Deanship of Graduate Studies

Al- Quds University

Hypertensive patients' satisfaction with services provided at Gaza governmental primary health care centers

Yaser Nasr Alla Salem Ibrahim

M.P.H Thesis

Jerusalem - Palestine

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Hypertensive patients' satisfaction with services provided at Gaza governmental primary health care centers

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إهداء

أهدى هذا العمل إلى روح والدي الطاهرة الذي غرس في القيم والمبادئ وحب التعلم والتضحية من أجله وإلى والدتي الغالية وإخواني وأخواتي الأعزاء وزوجتي وأبنائي الأحباء ، ولا أنسى أصدقائي الأوفياء.

ياسر إبراهيم

Dedication

This work is dedicated to the memory of my father, for instilling in me the values of hard work, a good attitude and persistence, and for stressing the value of education. His love, concern and pride in my work were always a major source of strength to me. His encouragement, support and personal sacrifices made an everlasting impression on my life.

This work is also dedicated to my mother, Brothers, Sisters, wife, Sons, and to my best friends.

Yaser Nasr Alla Ibrahim

Declaration

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

Signed

Yaser Nasr Alla Salem Ibrahim

Date: 27.04.2009

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Abstract

No one can deny that client satisfaction is crucial central concept in assessing the quality of health care, it have gained increasing attention in the recent days and future. Also it is considered as important indicator for quality improvement of health services.

This study aimed to assess hypertensive patients' satisfaction with services provided at Gaza governmental primary health care centers. A cross sectional study design with accidental sample was used. A standardized structured questionnaire was developed and distributed to patients who attended non communicable department for receiving treatment and care for hypertension in two different localities, Rafah Martyr's clinic and Rimal Martyr's clinic. The selected sample was 370 clients (300 from Rafah and 70 from Gaza). The response rate was 100%. Psychometric methods and tests were applied and their (results approved the reliability and validity of the questionnaire (Cronbacks Alpha) was 0.760).

The study explored six dimensions of satisfactions including general satisfaction, health education, accessibility, communication and interaction, medical counseling and direction respect.

The study results were general satisfaction (68.6%), satisfaction with health education (25.1%), satisfaction with accessibility to services (53.2%), satisfaction with communication and interaction (19.7%) and satisfaction with medical counseling (70%). The highest level of satisfaction was expressed toward direction respect (75.9%) which is reflecting client trust toward providers.

The study showed that female, older age, villagers, divorced, illiterate, unemployed and smokers showed high level of satisfaction. Male, other ages, city citizens, educated, employed, married and non smokers show low level of satisfaction.

The study showed that improving communication styles and improving health education programs in primary health care centers are important factors to improve patient satisfaction. Moreover, health managers and health planners in the ministry of health could use the findings of the study to know the factors that lead to dissatisfaction and work to improve them to increase client satisfaction.

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List of abbreviations

AMI	Acute Myocardial Infarction
APN	Advanced Practice Nurse
B.C	Before Christ
BMI	Body Mass Index
BP	Blood Pressure
CNMs	Certified Nurse Midwives
CVD	Cardiovascular Disease
DBP	Diastolic Blood Pressure
GG	Gaza Governorates
HDL	High Density Lipoprotein
HIS	Health Information System
IOF	Israeli Occupied Forces
IOM	Institute of Medicine
LDL	Low Density Lipoprotein
MOH	Ministry of health
NGOs	Non Governmental Organizations
NPs	Nurse Practitioners
NSHP	National Strategic Health Plan
PA	Physician Assistant
PCBS	Palestinian Centre Bureau of Statistic
PNA	Palestinian National Authority
PHC	Primary Health Care
QOF	Quality and outcomes framework
SBP	Systolic Blood Pressure
SPSS	Statistical Package for Social Sciences
UNRWA	United Nation Relief and Work Agency
US	United State
WHO	World Health Organization

Operational definition of terms

- **Customer/Client:** customer is any one who is internally or externally and impacted by the product or process (Juran 1992).
- **Patient satisfaction:** The individualized cognitive evaluation and prioritization of the client's perceptions of care and the health care visit (Davis, 1995).
- **Patient:** A patient is one who is sick or being treated for an illness or injury (Curington, 2000).
- **Primary Care:** Basic or general care given by a practitioner who assumes ongoing responsibility for health maintenance and therapy for illness, including consultation with specialists (Lee, 2001).
- **Rural community:** A non-urban area, where most medical care is provided by a small number of general practitioners to patients who have limited or distant access to specialist resources and high technology health care facilities (Lee, 2001).
- **Nurse Practitioner:** Licensed registered nurse with advanced clinical skills for the delivery of a majority of general health promotion, prevention, and illness care to individuals and families (Curington, 2000).
- **Physician:** A health professional that holds a doctor of medicine (Curington, 2000).

Chapter One

Introduction

Chapter one

Introduction

1.1 Background

Primary Health care seeks to meet the essential health needs of people as possible at the lowest possible cost. It also includes what individuals and families can do for themselves" (WHO, 2003). The World Health Organization declaration of Alma Ata stated that primary health care was the key to achieve the objective of " Health for all by the year 2000" and that it should be an integral part of country's health care scheme (WHO, 1978).

Hypertension is a major risk factor for cardiovascular disease (CVD) cerebrovascular events and ischemic heart disease and is therefore one of the most important preventable causes of premature morbidity and mortality in developed and developing countries. Recent Quality and outcomes framework (QOF) data suggest a prevalence of blood presure is 11.3% in the UK population. It is often symptomless, so screening is vital before damage is done. Many surveys continue to show hypertension remains underdiagnosed, undertreated and poorly controlled in the UK (Wolf-Maier K, 2004)

Quality improvement in health care setting is getting more attention now adays by health care organization all over the world. One of the main components in assessing the quality of health care services is client's satisfaction. In such competitive world, the health care organization is continually monitoring client's satisfaction with client's surveys to better understand the needs of client's evaluate services and identify opportunities for improvement. The literature indicates that satisfied clients are more likely to follow- up medical advice and show fewer complaints (Hill, 1997).

In addition to that, clients satisfaction is consider a significant factor in determining the quality of life particularly in chronically diseased patients. The client dimension of quality reflects the assessment of how the client perceives the health care received and this is manifested in the measurement of satisfaction. It becomes common to include client satisfaction as measure of quality care (Oermann et al, 2002).

Moreover, there is a noticeable concern with learning factors that are related to positive patient out - comes (Jacox, Bausell and Mahrenholz, 2000) this mean that health care providers need to implement continuously effective ways to offer quality services to client's with resources constrains (Balestracci and Barlow,1999).

The MOH had been established since the Oslo agreement. It's carried a major responsibility towards promoting and protecting the health and well being of the population. Despite the large aid assistance, the MOH and the entire sector was suffering from financial crisis. The deepening of the political crisis and subsequence economic recession meant a decrease in the real MOH budget. It was difficult to stratify the raising demand for free health care services (Abed, 2007).

The demographic and health situation of Palestine since year 2001 is unique. Palestine is undergoing a dual faceted epidemiological transition similar to that of middle-income countries.(Majed Abu-Ali, 2003).

Satisfaction is an abstract concept, which cannot be directly observed or measured. Despite the growing literature devoted to the patient satisfaction, no unified approach has been devised for its measurement and there is disagreement as to whether patient satisfaction exists and what it means (Avis, Bond and Arther, 1995).

Client satisfaction studies are seen as an important way for obtaining a wealth of information about the dimensions of satisfaction related to health services, and exploring variables influencing client's satisfaction

Several studies explored the relationship between patient satisfaction and variables that might affect it, such as gender, age, income and level of education (Abd al Kareem, Aday and walker, 1996).

Quality of health care has been identified as an important area for improvement in the Palestinian health sector. Therefore, it has been addressed as one of the ten guiding principle activities in health sector in Palestine in the policy statement of Palestinian delegation (Massoud ,1994). Massoud who analyzed the quality of health care system in Palestine pointed to the quality defect, which is reflected in the inefficiency of health care system to deliver quality health care. Massoud (1994) pointed that there appears to be an over investment in health care system in Palestine which is leading to outcomes that can be obtained with less investment of resources. National inputs into health care in Palestine seem to be high in comparable to those nations with similar economic status. Also he reported that there is general dissatisfaction among public and professionals regarding quality of health care in Palestine (Massoud, 1994).

