provision.

The outcomes of provided services through FHT approach was assessed in this mixed methods study. The assessed outcomes were the perceived quality, appropriateness of provided services and clients satisfaction with the services provided through FHT approach. The study took into consideration the perspectives of healthcare beneficiaries and health care providers. The data provided by the study participants were thoroughly analyzed and based on findings of primary research done in forms of survey questionnairewith clients, and in-depth interviews and focus group discussion with health care providers. The participants for this study were selected randomly from the ten Centers in which FTH was implemented and has been underway for a duration of five years. Furthermore, participants were also selected randomly through a simple random sampling technique.

The quantitative findings of this study were collected from female (82.8%) and male (17.2%) clients. The vast majority of participants are not employed (82.1%), and the mean age of the study participants is (32.37 years). Of the total participants, 78.4% of them reported that they do not have chronic diseases, and only about one fourth of the participants reported having chronic diseases and most of them were diabetic patients. Additionally, more than half of the participants with a chronic disease don’t conduct a regular follow up (53.9%). On the other hand, almost one fourth of the study participants were approached by their health care provider for not conducting regular follow up to avoid any late complications.

In regards to the participants who receive health services from other providers, less than half of the participants utilize services from other providers such as MoH, in addition to utilizing services from UNRWA centers. About 60% of the participants stated that they

utilize health services only from UNRWA health centers. The study also reflected that there are several factors why a considerable percentage of the participants seek health services from other service providers along with utilizing UNRWA centers due to factors such as quality of care, level of accessibility as well as the convenience of working hours. On the other hand, almost more than two thirds of the study participants received health services from UNRWA since the last five years.

With regards to the outcomes of the health services provided by FHT compared to the traditional way of service provision, the vast majority of the participants (86%) prefer FHT approach, while less than one sixth of them (14%) preferred the traditional system of health service provision. As for gender preferences of health care providers by beneficiaries, more than two thirds of the study participants prefer female health care providers, on the other hand 75% of the study participants don't feel embarrassed if they are treated by other gender and considered it as an issue of least significance. Moreover, more than half of the study participants indicated that they received a good quality of healthcare through the FHT. These results reflected on points addressing the main reason of implementing FHT approach in UNRWA clinics. The vast majority of the study participants (86%) reported that their health was improved by utilizing health service through FHT.

Furthermore, the study findings have revealed the overall mean of perceived quality of health services provided by FHT approach was 76.72%, additionally the satisfaction overall mean was 74.80% with the provision of health service through FHT. The overall appropriateness mean of provision of services through FHT approach was 76.57%.

The vast majority of the study participants (93.5%) would recommend the utilization of health service though FHT to their relatives and friends. In addition more than half prefer to come the health center regularly. Furthermore, 62% of the study participants reported that health provision met their expectations and health needs. By asking the participants about their overall satisfaction with the provision of health services through FHT approach, more than half reported that they were moderately satisfied while more than one third were highly satisfied provision of health services through FHT.

The study findings revealed a statistical significant relationship between age of the participants and the overall perceived quality of the FHT approach and also the overall satisfaction with the FHT approach. However, there was no significant relationship

between age of participants and appropriateness of provision of services though FHT in UNRWA clinics. The study findings also revealed a statistical significant relationship the overall mean of years of schooling and satisfaction with the provision of services though FHT, while, in other hand, the study could not prove significance of the relationship between perceived quality and years of schooling, but there was a marginally statistical significant relationship between years of schooling and the appropriateness of provision of services though FHT. Additionally, the study findings have revealed a statistical relationship between having health insurance and perceived quality as well satisfaction. Conversely, there was no statistical significant relationship between appropriateness of the provision of services through FHT and health insurance. The study findings also revealed that there is a strong statistical relationship between having chronic diseases and perceived quality, and there was a statistical significant relationship between having chronic diseases and satisfaction with the provided services. The relationship between having chronic disease and appropriateness of provision of health services through FHT was marginally statistically significant.

With regards to the study findings about client regular follow ups of the FHT, it was revealed that there is a statistical significant relationship between perceived quality of the provided services through FHT and overall mean of regular follow up. Furthermore, there was a statistical significant relationship between conducting regular follow up and appropriateness services provided by FHT.

It is noteworthy that the qualitative study emphasized the importance of health care providers' factors as of qualification, knowledge, attitude, and opinion, which were enabling requirements to implement FHT, as well as the FHT process factors as of staff training, staff readiness, monitoring and supervision, workload, E-health system, and availability of protocols. Results of focus group discussions with participants have revealed that more than two thirds of the health staff has acquired proper training and have the needed skills to provide services through FHT. From providers' perspective, more trainings are needed, particularly on NCDS technical instructions generally, from providers perspective, FHT was viewed as a new integrated model for service delivery that could enable them to provide comprehensive complete and patient-centric care.

## 5.2 Recommendations

### General recommendations

1. There is a need to strengthen the coordination with other health care providers to avoid duplication of services, as evident by this study
2. Quality of the provided services through FHT needs to be improved. This could be done through implementing different measures such as increasing the contact time, reducing the waiting time, and improving the follow up
3. The currently available technical instructions and protocols needs to be updated and revised to be more comprehensive ones
4. UNRWA needs to strengthen its follow up care, particularly follow up of clients who have chronic diseases
5. It is recommended to have in place systematic monitoring to improve the quality and effectiveness of the provided services through FHT
6. Enhancing providers' skills and knowledge is needed. It could be done through in-service education programs
7. As the current workload is high, measures to reduce the workload, including recruiting staff and better time management strategies are highly needed

### 5.3 Recommendation for further research

1. Conduct research studies that involve further exploration of the leading factors affecting the quality of services provided through FHT
2. Conducting mixed methods research studies that aim to assess the impact of provision of services through FHT in relation the value of services provided from beneficiaries perspective (e.g., FHT increased the frequency of visits to health centers)
3. Conduct a research that may cover a wider range of UNRWA health centers in which FHT is implemented to assess and compare the mechanisms of services' provision between UNRWA clinics and governmental health centers
4. Comparative studies could be done to assess the impact of implementing FHT across the five locations of UNRWA's work
5. Mixed methods studies could be conducted to deeply assess the long-term impact of implementing services through FHT
6. Mixed methods studies are needed deeply assess the quality of services implemented through family health team

7. Research studies are highly needed to examine the long-term impact of providing services through FHT and overall health of Palestinian refugees in the Gaza Strip

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# Annexes

**Annex (1): Map of Palestine**

## Annex(2): Sample size Calculation

| What margin of error can you accept? | 5 % | The margin of error is the amount of error that you can tolerate. If 90% of |
|---|---|---|

| | | |
|---|---|---|
| 5% is a common choice | | respondents answer *yes*, while 10% answer *no*, you may be able to tolerate a larger amount of error than if the respondents are split 50-50 or 45-55.<br>Lower margin of error requires a larger sample size. |
| What confidence level do you need?<br>Typical choices are 90%, 95%, or 99% | 95 % | The confidence level is the amount of uncertainty you can tolerate. Suppose that you have 20 yes-no questions in your survey. With a confidence level of 95%, you would expect that for one of the questions (1 in 20), the percentage of people who answer *yes* would be more than the margin of error away from the true answer. The true answer is the percentage you would get if you exhaustively interviewed everyone.<br>Higher confidence level requires a larger sample size. |
| What is the population size?<br>If you don't know, use 20000 | 12243[illegible] | How many people are there to choose your random sample from? The sample size doesn't change much for populations larger than 20,000. |
| What is the response distribution?<br>Leave this as 50% | 50 % | For each question, what do you expect the results will be? If the sample is skewed highly one way or the other, the population probably is, too. If you don't know, use 50%, which gives the largest sample size. See below under **More information** if this is confusing. |
| Your recommended sample size is | **385** | This is the minimum recommended size of your survey. If you create a sample of this many people and get responses from everyone, you're more likely to get a correct answer than you would from a large sample where only a small percentage of the sample responds to your survey. |

## Annex (3) Sample disruption needed data

| NO | Health Center | Population served During 2016 | Sample Size | Questionnaire disruption Quota |
| --- | --- | --- | --- | --- |
| **1-** | BeitHanoun HC | 30440 | 11.3% | 45 |
| **2-** | Beach HC | 51144 | 19.035% | 76 |
| **3-** | DeirBalah HC | 61052 | 22.7% | 90 |
| **4-** | Khan Younis HC | 106792 | 39.74% | 159 |
| **5-** | El Naser HC | 9652 | 3.5% | 15 |
| **6-** | Shoka HC | 9600 | 3.5% | 15 |
| | **Total** | 268680 | 100% | 400 |

**Annex (4):Questionnaire (Arabic and English version)**

**تقييم نـهج فريق صحة العائلة المطبق في عيادات وكالة الغوث الدولية بمحافظات قطاع غزة**

**استبانـة تقييم نـهج فريق صحة العائلة الذى تم تطبيقه في المراكز الصحية التابعة لوكالة الغوث في محافظات قطاع غزة**

**استبانـة المريض**

| **الجزء الاول : المعلومات الشخصية والاجتماعية** | | |
|---|---|---|
| **الرقم المتسلسل......................** | | |
| -1 | المحافظة | محافظة شمال غزة ☐<br>محافظة غزة ☐<br>محافظة دير البلح ☐<br>محافظة خان يونس ☐<br>محافظة رفح ☐ |
| -2 | المركز الصحي | بيت حانون ☐ عيادة الشوكة ☐<br>عيادة الشاطئ ☐ عيادة دير البلح ☐<br>عيادة النصر ☐ عيادة خان يونس ☐ |
| -3 | العمر | ........................ سنوات |
| -4 | الجنس | ذكر ☐ أنثى ☐ |
| -5 | الحالة الاجتماعية | أعزب ☐ متزوج ☐<br>مطلق/ة ☐ أرمل/ة ☐<br>منفصل/ة ☐ |
| -6 | ما عدد السنوات التي تم تعلمها؟ | ................................. سنوات |
| -7 | ما هي حالة العمل لديك؟ | أعمل ☐ لا اعمل ☐<br>متقاعد ☐ |
| -8 | اذا كانت الاجابة نعم. ما هو عملك الحالي؟ | اداري ☐<br>مهني ☐<br>تقني او مساعد مهني ☐<br>ومقدم خدمات كاتب او بائع ☐<br>حرفي في الزراعة و الصيد. ☐<br>والعمل اليدوي او ما شابه<br>عمال الرجل الألي ☐ |
| -9 | هل لديك تامين صحى؟ | لا ☐ نعم ☐<br>لو الاجابة **نعم،**<br>حكومى ☐ خاص ☐ |
| -10 | ما هو متوسط دخلك الشهري للأسرة ؟من جميع المصادر | ..........................بالشيكل |
| **معلومات الملف الطبي** | | |
| -11 | ما هو الغرض الرئيسى لزيارتك المركز الصحى اليوم؟ | **1-العيادة العامة**<br>التهابات الجهاز التنفسي ☐<br>الامراض الجلدية ☐<br>أمراض الجهاز الهضمي ☐<br>أمراض جهاز المسالك البولية ☐<br>أمراض الجهاز التناسلي ☐<br>أخري , حدد .............. ☐<br>**2- صحة الامومة و الطفولة**<br>التطعيم ☐ رعاية الام بعد الولادة ☐ |