Patient satisfaction is increasingly seen as an important area of research in relation to quality of health care. It has been found that satisfied patients are more likely to benefit from their health care (Fitzpatrick, 1993).

1.2 Statement of the problem

Client satisfaction is considered as one of the indicators for the quality of health care system in Palestine. In general it appears to be an overinvestment in spite of the limited

resource and a noticeable clients dissatisfaction with the quality care in different health care settings (Massoud, 1994).

It was evident that patients were expecting more from professional and health institution in terms of physical accessibility and quality assistance (Abed, 2007). Therefore improvement of quality of care given to chronic patients is essential to achieve validity of services offered to start with improvement abase line scientific data.

This study is aimed to assess client satisfaction of hypertensive patients' about health services provided to chronic patient by the governmental primary health care centers.

The study findings might help and make recommendation for improving the quality of services offered to chronic patients in primary health care centers by providing some satisfaction indicators to start the improvement process.

1.3 Significant of the study

The purpose of the study is to assess the degree of satisfaction among hypertensive patients' seeking health services at chronic disease clinics in Rimal and Rafah primary health care centers to see the difference in level of satisfaction between the south area and the centre of Gaza. This study explores the main domains of satisfaction among patients attending the chronic disease clinics and explores the differences in satisfaction in relation to certain variables such as, demographic, socio-economic and the place of delivering the health services. Also it might help in identifying potential barriers and pinpoint areas in which client's expectations are not being met. The body of satisfaction research has been grown in developed countries, still there is limited data about satisfaction in developing countries (De Geyndt, 1995) particularly in Palestine where there are several research studies in this field is consider a significant factor in determining the quality of life particularly in key element of quality assessment in primary health care centers.

1.4 Objectives of the study

1.4.1 General objective:

The main aim of this study is to know the hypertensive patients' satisfaction about health services provided by the governmental primary health care centers.

1.4.2 Specific objectives:

1- To identify the level of clients' over all satisfaction regarding the services delivered by the Primary health care.

2- To rank the domains that underlies the level of clients' satisfaction.

3- To describe the relationship of socio-demographic characteristics on clients' satisfaction.

4- To make recommendations and suggestions for the primary health care centers in Gaza to promote and develop the health care services

1.5 Research questions

1- What are the levels of clients' over all satisfaction regarding the services delivered by the primary health care?

2- Are Socio-demographic characteristics influences the level of clients' satisfaction?

3- Are the customers satisfied with the communication they face during their interaction with the health care providers?

4- Does the Primary Health Care accessible to you in term of distance, affordability of medical care and lasting the administrative Bureaucracy procedure?

5- What are the recommended strategies that could promote and develop the health care services?

1.6 Context of the study

The information that describes health care services and population who received that care considered very important for proper planning and development of health care services .the health care situation is influenced by demographic, health care system and primary health care services. This study was conducted in Gaza strip in Palestine, therefore the following paragraphs provide some information about the Gaza strip population and their health status.

1.7 Demography

Palestine is situated on the Eastern coast of the Mediterranean Sea. It is of an ancient and of strategic important location. Now, Palestine comprises two areas separated geographically: the West Bank and Gaza governorates, the total area is 6,020 sq. Km. with total population living in is 3,762,005 individuals in 2007 with capita per sq Km 625. Gaza governorates is a narrow piece of land lying on the coast of the Mediterranean sea. Its position on the crossroads from Africa to Asia made it a target for occupiers and conquerors over the centuries. The last of these was Israel who occupied the Gaza governorates from Egyptians in 1967. Gaza governorates are very crowded place with area 365 sq. Km and constitute 1.3 % of total area of Palestinian territory land (Palestine, MOH, October, 2006). In mid year 2007 The total number of population in Palestine in 2007 was 3,761,646, Gaza Strip (GS) 1,416,539 (37.7%) and West Bank (WB) 2,345,107 (62.3%) (PCBS, 2007), mainly concentrated in the cities, small village, and eight refugee camps that contain two thirds of the population of Gaza governorates. In Gaza governorates, the

population density is 3,808 inhabitants/km2 that comprises the following main five governorates: North of Gaza, Gaza City, Mid -Zone, Khan-younis, Rafah. West Bank is divided into four geographical regions. The North of West Bank includes the districts of Jenin, Tulkarem, Qalqylia, Salfit and Tubas districts. The Center includes the districts of Ramallah and al-bireh, and Jerusalem. The South includes the Bethlehem and Al-Khaliel districts, and the sparsely populated Jordan valley including Jericho. The population density is 420 inhabitants/ km2 and constitutes 93.9% of total area of Palestinian territory land (Palestine, MOH, 2006). (Annex no.1).

1.8 Health care system

In principle, the Ministry of Health (MOH) has the prime responsibility for the health of the entire population, The MOH is the health authority responsible for supervision, regulation, licensure, and control of the whole health services. The MOH provides both primary and secondary health services and purchases tertiary services from private providers domestically and abroad. (Palestine, MOH, 2001)

Over the past years, the Palestinian health care system has been developing side by side with the development of Palestinian society in general. Five stages of development can be identified:

1. Since the early days of Israeli Military Occupation in the West Bank and Gaza strip, the Israeli Military Occupation have continuously attempted to takeover the existing Palestinian health care structures and to make them increasingly dependent on the Israeli health care system. In the early years of occupation, little development had taken place at most if the efforts of the Palestinian structures which were not taken over by the Israeli Military Authorities were directed towards maintaining their existence and providing needed health care services under numerous restrictions imposed by

Israeli Military Authorities. The Israeli restrictions took many forms, ranging from delays in licensing of projects to the point where such activities as health education became activities requiring permission from the military occupation authorities. During the period (June 1967 to the early 1970s) few Palestinian structures were erected.

2. Starting in the early 197-s a new trend began to build as many independent health care structures as possible. Despite the many restrictions imposed by the Israeli authorities, a number of indigenous health care organizations, predominantly charitable societies were able to obtain permits to operate in the Occupied Territories. This trend, however was mainly focused on curative health care services. Little emphasis on preventive health activities and primary health care services. Although a number of significant achievements were recorded during that period, the many restrictions imposed by the Israeli Military Authorities rendered further development of that sector virtually impossible.
3. During the late 1970s and early 1980s, another trend began to develop in the Occupied Territories. It was based on a more holistic concept of health, namely that health and illness were not merely biological phenomena and that the health of the population and not just the individual was an integral part of the social, economic, even the political context within which the population lived.
4. In early 1988, with the outbreak of the Palestinian uprising, the Palestinian health structure was put in a state of emergency due to the large number of casualties, which resulted from Israeli army violence. As a result of this situation, a large number of new clinics were established in the West Bank and Gaza Strip in order to meet the increasing need of medical services. The growth in the Palestinian health care structures during the years of the uprising was predominantly confined to the NGOs and charitable sectors.

5. Since 1992, and after Palestinian MOH had taken the responsibilities of health in Palestine, great improvement and development in term of quantity and quality of health services including policies, regulations, infrastructures and human resources development. Since then health care in Palestine is first and foremost the responsibility of the Ministry of Health. Thus, it is essentially a public and a governmental responsibility. Being so, it is regulated by mandates issued by Palestinian National Authority (Palestine, MOH, 2001).

1.9 Primary health care services in Palestine

The MOH is working with other health sectors in providing the primary health services mainly with UNRWA, and NGOs sector. At the end of 2005, there are 654 PHC centers in Palestine; these centers are cared for about 3.7 million people (129 centers in Gaza and 525 centers in West Bank). Classification of PHC according to providers shows that, the MOH is considered the main provider with 63.6% from the total PHC centers, followed by the NGOs with 28.3%, then UNRWA with 8.1%. It is worth to mention that, Private sector plays an important role in providing PHC services to Palestinian people but, there is limited information about theses centers. The average ratio of persons per center was 5,752 (10,774 in Gaza Strip and 4,519 in West Bank). The Number of PHC centers per 10,000 persons was 1.7 in 2005 while it was 1.9 in 2000 (Palestine, MOH, 2006).