| | | |
|---|---|---|
| | | رعاية الحوامل رعاية ما قبل الحمل ☐ ☐<br>تنظيم الاسرةمراقبة نمو الاطفال ☐ ☐<br><br>**3 - الامراض المزمنة**<br>ضغط الدم المرتفع ☐ مرض السكرى ☐<br>مرض السكرى مع ارتفاع في ضغط الدم ☐<br>الامراض الرئوية المزمنة ☐<br>الامراض النفسية ☐ امراض القلب ☐<br>أخرى حدد............ |
| -12 | هل انت تعانى من أي مرض مزمن؟ | نعم ☐ لا ☐<br><u>اذا كانت الاجابة( **لا**) تجاوز عن سؤال:13</u> |
| -13 | اذا كانت الاجابة نعم, ما هو المرض الذى تعانى منه؟( غير منطوق- ممكن اكثر من خيار واحد) | ضغط الدم المرتفع ☐ مرض السكرى ☐<br>أمراض السكرى و ضغط الدم المرتفع معا ☐<br>امراض القلب ☐ امراضالجهازالبولي ☐<br>امراضالجهازالتنفسى المزمنة ☐<br>اخرى حدد................ ☐ |
| -13.1 | منذ كم عام تم تشخيصك بالمرض الاول؟ | ...................سنوات |
| -13.2 | منذ كم عام تم تشخيصك بالمرض الثاني2 ؟ | ................سنوات |
| -13.3 | منذ كم عام تم تشخيصك بالمرض الثالث3؟ | .................سنوات |
| -14 | هل تقوم بزيارة متابعة للعيادة بانتظام ؟ | نعم ☐<br>لا ☐<br>**لو كانت الجابة نعم تجاوز السؤال (15)** |
| -15 | هل سبق ان قام مقدم الخدمة بتأنيبك لأنك لم تحضر الى متابعتك بشكل منتظم؟ | نعم ☐<br>لا ☐ |
| -16 | هل تتلقى خدمات صحية من اماكن اخرى؟ | 2- لا ☐ 1- نعم ☐<br>**لو كانت الاجابة لا (تجاوز عن سؤال (17,18)**<br>لو كانت الجابة نعم حدد المكان<br>مستوصفات الحكومة ☐<br>عيادات المؤسسات الغير حكومية ☐<br>العيادات الخاصة ☐<br>اخرى ,حدد .......... ☐ |
| -17 | <u>لو كانت الاجابة نعم, لماذا اخترت هذه المؤسسة لتتلقى الخدمات منها؟</u><br><u>**( ممكن تختار اكثر من خيار.)**</u> | لديها خدمات أكثر ☐<br>لديها جودة افضل في الخدمات ☐<br>لديها موظفين أكفاء ☐<br>لديها ساعات العمل مريحة اكثر لي ☐<br>لأنها تحافظ على خصوصيتي ☐<br>بجانب منزلي ☐<br>أسباب أخرى حدد............ ☐ |
| -18 | كم عام مضى عليك وانت تتلقى الخدمة من هذا المركز الصحي؟ | سنوات -------- |

| الرقم | السؤال | الإجابة |
|---|---|---|
| 19- | هل سبق ان تلقيت الخدمات الصحية عن طريق النظام الصحي القديم؟ النظام الذى كان يعمل به قبل نهج فريق صحة العائلة | نعم ☐ لو كانت الاجابة **نعم** أجب على سؤال رقم 20<br>لا ☐ |
| 20- | ما هو النظام الذى تفضله؟ | نهج فريق صحة العائلة, أجب السؤال21 ☐<br>النهج التقليدي القديم ☐ |
| 21- | لماذا تفضل نهج فريق صحة العائلة؟ | ________________________________ |
| 22- | هل تفضل/تفضلين ان يكون طبيبك؟ | ذكر ☐<br>أنثى ☐ |
| 23- | هل تفضل ان يكون/تكون ممرضتك؟ | ذكر ☐<br>أنثى ☐ |
| 24- | هل تعتقد/ين ان نوع جنس مقدم الخدمة يؤثر على تقديم الخدمات؟ | نعم ☐<br>لا ☐ |
| 25- | هل عمرك شعرت بالإحباط وانت تعالج من قبل جنس اخر؟ | نعم ☐<br>لا ☐ |
| 26- | كيف تصف جودة الخدمات التي تلقيتها؟ | جودة عالية ☐<br>جودة متوسطة ☐<br>جودة متدنية ☐ |
| 27- | كيف تصف جودة الخدمات التي تلقيتها في هذا المركز الصحي؟ | جيدة ☐<br>لا يوجد تحسن ☐<br>الحالة الصحية تتدهور ☐<br>انا لا اعلم ☐ |