1.9.1 PHC centers:

Primary health care system (PHC) is a major component of Palestinian health care system; this system has provided health care to all Palestinian people especially for children and other venerable groups. Primary health care centers in Palestine provide primary and

secondary health care services as well as tertiary services. In the Last five Years and after the uprising of second Intifada (Al Aqua), PHC centers in Palestine have been developed in a dynamic way to face the instability of Palestinian situation were Israeli occupied Forces (IOF) tends to divide Palestinian localities into isolated geographical areas. PHC centers try to offer accessible and affordable health services for all Palestinians regardless the geographical locations. According to MOH policy, PHC centers classified from level I to level IV. They offer different health services according to clinic level, theses services include maternal and child health care of chronic diseases, daily care, family planning, dental, mental services and other services according to center level (Palestine, MOH, 2006).

1.10 Overview of remaining chapters

This section outlines the coming chapters. A review of the literature that encompasses previous research and relevant literature related to management training development programs and training needs assessment is provided in Chapter 2. The research conceptual framework outlined in Chapter 3 .The research methodology containing:

1) a description of the setting, population, and sample; 2) development of the questionnaire; 3) the survey procedure; and 4) plans for data analysis are outlined in Chapter 4. The data obtained and the findings from the analysis of the survey data are presented in Chapter 5. A summary of the study, discussions of the findings, conclusions of this research, and recommendations for further research are provided in Chapter 6.

Chapter two

Literature Review

Chapter 2

Literature Review

2.1 Introduction

The term primary care is thought to date back to about 1920, when the Dawson Report was released in the United Kingdom. That report, an official "white paper," mentioned "primary health care centers," intended to become the hub of regionalized services in that country. Although primary care came to be the cornerstone of the health services system in the United Kingdom as well as in many other countries, no comparable focus developed in the United States. Indeed, the formation of one after another specialty board in the early decades of the 20th century signaled the increasing specialization of the United State (US) physician workforce (Stevens, 1971). The resulted of two reports from the Institute of Medicine (IOM) (Donaldson et al. 1996; IOM, 1978) defined primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." This definition is consistent with at least two international reports (WHO, 1978) and has been used to measure the four main features of primary care services: first-contact access for each new need; long-term person- (not disease) focused care; comprehensive care for most health needs; and coordinated care when it must be sought elsewhere.

Primary care is assessed as "good" according to how well these four features are fulfilled. For some purposes, an orientation toward family and community is included as well (Starfield, 1998). Despite the greater recognition of the importance of primary care to

health services systems (WHO, 2003), professionals have recently called for increasing even further the supply of specialist physicians in the United States (Cooper et al., 2002).

The prevalence, awareness, treatment and control of hypertension make this condition an important epidemiological research topic worldwide. The screening of hypertension at special workplaces may be of interest from certain aspects. Various questions can arise such as what is the prevalence of hypertension under the worksite circumstances relative to the prevalence of hypertension within the surrounding general population? Theoretically, the prevalence can be different, because various factors (e.g. different working circumstances) could influence the blood pressure (BP) in a particular (Fogari R et al., 1997)

2.2 Prevalence of hypertension globally, regionally, and locally

2.2.1 Global burden of hypertension:

By the year 2025, approximately 1 in 3 adults aged over 20 years worldwide will have hypertension (Kearney PM, Whelton M, Reynolds K, et al., 2005). Overall, 26.4% of the world's adult population in 2000 had hypertension (26.6% of men and 26.1% of women). This meant an estimated 972 million adults, broken out as 333 million in economically developed countries and 639 million in economically developing countries, in a 1: 2 ratio. In men, hypertension prevalence was highest in the Latin American and Caribbean region, whereas in women it was highest in the "former socialist countries" of Europe. The lowest prevalence for both men and women was in the "other Asia and islands" region. In general, the prevalence of hypertension at younger ages was higher in men than in women, but among older people (> 60 years) it was higher in women (American Heart Association., 2005).

He and colleagues in the year of (2000) calculated and estimated the prevalence of hypertension for the year of 2025 that hypertension will increase by about 60% to a total of 1.56 billion. This mean (29.0% of men and 29.5% of women) will have hypertension. Based on projected changes in age distribution, there will be 9% increase in hypertension among men and a 13% increase in women. Most of this increase will occur in the economically developing regions. They predict that the number of people with hypertension in these regions will increase by 80% compared with a much smaller (24%) increase in the economically developed regions (American Heart Association., 2005).

Thus, by 2025, almost three quarters of the world's hypertensive population will be in economically developing countries. Dr. He and colleagues' stress that their figures for 2025 could be an underestimate, since they were based on the assumption that country, age, and sex-specific prevalence estimates for 2000 will remain constant. However, hypertension prevalence may be increasing in some economically developed countries, as well as developing countries. The prevalence of hypertension in the United States based on data published in 2000 was (23.4%) in the Tulane study, and the latest American Heart Association statistical update shows the prevalence of hypertension in the United States in 2002 as (32.3%) (American Heart Association, 2005).

2.2.2 Regionally burden of hypertension:

In 2000, in all countries of the region, there was more awareness about cardiovascular diseases as a main cause of mortality and morbidity. This awareness on cardiovascular diseases was addressed by national inter-country workshops (Bahrain, Lebanon, Oman, Saudi Arabia and United Arab Emirates). Egypt, Lebanon, Oman, Pakistan and Saudi Arabia made significant progress in national plans on hypertension prevention, as well as understanding of risk factors in order to improve skills and knowledge of cardiovascular

disease epidemiology. Technical reports on guidelines for management of hypertension with emphasis on primary care were established in Kuwait and Saudi Arabia. Promotion of healthy lifestyles was advocated and strengthened through workshops and country publications (Bahrain, Cyprus, Jordan, Lebanon, Morocco, Oman, Saudi Arabia, Syrian Arab Republic and Tunisia). The Regional Office continues to support the development of comprehensive, integrated policies in countries for prevention and control of cardiovascular diseases, such as the Nizwa project in Oman (WHO, 2000).

Cardiovascular diseases are the main non-communicable diseases and are major public health concerns worldwide. According to the world health report 2001, cardiovascular diseases accounted for (9.2%) of the total deaths in the African Region in 2000 compared with (8.15%) in 1990. The most important CVDs are hypertension, stroke, cardiomyopathies (especially the dilated form) and rheumatic heart disease. Hypertension is a main physiological risk factor for other CVDs. It is estimated that more than 20 million people are affected in the African Region, mainly in urban areas. Prevalence ranges from (25%) to (35%) in adults aged 25 to 64 years. Some studies reveal a clear relationship between level of blood pressure, salt and fat consumption, and body weight. Studies in Ghana, Mauritius, South Africa and Zimbabwe show an increase in stroke mortality that could be related to increasing levels of hypertension, obesity, tobacco use and diabetes. Prevention and control of hypertension could avoid at least 250 000 deaths per year (WHO, 2004).

Trends in Egyptian statistics indicate that the main causes of mortality shifted in Egypt between 1970 and 1989. It is believed that the situation they reveal exists in many other developing countries. Furthermore, the results of the Egyptian National Hypertension Project showed that hypertension is extremely common among Egyptians. Cardiovascular

diseases are now the main cause of death, being responsible for (42.5%) of all deaths, while 20 years earlier they accounted for only (12.4%) of mortality {Central Agency for Public Mobilization and Statistics CAPMAS, 1990 }. Statistics from the Egyptian Ministry of Health show that there is an increase in life expectancy. Over the past three decades it increased for males from 51.5 to 62.8 years and for females from 53.8 to 66.4 years (CAPMAS, 1993). Furthermore, the results of the Egyptian National Hypertension Project showed that hypertension is extremely common among Egyptians. It is believed that the situation they reveal exists in many other developing countries. Comparing the prevalence of hypertension in three countries, China, Egypt and the USA, using the same definition of hypertension, Egypt has the highest prevalence rate among the three countries. According to the National Hypertension Project data (1995) showed that 26% of adult Egyptians suffer from high blood pressure.

2.2.3 Locally, in Palestine:

The demographic and health situation of Palestine since year 2001 is unique. Palestine is undergoing a dual faceted epidemiological transition similar to that of middle-income countries. Disease patterns are characterized by diseases typical of developing countries like (respiratory infections, diarrhea, and parasitic diseases), and diseases of developed countries like (ischemic heart disease, hypertension, cancer, and diabetes).(Majed Abu-Ali, 2003).