**الجزء الثاني :الادراك الحسى للجودة**

من فضلك اختر واحدة من الخيارات الخمسة لكل جملة على حدة

**1-غير موافق بشدة**  **2- غير موافق**  **3-متعادل**  **4- موافق**  **5- موافق بشدة**

| **الرقم المتسلسل** | الجملة | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1- | نهج فريق صحة العائلة يؤكد على تقديم الخدمات الصحية بشكل مناسب | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 2- | نهج فريق صحة العائلة يؤكد على تقديم الخدمات الصحية في الوقت المحدد. | | | | | |
| 3- | نهج فريق صحة العائلة يطور اداء الموظفين بشكل جيد. | | | | | |
| 4- | نهج فريق صحة العائلة يساعد على المحافظة على استمرارية الخدمة. | | | | | |
| 5- | نهج فريق صحة العائلة يطور الحصول على رعاية متكاملة. | | | | | |
| 6- | لقد كان من السهل التأقلم على تلقى الخدمات من خلال فريق صحة العائلة. | | | | | |
| 7- | نهج فريق صحة العائلة طور ايجابيا جودة الخدمات التي تتلقاها | | | | | |
| 8- | خدمات نهج فريق صحة العائلة التي تلقيتها كانت بناء على احتياجاتي . | | | | | |
| 9- | أعضاء فريق صحة العائلة لديهم المعرفة عن وضعك الصحي. | | | | | |
| 10- | أعضاء فريق صحة العائلة لديهم كل المهارات ليقدموا الخدمات | | | | | |
| 11- | نهج فريق صحة العائلة يساعد على بناء الثقة مع مقدمي الخدمة | | | | | |
| 12- | نهج فريق صحة العائلة يحافظ ويحترم سرية السجلات الصحية. | | | | | |
| 13- | نهج فريق صحة العائلة يؤكد على التزام مقدم الخدمة باتجاه مرضاه. | | | | | |
| 14- | نهج فريق صحة العائلة يعطى مقدم الخدمة الفرصة ان يكون باتصال مباشر مع مرضاه. | | | | | |
| 15- | نهج فريق صحة العائلة يطور من اللطف والسلوك الأدبي لمقدم الخدمة باتجاه مرضاه. | | | | | |
| 16- | نهج فريق صحة العائلة يؤكد على تقديم المعلومات المتعلقة بصحة المريض | | | | | |
| 17- | نهج فريق صحة العائلة يعطى الموظفين الاحساس بالثقة في اثناء تقديم الخدمة للمرضى. | | | | | |
| 18- | نهج فريق صحة العائلة يعطى المريض الاحساس بالراحة عندما يتلقى الخدمة الصحية ويعطى ايضا الاتصال المباشر مع مقدم الخدمة | | | | | |
| 19- | نهج فريق صحة العائلة يوفر البيئة المناسبة للاتصال المباشر مع مقدم الخدمة وتلقى الرعاية بشكل مناسب. | | | | | |
| 20- | نهج فريق صحة العائلة قد حسن من قدرة مقدم الخدمة على المساعدة. | | | | | |
| 21- | نهج فريق صحة العائلة جعل الوصول لمقدم الخدمة افضل. | | | | | |
| 22- | نهج فريق صحة العائلة ساعد على استطاعة مقدم الخدمة ان يوفر الخدمة برعاية جيدة. | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 23- | نهج فريق صحة العائلة يركز عليك ككل اكثر وليس كمريض فقط. | | | | | |
| 24- | نهج فريق صحة العائلة يعطى المقدرة لمقدم الخدمة ان يفهم احتياجات المرضى الخاصة. | | | | | |
| 25- | فوق كل شيء نهج فريق صحة العائلة حسن الاتصال بين مقدم الخدمة و المريض. | | | | | |
| 26- | نهج فريق صحة العائلة ساعد مقدم الخدمة على ان يحافظ على افضل اهتمامات المرضى. | | | | | |

**الجزء الثالث : الرضا**

من فضلك اختر واحدة من الخيارات الخمسة لكل جملة على حده

**1-غير راضي بشدة 2- غير راضي 3- متعادل 4- راضي 5- راضي بشدة**

| الرقم المتسلسل | **كيف ستقدر مستوى رضاك في الحالات التالية** | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1- | سهولة الحصول على الخدمة من المركز الصحي عن طريق نهج فريق صحة العائلة | | | | | |
| 2- | مدة الانتظار في المركز | | | | | |
| 3- | الحصول على موعد لمتابعة العلاج | | | | | |
| 4- | على كل الاحوال اداء فريق صحة العائلة جيد | | | | | |
| 5- | الاستيضاح عن وضعك الصحي من خلال مقدم الخدمة | | | | | |
| 6- | مقدم الخدمة يحترم خصوصيتك. | | | | | |
| 7- | الموضع المكاني والبيئي لفريقي (فريق صحة العائلة) في المركز الصحي. | | | | | |
| 8- | .مقدم الخدمة يجيب على جميع اسئلتك. | | | | | |
| 9- | مواد الارشاد الصحي الت احصل عليها دائما بانتظام من موظف فريق صحة العائلة | | | | | |
| 10- | الاستشارة الصحية التي تلقيتها من موظف فريق صحة العائلة | | | | | |
| 11- | المدة الزمنية اثناء تلقى الخدمة الصحية من فريق صحة العائلة | | | | | |
| 12- | مدة زياراتك للمركز الصحي(من لحظة دخولك المركز حتى لحظة مغادرة المركز) | | | | | |
| 13- | فتح الملف للتسجيل. | | | | | |
| 14- | عموما انت راضي عن اداء موظفي فريق صحة العائلة | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| -15 | الترحيب والتحية من مقدم الخدمة. | | | | | |
| -16 | المدة الزمنية التي يعطيها فريق صحة العائلة لكى توضح شكواك. | | | | | |
| -17 | فريق صحة العائلة يحترم مواعيد المرضى. | | | | | |
| -18 | استطاعة فريق صحة الاسرة على مساعدة مرضاهم. | | | | | |
| -19 | مدى استجابة فريق صحة العائلة لطلباتك و استفساراتك. | | | | | |
| -20 | قدرة فريق صحة العائلة لكى تطور من ثقتك بنفسك. | | | | | |
| -21 | مقدمي الخدمة في فريق صحة العائلة يجعلوك تشعر بالأمان. | | | | | |

**الجزء الرابع: الملائمة**

الرجاء اختر واحدة من الخيارات الخمسة لكل جملة على حدة

**1- غير موافق بشدة** **2-غير موافق** **3-متعادل** **4-موافق** **5-موافق بشدة**

| الرقم | السؤال | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1- | فريق صحة العائلة يقدم الخدمة الصحية للمرضى بطريقة سهلة. | | | | | |
| 2- | فريق صحة العائلة يساعد مقدم الخدمة على توفير متابعة طبية بشكل مناسب | | | | | |
| 3- | من خلال فريق صحة العائلة تستطيع ان تحصل على . معلومات كافية عن علاجك. | | | | | |
| 4- | من خلال فريق صحة العائلة تستطيع ان تحصل على . معلومات كافية لها علاقة بالخيارات التي توفرت لك. | | | | | |
| 5- | نهج فريق صحة العائلة يلبى كل احتياجاتك الصحية. | | | | | |
| 6- | مقدم الخدمة في فربق صحة الاسرة التي تتبع لها . يعطيك الوقت الكافي ليحدد معك كل اهتماماتك. | | | | | |
| 7- | أعضاء فريق صحة العائلة يوفرون الخدمات الصحية بطريقة مهنية. | | | | | |
| 8- | مفدم الخدمة في فريق صحة العائلة التي تتابع معها يظهر اهتمام لأسئلتك. | | | | | |
| 9- | نهج فريق صحة العائلة قد غير طريقة تقديم الخدمة الصحية ايجابيا (زيادة في التركيز على الشخص نفسه) | | | | | |
| 10- | نهج فريق صحة العائلة يوفر تعاون بين جميع الخدمات الموجودة في المركز الصحي. | | | | | |
| 11- | نهج فريق صحة العائلة يسهل الاتصال بين جميع اعضاء فريق صحة العائلة. | | | | | |