Reliable data about mortality and morbidity in Palestine are lacking, and the current health information system (HIS) is inadequate and lacks standard operations both at regional and international levels, (Palestine, National Health Plan, 1999-2003). The presence of two region, (West bank and Gaza strip) under control of Palestinian National Authority (PNA) is one of the major problems faced Palestinian Planer and HIS. The impact on Palestinian

Economy of Confrontations (2001) Studies focused on Lifestyle factors relevant to coronary risk factors show differ between Palestinian communities. They have been exposed, albeit differently, to the stressors of the long-term conflict. According to the WHO, (1998) the health situation in Palestine is probably similar, (Majed Abu-Ali, 2003) to Egypt, Syria, and Jordan since many of risk factors are similar. There are little data available on the rates of occurrence, risk factors and mortality due to acute myocardial infarction among the various ethnic groups living in Palestinian territories. Hypertension and heart diseases are at a rate which almost the same as that reported in the neighboring countries before year 2001 (Palestine, MOH, 2003). Heart diseases are the first leading cause of death among general population, and there are 2,087 persons died among both sexes with a proportion of (30, 5 %) male and (23.1 %) in female. Ischemic heart diseases are the leading cause of cardiovascular mortality (33.7%) and of all cardiovascular disease (81.5%), with a rate of 35 per 100,000 populations. Coronary risk appears to be particularly high among Palestinian communities. Determinants of these unexpected findings should be sought and prevention programs initiated. Recent statistics indicate that acute myocardial infarction (AMI) is becoming very common in Palestine There is scope for lifestyle change in reducing AMI risk, by changes in physical activity, smoking and dietary habits. In addition, measures to control hypertension and diabetes should be given a high priority in any national health policy to prevent AMI (Community Health Department, 1995). By the end of 2006, the total number of the registered hypertensive patients in Gaza Strip was nearly about, 84208 patients. The highest prevalence rate of hypertension was in Gaza City and the lowest was in Rafah among the total population. The prevalence of hypertension are very low among population aged less than 20 years and the highest rate was among population aged between 45-60 years (51.6)% of the total population.(Palestine, MOH, 2006).

2.3 Definitions of hypertension

Hypertension is the exerted by bloodstream against the walls of arteries, every one has to have some blood pressure, which is absolutely necessary to get blood to the vital organs and muscles. Hypertension is defined as a systolic blood pressure (SBP) of 140mmhg or greater and/or diastolic blood pressure (DBP) of 90 / mmhg or greater in subject who are not taking anti-hypertension medications. While measuring the blood pressure, first appearance of sound is used to define SBP the disappearance of sound is used to define DBP (WHO, 2003). High blood pressure makes the heart work harder. It increases the risk of developing heart disease, as well as kidney disease and stroke. Weight reduction, physically activity; follow a healthy eating plan, including foods lower in salt help in prevention or control high blood pressure and if a medication was prescribed, compliance is required (Leon A Simons, Judith Simons, 2005). Hypertension is not itself a disease but it's a condition of consistently raised blood pressure above 'normal'. If hypertension left untreated it carries a risk of increased morbidity and mortality from various cardiovascular diseases, including stroke coronary heart disease and renal impairment (Susan Skankie, 2001).

Having high blood pressure is one of several risk factors that can increase the chance of developing heart disease, stroke and other serious conditions. As a rule, the higher the blood pressure is the greater the risk. Treatment includes a change in lifestyle risk factors where these can be improved - losing weight if the patient is overweight, regular physical activity, a healthy diet, cutting back if the patient drink a lot of alcohol, stopping smoking, and a low salt intake. If needed, medication can lower blood pressure (Alderman MH Lancet, 2000).

Blood pressure (BP) has a skewed normal distribution within the population and the currently accepted model assumes risk is continuously related to blood pressure. When defining hypertension, we choose to select a value above which risk is significantly increased e.g. a total CVD risk 20% over 10 years, and the benefit of treatment is clear-cut. A figure of 160/100 mmHg is usually quoted. High blood pressure is a blood pressure that is 140/90 mmHg or above each time it is taken. High blood pressure can be:

- Just a high systolic pressure, for example, 170/70 mmHg.
- Just a high diastolic pressure, for example, 120/104 mmHg.
- Both, for example, 170/110 mmHg.

However, it is not quite as simple as this. Depending on various factors, the level at which blood pressure is considered high enough to be treated with medication can vary from person to person (Port S, Demer L. Lancet, 2000). Blood pressure of 160/100 mmHg or above this is definitely high. All people with a blood pressure that stays at this level are usually offered medication to lower it. Blood pressure of 140/90 mmHg or above but below 160/100 mmHg sometimes called 'mild' high blood pressure. Ideally, it should be lower than this but for many people the risk from mild high blood pressure is small and drug treatment is not indicated. However, certain groups of people with blood pressure in this range are advised medication to lower it (Ezzati M Lancet, 2002).

Blood pressure between 130/80 and 140/90 mmHg for most people is fine however, current UK guidelines suggest that this level is too high for certain groups of people. Treatment to lower your blood pressure if it is 130/80 mmHg or higher may be considered if you:-

- Have developed a complication of diabetes, especially kidney problems.

- Have had a serious cardiovascular event such as a heart attack, TIA or stroke.
- Have certain chronic kidney diseases.

2.3.1 Medical examination:

- General medical examination as blood pressure, weight and BMI.
- Cardiovascular system as heart size, heart failure, disease of carotid, renal and peripheral arteries and coarctation of aorta.
- Lungs sound as rales and bronchospasm.
- Abdomen such as present of bruits, enlarged kidneys and masses.
- Eyes, optic funds and cataract.
- Nervous system, cerebrovascular damage signs.

Basic laboratory investigations, as kidney function test including high density lipoprotein (HDL) and low density lipoprotein (LDL), cholesterol, triglycerides, creatinine, fasting plasma glucose, complete lipid profile may be required if the condition is uncontrolled and total cholesterol equal or more than 200mg/dl (Wolf-Maier K, 2004).

2.3.2 Management Principle:

Decisions about the management of patients with hypertension should not be based on the level of –BP- alone but also in the presence of other risk factors, target organ damage and concomitant disease as well as other aspects of the patients' personal, medical and social conditions. The primary goal of treatment is to achieve the maximum reduction in the total of cardiovascular morbidity and mortality and this required the following interventions (Wolf-Maier K., 2004):-

- Initiate lifestyle measure wherever appropriate in all including those who require drug treatment
- Smoking cessation
- Weight reduction

2.3.3 Management plan:

General consideration among persons 50 years old and more, systolic blood pressure (SBP)> 140mmhg, is a much important cardiovascular disease CVD risk than diastolic blood pressure (DBP). The risk of (CVD) is beginning at 115/75mmhg doubles with each increment of 20/10 mmHg. Individuals with SBP of 120-139 or DBP 80-89mmHg should be considered as pre-hypertension and need education and counseling on lifestyle modifications to prevent CVD. Motivation of patients through positive experience and trust in care provider is essential for the success of treatment, as a role management should always be started with life-style modification including advice on change in diet, physical activity and weight reduction. Pharmacological therapy could be added if the blood pressure is still uncontrolled after attempting these measures (Wolf-Maier K, 2004).

2.3.4 Follow up:

At least every 6 months, frequency of visits depending on degree of control, complexity of therapy and compliance. Annual urinalysis for protein, blood for glucose, creatinine and electrolytes (± total and HDL cholesterol) and evaluation of CHD/CVD risk recommended: with routine visits to measure weight, BP and to enquire about general health, side-effects, treatment problems and to re-inforce non-drug measures. A robust call/recall system is essential. It may be possible to gradually titrate down or stop medication in patients who successfully modify their lifestyle (Wolf-Maier K, 2004).

2.3.5 Prevention of hypertension:

Strategies for prevention of hypertension as described by the (WHO, 1995) are shown below.

2.3.6. Primary prevention:

Primary prevention covers activities aimed in preventing hypertension from occurring in susceptible individuals of population through modification of environmental and behavioral risk factors and determinants, or specific intervention for susceptible individuals. This includes any activity undertaken prior to development of clinically evident hypertension; there are two types of primary prevention. The first one is activities targeted in reducing the frequency or level of the causal factors for development of hypertension in whole population or groups of individuals particularly those in high risks, this approach is called the population approach. The second one is activities targeted in preventing specific individuals who are already manifesting early markers of the disease process from developing the full clinical expression of hypertension, these could include intervention strategies, Pharmacological or non-pharmacological in individuals with abnormal blood pressure tolerance or other metabolic abnormalities or immunological or other markers of destruction, this approach is called the high risk approach. The population and the high risk approach are generally complementary (WHO, 1995).