| | | | | | نهج فريق صحة العائلة يؤكد على توفير رعاية صحية شاملة. | 12-- |
|---|---|---|---|---|---|---|
| | | | | | نهج فريق صحة العائلة يعطى الفرصة للتقليل من انتشار الامراض المعدية. | 13- |
| | | | | | نهج فريق صحة العائلة يساعد مقدم الخدمة أن يتفهم حالتك الصحية | 14- |
| | | | | | نهج فريق صحة العائلة يشارك الاسرة في تفاعلها مع القضايا الصحية. | 15- |

| | | |
|---|---|---|
| لا ( ) نعم ( ) | هل تنصح باستخدام نهج فريق صحة العائلة للرعاية الصحية لأى احد من اقربائك او اصدقائك؟ | 1- |
| بانتظام ( )<br>عند الحاجة( )<br>انا لا اشعر إنني سآتي هنا مرة اخرى( ) | انت تحب ان تأتى للمتابعة في المركز الصحي | 2- |
| بعض الشيء☐ لا☐ ☐ ☐ | هل تشعر ان الخدمات الصحية الت تلقيتها من خلال نهج فريق صحة العائلة قد لبت توقعاتك؟ | 3- |
| افضل☐ أسوء☐ | لو كانت الجابة لا, كيف تتوقع الخدمات ان تكون؟ | 3.1 |
| مرتفعة ☐ بعض الشيء☐ متوسطة ☐ غير راضي ☐ | ما هو مستوى الرضا عن الخدمات التي تلقيتها؟ | 4 |

ماذا ممكن ان نعمل لكى نحسن خدمات فريق صحة العائلة؟(لنجعل الخدمات أفضل)

....................................................................................................................................

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ما هي..............................................................................................................................

اكثر الاشياء التي لم تحبها في أثناء تقديم الخدمات الصحية من خلال فريق صحة العائلة ؟(من وجهة نظرك)

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ماهي مقترحاتك لكى نحسن جودة الخدمات التي تقدم من خلال نهج فريق صحة العائلة؟

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**شكرا جزيلا لتعاونك معنا**

**This questionnaire is for Evaluation of the family health team approach implemented at UNRWA health centers in the Gaza governorates**

## Client questionnaire

| Part One : Socio-demographic Data | | |
|---|---|---|
| Serial number ------ | | ☐ North Gaza<br>☐ Gaza<br>☐ Deir Al Balah<br>☐ Khan-Younis<br>☐ Rafah |
| 1- | Governorates | |
| 2- | Name of the health center | ☐ Beit Hanoun ☐ Shoka<br>☐ Beach ☐ Deir Al Balah<br>☐ El Naser ☐ Khan Younis |
| 3- | Age | ………… Years |
| 4- | Gender | ☐ Male ☐ Female |
| 5- | Marital Status | ☐ Single ☐ Married<br>☐ Divorced ☐ Widow<br>☐Separated |
| 6- | Years of completed schooling | ………… Years |
| 7- | What is your Employment status? | ☐nployed ☐employed<br>☐ Retired . |
| 8- | If yes, what is your job? | ☐ Managerial<br>☐ Professional<br>☐ Technicians and Assistants of Professionals.<br>☐Clerks, sales and service workers<br>☐Skilled workers in agriculture, forestry, fisheries, Craftsmen (artisans) and related professions.<br>☐ Employees of armed robots. |
| 9- | Do you have health insurance? | ☐ Yes ☐ No<br>If yes,<br>☐ Governmental ☐ Private |
| 10- | What is the average monthly income of your family? From all sources | …………. ILS |
| **Medical Profile data** | | |
| 11- | What is the main purpose of your today's visit? | **1- General**<br>☐ Upper respiratory tract infection<br>☐ Skin diseases<br>☐ Gastrointestinal diseases<br>☐ Urinary tract diseases<br>☐ Sexual and reproductive diseases<br>☐ Others, specify-------------<br>**2- Mother and Child Health (MCH)**<br>☐ Immunization ☐ Postnatal Care |

| | | |
|---|---|---|
| | | ☐ Antenatal care ☐ Preconception care<br>☐ Family planning ☐ Growth monitoring<br><br>**3-Non Communicable Diseases (NCDs)**<br>☐ Hypertension ☐ Diabetes Mellitus<br>☐ Hypertension and Diabetes Mellitus<br>☐ Chronic obstructive lung disease(COPD)<br>☐ Mental<br>☐ Cardiac ☐ Others, Specify ---- |
| 12- | Do you suffer from any chronic diseases? | Yes ☐ No ☐ if no, <u>skip questions: 13</u> |
| 13- | If yes, what do you have? (unprompted - more than one option) | ☐ Hypertension ☐ Diabetes Mellitus<br>☐ Hypertension and Diabetes Mellitus<br>☐ Cardiac diseases ☐ Renal diseases<br>☐ Chronic Obstructive Lung Diseases<br>☐ Others -- specify |
| 13.1 | How many years since were your diagnosis with disease 1? | ----------------Disease name<br>----------------Years |
| 13.2 | How many years since were your diagnosis with disease 2? | ----------------Disease name<br><br>----------------Years |
| 13.3 | How many years since were your diagnosis with disease 3? | ----------------Disease name<br><br>----------------Years |
| 14- | Do you conduct regular follow up? | ☐ Yes if yes **Skip question Q 15**<br>☐ No |
| 15- | Have you been approached by provider because you did not follow up regularly? | ☐ Yes<br>☐ No |
| 16- | Did you receive health services from other service providers? | 1-☐ Yes. ☐ 2- No. **<u>(skip Q17 & 18)</u>**<br><br>If yes, from<br>☐ Governmental clinic<br>☐ Non-governmental organization clinic. |