2.3.7 Secondary prevention:

Secondary prevention covers activities such as screening, which aim in early detection of hypertension and effective management of the condition with the purpose of reversing the condition or holding its undiagnosed cases of hypertension. Activities can be targeted in population or high-risk groups or in high risk individuals (WHO, 1995).

2.3.8 Tertiary prevention:

Tertiary prevention is any measure undertaken to prevent or delay the negative health consequences of hypertension among individuals who have already developed the disease, this means early detection, effective management, education and metabolic control, as well as the correction or reduction of major risk factors for specific disorders among people with hypertension (WHO, 1995).

2.4 Surveillance

Hypertension is usually a symptomless disease, the common belief that symptoms such as headache, dizziness or drumming in the ears are indicative of hypertension has contributed to that fact, a good proportion of hypertensive individuals remain undiagnosed and so unaware of their disease. Since hypertension is usually symptomless confirmation of the diagnosis is the responsibility of the health provider. Health staff should explain to patients the meaning of their –BP- readings advised them on the need for periodic –BP- measurement and take appropriate action to monitor their condition according to the guidelines outlined below in the table (2.1):-

Table No. (2.1)
The guidelines of blood pressure readings and the appropriate action

Initial Blood Pressure (mmHg)		**Follow-up Recommended**
Systolic	**Diastolic**	
<130	<85	Recheck in 2 years + advice on lifestyle modification.
130-139	85-89	Recheck in 1 year + advice on lifestyle modification
140-159	90-99	Confirm within 1week
160-179	100-109	Evaluate within 1day-one week
>180	>110	Evaluate immediately, depending on clinical situation.

Individuals whose blood pressure was found initially > 140/90 mmHg should have the measurement repeated after at least 10 minutes, any patient found to have high blood pressure should be placed on lifestyle management and his/her condition periodically assessed. Treatment of hypertension has been shown to reduce the relative risk of cardiovascular mortality and morbidity by 30% (Collins R, Peto R., 1994). National experts have produced recommendations on detecting and treating hypertension (Jackson R, Barham P, Bills J, Birch T, McLennan I.,1993). However, despite the wealth of evidence from randomized controlled trials these guidelines differ both in content and in emphasis (Swales J., 1993). Recently, more emphasis has been put on targeting treatment at people who have a higher absolute risk of cardiovascular disease Davey Smith G. (1994). A recent systematic review showed that 58 elderly people need to be treated for five years to prevent one cardiovascular death compared with 205 people in middle age. Similarly, history of a cardiovascular event, presence of diabetes, left ventricular hypertrophy, and continued smoking increase absolute risk from 5.4% to 32.9% over 10 years (Alderman MH., 1993).

Guidelines on managing hypertension have tried to reflect this variation in risk. The attempts vary between an explicit risk matrix according to age, sex, blood pressure, and the presence of major and minor risk factors to a guideline mentioning that "several factors other than diastolic and systolic blood pressure may influence the decision to begin drug treatment" followed by a list of the factors that should be taken into account (Alderman MH., 1993).

2.5 Theories of satisfaction

Most theories which have been put forth to explain patient satisfaction come from or are based on motivation theories which have been developed and mainly used in the

workplace. Maslows Hierarchy of needs was the first theorist who connects the creation of the existence of people's perception with the maintenance of the classified needs (Maslow, 1943). He suggests that human needs are arranged in a series of levels, a hierarchy of important. Maslow identified eight innate needs, including the need to know and understand aesthetic needs and the need for transcendence. However, the hierarchy is usually shown as ranging through five main levels, from the lowest level physiological needs, through safe needs, love needs, and esteem needs to the need for self-actualization at the highest level (Maslow, 1987).

The hierarchy is shown in form of a pyramid that explains the following needs; physiological needs, such as satisfaction of hunger, thirst, sex, and shelter. Security needs include safety and security, freedom from pain or threat of physical attack, protection from danger or deprivation. Love needs refer to social needs; these include good relations with the environment, friendship, and fellowship, to love and to be loved. Esteem needs these include both self-respect involves the desire for self-confidence, strength, independence and freedom and achievement. Esteem of others involves reputation or prestige, status, recognition, attention and appreciation. Self-actualization needs, this is the development and realization of one’s full potential (Mullin, 1999).

Oberst (1984) has also suggested that patients form two groups of expectations, the ideal ones, which one rarely finds in every day conditions, and one group of more realistic expectations which are taken into greater consideration the more the limitations increase. Also significant is the fact that almost all the researchers recognize that expectations are an important factor in the shaping of patient satisfaction.

Donabedian (1980) urged that patient satisfaction is an opinion of the quality of care and represents specific elements of quality, which are mainly related to the expectations and

values of the patient. According to Donabedian, Quality is simply and an attribute that the technical and interpersonal aspects of medical care manifest ii varying degrees. He provided criteria for what constitutes good care, using the framework of structure (related to physical environment and facilities), process (related to interaction with service personnel) and outcome (the result of the interaction). Donabedian developed seven attributes of health care quality.

• Efficacy, (the best result or benchmark for a particular diagnosis).

• Effectiveness, (ordinary medicine, or the industry average).

• Efficiency, (a measure of cost, or the less costly of two identically effective treatments).

• Optimality, (cost-benefit evaluation. or the point at which further resources do not add benefit).

• Acceptability, (adaptation of care to the wishes, expectations and values of patients and their families).

• Legitimacy, (the community's view of care).

• Equity, (the principle by which one determines what is just or fair in the distribution of care and its benefits among the members of a population).

The two factor theory presented by Herzberg Mausner and Snyderman give a possible interpretation to the factors which lead patients to satisfaction or dissatisfaction (Altschul1983; Bond and Thomas1992).

Bond and Thomas (1992), applied Herzberg's theory to explain patient satisfaction with nursing services, contended that patients are satisfied when internal needs are met, such as

the need for interpersonal relations, recognition and participation in decision making, while they become dissatisfied when the environmental factors and amenities which are not the right ones.

The Risser Scale (1975) identified a dissatisfaction factor and drew the conclusion that satisfaction and dissatisfaction are not exact opposites of the same straight line, thus verifying in part Herzberg's theory. The double meaning, which Herzberg gave to satisfaction, is found to be consistent with Jurans definition (1984) regarding quality as the lack of faults or errors (which lead to dissatisfaction) and responding to patient-client needs (which lead to satisfaction).

2.6 Concepts of satisfaction

Client satisfaction is one of the major determinants of project success and therefore is a fundamental issue for construction participants who must constantly seek to improve their performance if they are to survive in the marketplace. However, client satisfaction has remained an elusive issue for a majority of construction professionals. many research studied were done to investigate the performance of construction consultants to determine those key performance attributes which have a crucial impact on client satisfaction, and from that to identify ways of improving the services provided by such consultants (Jianxi Cheng, David G. Proverbs, Chike F. Oduoza, 2006).

Consumers satisfaction, generally defined as the consumers view of services received and the results of treatment has been used for program evaluation to enhance health care providers ability to render services that meet consumers needs (Sheppard, 1993).

The satisfied customer is an indispensable means of creating a sustainable advantage in the competitive environment (Patterson P, Johnson L, Spreng R., 1997). The terms

'satisfaction' and 'quality assessment' are often used interchangeably and while they have certain things in common. Satisfaction is generally seen to be the broader concept and one that can be viewed either at the individual service encounter (transaction) level or at a more global level, encompassing all experiences with an organization (Bitner M, Hubbert A., 1994). Relatively few studies have attempted to define satisfaction or base a definition or their measurement of satisfaction within a theoretical model (Pascoe, 1983) as follow:-

A) Patient satisfaction is a concept partially driven by consumer demands for quality health care and accountability of health care services (Avis et al. 1995, O'Connell et al. 1999; Oermann et al., 2002).

a- Patient satisfaction was measured in general through satisfaction surveys and scientific research studies. There is no standard definition of satisfaction was observed in the literature due to the fact that patient satisfaction is a multidimensional concept that is difficult to be accurately defined and measured (Anderson, Maloney and Bread, 1998).

b- Its utility is based on the notion that, if patients are satisfied, they have in fact received good care. However, problematic this notion may be a search of the health care literature reveals a multitude of references confirming that the concept is in common use.