| | | ☐ Private clinic.<br>☐ Other, specify………. |
|---|---|---|
| 17- | If yes, why you are seeking services from such organization? (You could choose more than one option) | ☐ Have more services<br>☐ Better quality of services<br>☐ Have staff that is very qualified<br>☐ More convenient working hours<br>☐ To maintain my privacy<br>☐ Closer to home<br>☐ Other reasons, specify………… |
| 18- | How many years since you been receiving services from this health center? | **--------** years |
| 19- | Have you received services through the old traditional system? **The one before adopting the family team approach** | ☐ Yes if yes Ask question 20<br>☐ No |
| 20- | Which approach do you prefer ? | ☐ Family team approach, ask question 21<br>☐ Traditional approach |
| 21- | Why do you prefer family team approach? | -------------------- |
| 22- | Do you prefer your physician to be? | ☐ Male<br>☐ Female |
| 23- | Do you prefer your nurse to be? | ☐ Male<br>☐ Female |
| 24- | Do you think the gender of your provider affects the service provision? | ☐ Yes<br>☐ No |
| 25- | Have you ever felt embarrassed to be treated by a different gender, **other than yours**? | ☐ Yes<br>☐ No |
| 26- | How do you describe the quality of the services that you received? | ☐ Of high quality<br>☐ Reasonable quality<br>☐ Low quality |
| 27- | How do you describe your health status after receiving services from this center? | ☐ Good<br>☐ No improvement<br>☐ Getting worse<br>☐ I do not know |

| **Part Two: Perceived Quality** |
|---|
| For each of the below statement, please select one of the five options: 1=Strongly |

| disagree 2= Disagree 3-Neutral 4=Agree 5=Strongly agree | | | | | | |
|---|---|---|---|---|---|---|
| **NO** | **Statement** | **1** | **2** | **3** | **4** | **5** |
| 1- | The FHT approach ensures providing health services that are appropriate | | | | | |
| 2- | The FHT approach ensures providing health services at the right time | | | | | |
| 3- | FHT approach promotes good performance of staff | | | | | |
| 4- | FHT approach helps in maintaining continuity of care | | | | | |
| 5- | FHT approach promotes providing comprehensive care | | | | | |
| 6- | It was easy to adapt to receiving health services through FHT | | | | | |
| 7- | FHT approach has positively improved the quality of services you received | | | | | |
| 8- | FHT services that you received were based upon your needs | | | | | |
| 9- | FHT staff members were knowledgeable regarding to your health conditions | | | | | |
| 10- | FHT staff members have all the required skills to provide you with the needed services | | | | | |
| 11- | FHT approach helps you in building trust with the health care provider. | | | | | |
| 12- | FHT approach maintain and respect confidentiality of health records | | | | | |
| 13- | FHT approach ensures the commitment of the health care providers towards their clients | | | | | |
| 14- | FHT approach gives health care providers the chance of being in close contact with their clients | | | | | |
| 15- | FHT approach promotes courteous and polite provider behavior towards clients | | | | | |
| 16- | FHT approach ensures providing of information to the patients about their health | | | | | |
| 17- | FHT gives the staff the feeling of trust in providing health care to clients | | | | | |
| 18- | FHT gives the clients comfortable feeling in receiving health care and communication with staff | | | | | |
| 19- | FHT approach provides the appropriate atmosphere for communicating with health staff and receiving care | | | | | |
| 20- | FHT approach has improved the providers willingness to help. | | | | | |
| 21- | FHT approach makes health care providers more accessible | | | | | |
| 22- | FHT approach enabled providers to provide you with good care | | | | | |
| 23- | FHT approach focus more on you as a whole | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | person(not only as a case) | | | | | |
| 24- | FHT approach enabled providers to understand the specific needs of clients | | | | | |
| 25- | Overall FHT approach improved the communication between patients and providers | | | | | |
| 26- | FHT approach has helped providers to maintain the best interest of the clients | | | | | |

## Part Three: Satisfaction

For each of the below statement, please select one of the five options: 1=Strongly dissatisfied 2= Dissatisfied 3-Natural 4= Satisfied 5=Strongly satisfied

| NO | How would you rate your satisfaction with/of | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1- | The ease of obtaining service from the health center through the FHT | | | | | |
| 2- | The performance of the FHT all in all is good | | | | | |
| 3- | The services providers’ explanations about your health condition/s | | | | | |
| 4- | The services providers’ respect of your privacy | | | | | |
| 5- | The physical environment allocated to my FHT in the health center | | | | | |
| 6- | The services providers answers to your questions. | | | | | |
| 7- | The health education materials that I receive regularly from my FHT staff | | | | | |
| 8- | Health counselling you received from your FHT staff | | | | | |
| 9- | The contact time with the FHT health care provider | | | | | |
| 10- | The length of your visits (from the moment where you entered until the moment you left the center) | | | | | |
| 11- | Opening file for registration | | | | | |
| 12- | Welcoming and greeting of service providers. | | | | | |
| 13- | The time that FHT team gives you to explain your complaints | | | | | |
| 14- | FHT respects patients appointments | | | | | |
| 15- | The willingness of FHT to help their patients. | | | | | |
| 16- | The response of FHT to your questions and requests | | | | | |
| 17- | The ability of FHT to promote your self-confidence | | | | | |
| 18- | FHT providers make you feel safe | | | | | |