C- Interestingly, it is not often defined (Williams et al., 1998), but a notable exception is a paper by Strasser and Aharony, (1993) who describe a comprehensive model of patient satisfaction that is organized around a theory of human judgment. They emphasize that patient satisfaction is a perceptual, multidimensional, relativistic, dynamic, patient-centered, attitudinal and individual process.

d- In contrast, when a conceptual definition is not given, patient satisfaction is usually treated as a product. A health care institution strives to 'achieve' patient satisfaction,

usually through responding to concerns raised by individual patient (Chan and Verdile, 1998).

B) Concepts are viewed as changing over time and worldviews (Rodgers, 1989). When clients express their satisfaction with the provided service features this means it responds to their needs. But, customer needs assessments are not equivalent to customer satisfaction surveys (Berwick, 1995). Berwick stated that needs assessments are not limited to existing services, because it will let people understand and determine what they need. On the other hand, customer satisfaction surveys concentrates on how customer perceive the services actually received (Berwick, 1995).

Several studies have used previously tested instruments, while other researchers developed new ones for estimating the optimal level of care and service features. Validation of an instrument is an important issue. The processes start with conceptual relevance, simplicity of instrument and measuring content and construct validity. Whenever the instruments measure what they are designed for, their reliability coefficient is considered to be high and the result could be interpreted with the maximum level of accuracy (Fagerstrom et aI., 2000).

Patient satisfaction is defined by (Bernna, 1995) as the appraisal of the extent to which the care provided has met patient's expectations and preferences. Donabedian (1988) was quite precise in defining the concept of the patient’s satisfaction. Few others have attempted to define the construct at all. Generally, where definitions have been advanced, they explicitly include the patient’s perspective but have referred to the various aspects of care rather than emphasizing the interpersonal process. For example, Goldstein, Elliott and Guccione (2000) stated that patient satisfaction is "a health care recipient’s reaction to aspects of the

service delivered and satisfaction over time which result in overall perceptions of quality of service".

2.7 Patient/client /customer

The literature does not discriminate among the terms patient, client, or customer, as they relate to satisfaction. The three terms are used interchangeably (Webster's, 1991). There are some lists of definitions for the three terms patient/client/customer:-

l- A person who is under medical care or treatment

2- A person or thing that undergoes some action

3- Characterized by or expressing such a quality

7- Able and willing to endure susceptible of client

Satisfaction has been viewed in terms of the relatively stable attitudes and values that patients hold with respect to aspects of their service experience (Fitzpatrick, 1984; Linder-Pelz, 1982a; Pascoe, 1983). Satisfied patients are more likely than unsatisfied one to continue using health care services, maintain relation ships with specific providers and comply with care regimens (Hill, 1997). Patient satisfaction has become an established indicator of the quality of health care despite the abundance of measurement surveys reported in the literature, which show that there are few theoretical underpinnings for this important concept. Analysis of the concept of patient satisfaction gives the potential for uniformed expectation, Crow notes that patients should be educated about appropriate expectation for the care and motivated to judge the quality of care the receiving (Crow ,Gage, and Hampson, 2002). The importance of defining satisfaction concept was stressed by Linder-Pelz who stated that "we need to understand the concept of satisfaction before

we can really explain why certain factors cause it and others caused by it" (Staniszewska and Ahmed, 1999).

Patient may use experience with other providers as comparative markers by which they establish expectations and judge subsequent providers. Their expectation of guilty of care and service are derived from their prior experience. When their expectations are met or exceeded, they state that they are satisfied and when their expectations are not met, they state they are dissatisfied (Faye, 1992).

Virtually every organization is nowadays concerned with satisfying the users of its products or services. They had known as clients, customers, or patients. The subject of satisfaction has been studied extensively in the fields of sociology, psychology, marketing and healthcare management and while the particular focus of interest in each individual discipline tends to be quite distinct, common themes do exist, especially in the approach to satisfaction found in the 'younger' discipline of marketing which draws on conceptual developments presented in the sociology and psychology literatures which called consumer satisfaction (Faye, 1992). Satisfaction is the core of modern marketing theory and practice which is based on the notion that organizations survive and prosper through meeting the needs of customers (Cardozo R., 1965). There has been a proliferation of research on the subject with an estimated 15,000 academic and trade articles published on consumer satisfaction during the past two decades alone (Peterson R.,1992). This interest is due primarily to the fact that for a business to be successful in the long run it must satisfy customers, while simultaneously satisfying its own objectives. The satisfied customer is an indispensable means of creating a sustainable advantage in the competitive environment (Patterson P, Johnson L, Spreng R., 1997).

Consumer satisfaction with healthcare has in recent years gained widespread recognition as a measure of quality, especially since the publication of the 1983 NHS Management Inquiry and its call for the collation of user opinion (NHS Management Inquiry, 1984).
This has arisen partly because of the desire for greater involvement of the consumer in the healthcare process and partly because of the links demonstrated to exist between satisfaction and patient compliance in areas such as appointment keeping, intentions to comply with recommended treatment and medication use (Willson P, McNamara J.,1982) Since high quality clinical outcome is dependent on compliance which, in turn, is dependent on patient satisfaction the latter has come to be seen as a legitimate health care goal and therefore a prerequisite of quality care. Simply, care cannot be high quality unless the patient is satisfied' (Vuori H., 1987). Patient satisfaction is considered one element of the desired outcomes of care. An expression of satisfaction or dissatisfaction is also the patient's judgment on in all aspects of quality of care, but particularly as concerns the interpersonal process. This focused that it is the patient's subjective perspective that is central to patient satisfaction (Ware et al.1983).

It is difficult to define the concept of satisfaction and there is no precise definition of patient satisfaction with physical therapy and any health care services. Pascoe (1983) defined patient satisfaction as "a health care recipient's reaction to salient aspects of the context, process and result of their process experience", Whereas Gerteis et al (1993) defined this concept by examining two distinct domains: the first one is "technical" domain that relate to the skills and techniques of care providers and the effectiveness of the results. The second is "experiential" domain that relate to the subjective perspective of quality based on a patient's experiences with care.

Ware et al (1983) advanced the definition of patient satisfaction concept as an attempt to capture the personal evaluation of care that cannot be known by observing care directly and to consider opinion of patients as a multidimensional subjective indicator of quality of care.

2.8 Measurement of patients' satisfaction

Measurement of patient satisfaction has become a common way to elicit patients' views of their health care. However, difficulties arising from the limited theoretical underpinning of satisfaction, the difficulty in defining expectations and satisfaction and the methodological problems associated with their measurement have cast doubt on the validity of studies (Staniszewska S, Ahmed L., 1999) How should we measure patient satisfaction? First, understand why we should measure it. Measuring patient satisfaction helps us to identify patients' expectations. Expectations are important because patients' judge the quality of the care they receive based on their internal standards of what defines quality. These internal standards are based in expectations. In addition, it allows us to learn about patients' perceptions of our service. By understanding their expectations and perceptions, we can begin to bridge the gap between how health care providers and patients define quality service (David P. Tarantino, 2004). Patients' perceptions of the quality of care and service they have received are based on two factors. The first one is their expectations of the service and the second one is their perceptions of the actual service they received. By using these two factors we have the ability to measure patient satisfaction truly (David P. Tarantino, 2004).

Patient satisfaction is an essential issue of service quality in health care organizations that discussed by Strasser and Davis (1991); Gann and Restuccia (1994) who considered that quality as perceived by the health care recipient is vitally important aspect. As a result of

this new focus, measurement of customer satisfaction has become equally important. From a management perspective, patient satisfaction with health care is important for various reasons. First, satisfied patients are more likely to maintain a consistent relationship with a specific provider. Second, by defining sources of patient dissatisfaction, an organization can address system weaknesses and shortness, thus improving its risk management (Dansky and Miles, 1997). Third, satisfied patients are more likely to follow and implement specific medical regimens and treatment plans. Finally, patient satisfaction measurement adds important information on system performance, thus contributing to the organization's total quality management. Gadallah et al., (2003) suggested that health service quality has three domains: client quality, professional quality and management quality. Client quality is the domain that receives most attention in discussions of quality of health care based on how satisfied clients are with their care. So, the real challenge is to improve staff performance and patient satisfaction in order to minimize rework, wastage, delay and costs.

Most definitions of patient satisfaction include the elements of subjectivity, expectations, and perceptions. The subjective nature of patients' evaluation of care was reported by Pascoe (1983) who defined patient satisfaction as a comparative process involving both a cognitive evaluation and an effective response to the structure, process, and outcome of services.

As a subjective assessment of the quality of health care, satisfaction represents a complex mixture of perceived need, expectations of care, and the experience of care (Wilkin et al., 1992). Patient satisfaction is influenced by the degree to which care fulfills expectations (Ferrans et al., 1987) and expectations have been defined as those responses that are influenced by environmental factors, past experience, and properties of the situation

(Frank, 1968). The challenge in measuring patient satisfaction is to 'define the facets of patient satisfaction and the possible stimuli, value judgments, and dispositional and experiential moderators that influence these reactions. To do this well, the patient satisfaction researcher and the health care manager must allocate a great deal of time and thought to this process' (Strasser and Davis, 1991). As a result of their review of the literature. Ware et al., (1978) developed taxonomy of patient satisfaction with eight dimensions art of care , interpersonal manner, technical quality of care, accessibility, convenience, finances or how the service is paid for, physical environment, availability of providers, continuity, and efficacy/outcomes.

In an attempt to develop a theory of patient satisfaction based on social psychology and job satisfaction theories, Linder- Pelz (1982a) defined patient satisfaction as 'positive evaluations of distinct dimensions of the health care (The care being evaluated might be a single clinic visit, treatment throughout an illness episode, a particular health care setting or plan, or the health care system in general)' Linder-Pelz (1982a) identified ten constructs that are very similar to Ware et al (1978) accessibility /convenience, availability of resources, continuity of care, efficacy/outcomes of care, finances, humaneness, information gathering, information giving, pleasantness of surroundings, and quality/competence. Linder-Pelz (1982b)found no support for a number of hypotheses she tested based on the original job satisfaction theory. The findings revealed that values did not directly explain much of the variance of satisfaction and that expectations explained only 8% of the variance of satisfaction.

One factor that can account for variation in patient perceptions of hospital care is differences in the measures of satisfaction. The patient satisfaction surveys developed by the Picker Institute focus on “experience of care” and take a problem-oriented approach,

asking questions about what did or did not happen during the hospitalization with regard to various aspects of care (Cleary, et al., 1991). Other satisfaction surveys take a “satisfaction with care” approach, asking the individual to rate their satisfaction with various aspects of care while they were hospitalized (Finkelstein, et al., 1998; Kane, et al., 1997; Marshall, et al., 1996). These two approaches to assessing patients’ views of their hospital experiences may reflect the two complementary but sometimes conflicting goals for developing such information, quality improvement by hospitals and public reporting for use by consumers. Measurement of patient satisfaction fulfils three distinct aspects: understanding patients' experiences of health care, identifying problems in health care, and evaluation of health care. Evaluation is regarded as the most important dimension (Sitzia and Wood, 1997).

Superficially, the question about satisfaction itself is strange, for given that the fundamental raison of the doctor is to serve the needs and wishes of the patient and work towards the good of the patient (Rheinhardt V., 1987). Understanding of patients' concerns and interests is central. One would have thought that assessing satisfaction would be a natural sequel, but less than a decade ago Ware el al felt obliged to defend their 'strange' preoccupation with patient satisfaction: 'even the most conservative critique of the literature would conclude that there is some evidence for the usefulness of the satisfaction concept in predicting what people do at a very general level (e.g. total consumption of health and medical care resources) and at the specific level (e.g. appointment keeping) Ware JE, Synder MK, Wright WR, Davies AR., (1983). Nowadays satisfaction with care had already been established as an important influence in determining whether a person seeks medical advice, complies with treatment and maintains a continuing relationship with a practitioner (Larsen DE, Rootman I, 1976). Direct associations had also been found with therapeutic outcomes and health status, although it is not yet established whether this is due to the therapeutic value of the doctor-patient relationship or to social aspects of

healing. Kincey J, Bradshaw P, Levy P., (1975) showed that satisfaction with information is significantly associated with subsequent compliance. There are also political reasons for the growing interest in the patient's views. In principle, if the perspective of the patient were to be given more importance, this would help to counteract the medical hegemony (Speedling EJ, Rose DN., 1985). The dominant political theme in the United Kingdom, however, has been the emphasis placed on consumer sovereignty; health care provision is expected to be shaped by (potential) patients' demands and preferences (Griffiths R., 1989*).* In this mode, consumer satisfaction would be considered as an outcome of the health care process. However, to be used in this mode, measured consumer satisfaction has to be sensitive to variations in the quality of the service provided. This criterion would exclude the routine use of in-patient questionnaires, as respondents to a standard questionnaire in the United Kingdom are typically 85-90 percent satisfied (Raphael W., 1979). In an attempt to explain more fully these differences and contradictions, researchers are taking a broader view of the term ‘expectations’, realizing that consumers can and do hold several different types of expectation and that these are characterized by a range of levels, rather than a single level.

As LaTour and Peat have observed, using expectations only in the sense of ‘what will happen’ leads to logical inconsistencies such as predicting that a consumer who expects, and subsequently receives, poor performance will somehow be satisfied (LaTour S, Peat N., 1979). In terms of services, Zeithaml V, Bitner M., (1996) distinguish between three types of expectation. The first is desired service, defined as the level of service the customer hopes to receive, the ‘wished for’ level of performance blending what the customer believes ‘can be’ and ‘should be’.

Customers hope to achieve their service desires but recognize that this is not always possible and for this reason they hold a second lower level expectation, adequate service, representing the 'minimum tolerable expectation' or bottom level of acceptable performance. Finally, predicted service is the level of service customers believe they are likely to get and implies some objective calculation of the probability of performance. Zeithaml and Bitner argue that customers recognize that service performance may vary and that the extent to which they recognize are willing to accept this variation is called the zone of tolerance (Zeithaml V, Bitner M., 1996). In theory predicted service could equate with either adequate or desired service but is most likely to fall between the two and hence within the zone of tolerance. The zone of tolerance is seen as the range or window in which customers do not particularly notice service performance. When performance falls outside the range (either very high or very low) the customer expresses satisfaction or dissatisfaction. Customer tolerance zones are thought to vary for different service attributes and the more important the factor, the narrower the zone of tolerance is likely to be (Parasuraman A, Berry L, Zeithaml V., 1991).

2.9 Quality of services

The terms 'satisfaction' and 'quality assessment' are often used interchangeably and while they have certain things in common, satisfaction is generally seen to be the broader concept and one that can be viewed either at the individual service encounter (transaction) level or at a more global level, encompassing all experiences with an organization (Bitner M, Hubbert A., 1994).

Perceived quality is just one of a number of antecedent factors driving satisfaction. This can be illustrated by the observation that quality perceptions can occur in the absence of actual experience with an organization (Zeithaml V., Bitner M., 1996). Quality of health

care in developing countries usually is defined by health care providers from technical perspective. Recent literature however emphasizes the importance of patient's perspective in assessing quality of health care (Andaleeb, 2001). Nowadays, the recognition of quality of health care as perceived by patients is actually important indicator as a result of this new focus, measurement of patient satisfaction has become equally very necessary. Although, the world of health care is changing and improving, but in developed countries the body of satisfaction research still limited and few data about patients satisfaction still needed (De Gyndt, 1995). In Palestine, Massoud (1994) pointed to the improvement of quality of health care is the main and important component in the Palestinian health care sector. According to analysis of quality of health care services, he illustrated that there is weakness and shortage in health care system which reflected inefficiency in this system. Generally, he emphasized that the concept of patient satisfaction is very rarely used in health care system and this lead to dissatisfaction of people about health care services in Palestine

Health professionals increasingly accept that patients' views on the quality of the services provided are important and that high-quality care comes from marrying patients and professionals' perspectives (Blumenthal D., 1996).