| Part Four: Appropriateness<br>For each of the below statement, please select one of the five options: 1=Strongly disagree 2= Disagree 3-Natural 4=Agree 5=Strongly agree | | | | | | |
|---|---|---|---|---|---|---|
| # | Question | 1 | 2 | 3 | 4 | 5 |
| 1- | FHT enables clients to receive health care services in an easy manner | | | | | |
| 2- | FHT helps health care provider to provide an appropriate follow up of care | | | | | |
| 3- | Through the FHT you have received sufficient information regarding treatment . | | | | | |
| 4- | Through the FHT you have received sufficient information regarding choices made available to you. | | | | | |
| 5- | FHT approach meets your health needs. | | | | | |
| 6- | The health care provider in the FHT you belong to gives enough time to address with you your concerns . | | | | | |
| 7- | The family health team members provide services in a professional way | | | | | |
| 8- | The health care providers of your FHT showed interest to your questions | | | | | |
| 9- | FHT approach has changed positively the way of providing health services—more person centric | | | | | |
| 10- | FHT provides enough cooperation's between different services at the health center. | | | | | |
| 11- | FHT has facilitated your communication with all the FHT members | | | | | |
| 12-- | FHT approach ensures comprehensiveness of provided health care | | | | | |
| 13- | FHT approach provides opportunity to decrease the spread of certain diseases | | | | | |
| 14- | FHT approach helps providers to better understand your health conditions | | | | | |
| 15- | FHT effectively engages my family in my health issues | | | | | |

| | | |
|---|---|---|
| 1- | Will you recommend the use of health services through FHT approach to any of your relatives and friends? | ( ) Yes ( ) No |
| 2- | You would like to come to the center for follow-up? | ( ) Regularly<br>( ) When necessary<br>( ) I don't feel will become her again |
| 3- | Have the health services you received through FHT met your expectation? | ☐ Yes ☐ No ☐ Some extent |
| 3.1 | If No, how did you expect the services to be? | ☐Better ☐Worse |
| 4- | How satisfied are you with the services received? | ☐ To high extent ☐ Moderate ☐ Not satisfied |

What could be done to improve the FHT services (to make the services more better)?

……………………………………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………………………………
…………………………………………………………………………………………………………………………………

What are the most things that you dislike of providing health services through FHT? (From your point of view)

……………………………………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………………………

What are your suggestions for improving the quality of service provided through FHT approach?

……………………………………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………………………

**Thank you for co-operation**

Thank you

**Annex (5): In-depth interview questions for health care providers and decision makers**

**In-depth Interviews Questions with the health care providers and decision makers**

1. Before shifting from traditional provision of services to Family Health Team approach, do you think providers were ready for such shift?

    - If yes, how
        - Received training on Family Health Team approach
        - System readiness- e health
        - Monitoring tools
    - If no, why

2. With regard to Family Health Team approach, do you have written protocols and technical instructions that you can use as references?

**Probing questions**

- If available, do you have access to such protocols?
- If available, do you think your colleagues fully applying the written protocols, full compliance?
    - If no, why
    - If sometimes, why not all the time
- Have you received training on those protocols?
- Are these protocols up-to-date?
- If you have the option, what could you add to the current protocol?

3. From your perspectives, do you think the available human resources are sufficient and qualified to provide services through Family Health Team approach?

   **Probing questions**

    - The workload is suitable
    - The number of providers is appropriate
    - Providers are qualified
    - Providers are knowledgeable
    - Providers have all the required skills

4. Do you get the needed support from your administration?
   **Probing questions**
   - If yes, how?
   - If no, why?
   - How do you evaluate the interaction with your line manager?
   - Available monitoring tools?
   - Receiving regular feedback about your performance?

5. From your perspectives, what do you think of the provided services through Family Health Team approach compared to the traditional approach of providing health services?

**Probing Questions**

- Opinion
- Attitude
- The workload
- Quality of services

6. From your perspective, to what extent the provision of services through Family Health Team approach meet clients' needs?
   **Probing questions**
   - To large extend, how?
     - Quality of services
     - Continuity of care
     - Waiting time
     - Comprehensiveness of care
   - Not at all, why?

7. From your perspective, to what extent the provision of services through Family Health Team approach meet provider's needs?
   **Probing questions**
   - To large extend, how?
     - Worked load
     - Communication with colleagues
     - Professional development
   - Not at all, why?

8. Compared to traditional approach of providing health services, do you think Family Health Team approach is more effectives in providing health services?

**Probing Questions**

- If yes, How
    - Quality of care
    - Comprehensive of care
    - Continuity of care
    - Access to the service
    - Confidentiality
- If No, why

9. What are the main strength points of providing services through Family Health Team approach?

10. What are the main weakness of providing services through Family Health Team approach?

11. Do you have questions?

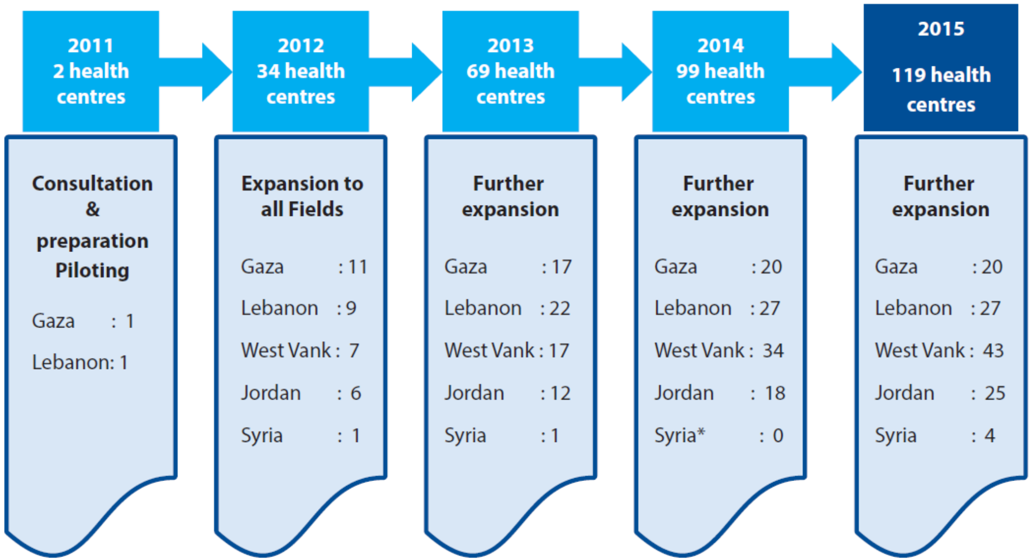
Thanks a lot for your effort and time

## Annex(6) Diagram shows the exact time of FHT Approach implementation

Before the end of 2015, the FHT approach was operational in 119 health centres serving 90.0% of the Agency served population. It was expanded to all health centres in Lebanon, West Bank and Jordan. In Gaza, only two out of 22 health centres are still implementing the old vertical model, as they were under construction, and the Field will achieve full expansion of FHT to all its health centres during 2016. In Syria, exceptional efforts were made by the Field to roll out FHT at 4 health centres in 2015.

The goal for 2016 is to launch FHT in a total of six health centres in Syria, as the security situation and the suitability of the infrastructure allow.

Since 2012, several assessments have been conducted at health centres that have been implementing the FHT approach. Different methods for the assessment were used including: focus group discussions, client flow analysis exercises and patient and staff satisfaction surveys. These assessments have shown very positive responses to the FHT approach from both staff and patients.




"Syria Field started the implementation of the FHT in Khan El-Sheih health centre in April 2014. This health centre was heavily affected by the conflict and it is not functioning

Figure 3- Progress in the implementation of the Family Health Team approach at health centres in the Fields.

## Annex (7): List of experts

| NO | Name | Position |
|---|---|---|
| 1- | Dr Yehia Abed | Al Quds University |
| 2- | Dr Bassam Abu Hamad | Al Quds University |
| 3- | Dr Yousef Al jaish | Islamic University |
| 4- | Dr Ashraf Al Jaidy | Islamic University |
| 5- | Dr Ahmad Al Shaer | Islamic University |
| 6- | Dr Mahmoud Shaker | UNRWA |
| 7- | Dr Rihab QuQa | UNRWA |
| 8- | Dr Zohair Alkhatib | UNRWA |
| 9- | Dr Tamer Al Shaer | UNRWA |
| 10- | Dr Sameha Shaker | MoH |
| 11- | Jihad Okasha | MoH |

## Annex (8):Helsinki approval

المجلس الفلسطيني للبحث الصحي

Palestinian Health Research Council

تعزيز النظام الصحي الفلسطيني من خلال مأسسة استخدام المعلومات البحثية في صنع القرار

Developing the Palestinian health system through institutionalizing the use of information in decision making

**Helsinki Committee**

**For Ethical Approval**

**Date: 2017/08/07** **Number:** PHRC/HC/248/17

**Name:** ADHAM KH. SAFI الاسم:

We would like to inform you that the committee had discussed the proposal of your study about:

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:

**Evaluation Of The Family Health Team Approach Implemented At UNRWA Health Centers - Gaza Governorates**

The committee has decided to approve the above mentioned research. Approval number PHRC/HC/248/17 in its meeting on 2017/08/07

و قد قررت الموافقة على البحث المذكور عاليه بالرقم والتاريخ المذكوران عاليه

**Signature**

**Member** **Member**

**Chairman**

**Genral Conditions:-**

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

**Specific Conditions:-**

E-Mail:pal.phrc@gmail.com

Gaza - Palestine غزة - فلسطين

شارع النصر - مفترق العيون

**Annex (9) UNRWA –Health department**

Al-Quds University
Jerusalem
School of Public Health

جامعة القدس
القدس
كلية الصحة العامة

التاريخ 2017/9/18

Approved

حضرة / د. غادة أبو نحلة المحترم
مدير برامج الصحة بوكالة الغوث الدولية
تحيو طيبة وبعد،،،

الموضوع:مساعدة الطالب أدهم صافي

نشكر لكم دعمكم الدائم لمسيرة العلم والتعليم وخصوصاً دعم كلية الصحة العامة وطلابها، ونود أعلامكم بأن الطالب المذكورةأعلاه يقوم بعمل بحث كمتطلب للحصول على درجة الماجستير في الصحة العامة–مسار الإدارة الصحية عنوان:

***Evaluation of the Family Health Team Approach Implemented at UNRWA Health Centers -Gaza Governorates***

وعليه نرجو من سيادتكم التكرم بالموافقة على تسهيل مهمة الطالب في إنجاز هذا البحث حيث تشمل عينة الدراسة المرضى المترددين على المراكز الصحية ومقدمي الخدمات العاملين في عيادات الوكالة التابعة لإدارتكم الموقرة.

شاكرين لكم حسن تعاونكم ودعمكم للمسيرة التعليمية،،،
و اقبلوا فائق التحية و الاحترام،،،

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ص.ب. 51000 القدس

**Annex(10): Participants approval letter**

**جامعة القدس**

عمادة الدراسات العليا

كلية الصحة العامة

عزيزي يا سيدي/سيدتي

**"الموضوع": الاستبيان**

هذا الاستبيان على استعداد لإجراء دراسة ميدانية حول "تقييم نهج فريق صحة العائلة المطبق في المراكز الصحية التابعة لوكالة الغوث الدولية في محافظات قطاع غزة "للحصول على درجة الماجستير في الصحة العامة قسم الادارة الصحية. ولذلك، يرجى ملء هذا الاستبيان بموضوعية، وسيتم استخدام المعلومات الخاصة بك لأغراض البحث العلمي فقط.

يقدر تقديراً عاليا جهودكم في دعم البحوث العلمية.

الباحث

أدهم خليل صافي

## Annex (11) Timetable of Thesis Research Activities

| Activity | 3/4 2017 | 5 2017 | 9/10 2017 | 11/12 2017 | 1 2018 | 2/3 2018 | 4/5 2018 | 8 2018 |
|---|---|---|---|---|---|---|---|---|
| Proposal Writing | | | | | | | | |
| Proposal defense and approval from Helsinki Committee &UNRWA | | | | | | | | |
| Development of instruments & check for validity | | | | | | | | |
| Training of personnel | | | | | | | | |
| Pilot Study & Modifications | | | | | | | | |
| Data Collection | | | | | | | | |
| Data Entry | | | | | | | | |
| Data cleaning & Analysis | | | | | | | | |
| Research writing | | | | | | | | |
| Dissemination of findings | | | | | | | | |