As health care delivery systems experience unparalleled economic and competitive challenges, they have adopted quality improvement principles to improve their economic situation, with a particular focus on patient-centered care and consumer satisfaction. Patient satisfaction, along with outcomes and costs, has become an important measure of health system performance. Recent use of patient satisfaction surveys has stirred controversy (Blumenthal D, Epstein AM., 1996). The delivery of quality health services is central to improving the health status of the population and results in decreased case

fatality rates and complication rates. Efforts to improve quality are particularly relevant in resource-constrained settings. Furthermore, satisfied patients and clients are more likely to follow advice and prescribed treatments. This becomes increasingly important in situations where the prescribed therapy is complex (WHO, 2003). Initial attempts to improve quality often took place on the basis or were linked to vertical programs. Early experience showed that it is relatively easy to improve structural and organizational aspects of quality of care, tackling technical quality including supervision and staff-patient interaction is more difficult – particularly in chronically underfunded health systems (WHO, 2003). Patients do not all think alike, nor do they judge quality in the same way, any more than health professionals (Williamson C. A., 1995). Health care managers seek to improve overall system effectiveness by strengthening their value chain, thereby increasing customer retention and market share. Better knowledge of conditions in the work environment that drive service-quality excellence and customer satisfaction is valuable to healthcare managers. It is becoming clear that strategic human resource practices that result in high performance work environments are linked with important organizational outcomes such as service quality, customer satisfaction, and loyalty in a wide variety of commercial industry contexts (Dean, 2004). Evidence also is accumulating that customer-oriented work climates produce superior service quality and customer satisfaction, operating independently or in conjunction with high-performance human resource practices in proprietary firms in retail services industries (Schneider, White, and Paul, 1998). Disconfirmation theory proposes that, all things being equal, the higher one's expectations, the less likely that service or product performance can meet or exceed them, the result being reduced satisfaction or even dissatisfaction; the higher the perceived level of performance, the more likely that expectations will be exceeded, resulting in increased satisfaction. This has led some observers to recommend deliberately under promising the

service to increase the likelihood of meeting or exceeding customer expectations (Davidow W, Uttal B., 1989). Zeithaml V, Bitner M., (1996) argue, however, that while under promising makes expectations more realistic thereby narrowing the gap between expectations and perceptions; it may also reduce the competitive appeal of the offer. Research also indicates that under promising may have the inadvertent effect of lowering customer perceptions especially in situations where consumers have little experience with a product or service (Boulding W, Kalra A, Staelin R, Zeithaml V., 1993). In addition, there is evidence to suggest that raising expectations prior to use often results in increased perceptions about performance even though the product or service may have performed poorly (Olson J, Dover P., 1979).

In this latter instance expectations are influencing satisfaction independently of perceptions, an effect which has been explained by the assimilation-contrast theory. This theory combines elements of Festinger's theory of cognitive dissonance Festinger L., (1957) which holds that when an individual receives two ideas which are dissonant, he or she attempts to reduce this mental discomfort by changing or distorting one or both of the ideas to make them more consonant. Disconfirmation theory suggests that when perceptions of attribute performance differ only slightly from expectations, there is a tendency for people to displace their perceptions toward their expectations - the assimilation effect. There comes a point either side of this range though where people can no longer effect displacement and instead they begin to exaggerate the increasingly large variation between perceptions and expectations — the contrast effect. A number of studies have also found that the effects of expectations differ under different conditions between consumer groups, across different product categories (high against low consumer-involvement products), and between products and services (Anderson E., 1994).

Quality of care continues to be a major concern for health care providers and a major focus for health services research (Brook RH., McGlynn EA., 1991). Although many operational definitions of "quality of care" focus on the personal knowledge, skills, and expertise of the clinician rather than on other aspects of the treatment experience and patient satisfaction, in our opinion, constitutes a dimension of care outside of the physical therapist's immediate control. Yet, technical quality and patient satisfaction are synergistically linked to influence the outcomes of care. Ellwood and Paul Ellwood PM Jr, Paul BA., (1986) imply, for example, that dissatisfied patients are less likely to use professional advice, thus undermining both primary and secondary prevention. Therefore, in light of the hypothesized relationships among the technical expertise of the care provider, the experience of the person receiving the care and how that person values care, and measures of outcomes of the care provided, any comprehensive formulation of an operational definition of "quality" in health care should state that patient satisfaction is a necessary construct (Donabedian A., 1988).

2.10 Patient outcomes and characteristics

Differentiating the performance attributes of physician and non-physician providers is important to advanced practice nurses. Such characteristics are important in determining the acceptance of the non-physician role. Horrocks, Anderson, & Salisbury (2002) found that nurse practitioners (NPs) provide care that promotes increased patient satisfaction and similar health outcomes when compared with care from physicians. Nurse practitioners provide a quality of care that is at least as good and in some ways better than physicians; they are known for longer consultations, more investigations, identification of physical abnormalities, providing more information, more complete documentation in the medical records, and offering more advice on self care than did physicians (Horrocks et al., 2002).

Although such characteristics make a difference in patient satisfaction, this prospective observational review found no significant differences in overall health outcomes of patients treated by physician and non-physician health care practitioners. Venning et al., (2000) also supported the finding increased satisfaction has been linked with longer consultations and NPs have been shown to spend longer with patients than general practitioners.

Hooker and McCaig (2001) also conducted a study to evaluate characteristics of the NPs and Pas (Nurse Practitioners) role in delivering traditional physician-type services. The physician group was more likely to order two or more tests than were PAs alone. Therapeutic and preventive services, which include counseling/education and other non-medication therapy, were ordered or provided during a higher proportion of NP-only visits than during PA-only or physician-only visits. There was no difference in the mean number of diagnostic screening services, therapeutic and preventive services, or number of medications ordered or provided by provider group. The mean duration for visits during which only a physician was seen (17.3 minutes) was lower than for visits in which a physician and a PA or an NP were seen (21.3 minutes). The results of this study are encouraging for the use of PAs and NPs in medically underserved areas.

Another issue is patient perception of the healthcare visit. Hooker, Potts, and Ray (1997) conducted a study to evaluate patient satisfaction with care as managed by different types of providers as physician assistants, nurse practitioners, certified nurse midwives (CNMs), and physicians. The researchers mailed questionnaires to members of a large health maintenance organization who visited medical offices in any of five medical specialties during 1995 or the first half of 1996. Mean scores were generated for patient ratings of each of eight provider attributes, by provider type. Scores were then compared to find

satisfaction reported by 89% to 96% of patients of PAs, NPs, CNMs, and physicians with regard to courtesy, understanding of problem, ability to explain, use of understandable words, listening, time spent, and confidence in provider. Clinicians in orthopedics and in obstetrics and gynecology scored slightly higher than did primary care clinicians.

No statistically significant differences were seen between providers by type, age, gender, or length of employment. Patient satisfaction with interpersonal care appears to depend on communication and style and not on type of provider.

Kelvin et al., (1999) conducted a review of the literature and personal perspective due to the need to explore new ways of achieving high quality patient care in radiation oncology. One thought was to rely on non-physician practitioners such as the advanced practice nurse (APN) and physician assistant (PA). Kelvin emphasizes that the non-physician practitioner is not a replacement or substitute for either a resident or a radiation oncologist. Instead, this role is a complementary one. The non-physician practitioner can assist in the diagnostic work-up of patients, manage symptoms, provide education to patients and families, and assist them in coping. This support facilitates the physician's ability to focus on the technical aspects of prescribing radiotherapy.

Chang et al., (1999) conducted a pilot study to investigate whether nurse practitioners are able to provide sufficient levels of primary care service in remote or isolated settings; the focus was wound management and treatment of blunt limb trauma. It was hypothesized that there would be no significant difference in either the quality of care or the level of client satisfaction whether care was provided by physicians or nurse practitioners. The study used a randomized trial design and collected both qualitative and quantitative data. Two hundred and thirty-two clients participated in the study. Participants were distributed between nurse practitioners and medical officers (n=169); 91 were randomized to medical

officers and 78 to nurse practitioners. Telephone interviews were conducted to evaluate client satisfaction. The results indicate that, as hypothesized, there were no significant differences between the two groups in relation to client satisfaction. Positive treatment outcomes were seen across groups in the study. The study also found that there was strong support for the role of the nurse practitioner in the rural emergency setting.

Kinnersley et al., (2000) conducted a randomized controlled trial with patients allocated by one of two randomization schemes (by day or within day) to determine differences between nurse practitioner and general practitioner care as perceived by patients seeking "same day" consultations in primary care. Participants (n=1368) were recruited from 10 general practices in south Wales and southwest England. Main outcomes measured were patient satisfaction, resolution of symptoms and concerns, care provided investigations, referrals, recall, and length of consultation. This study supports the wider acceptance of the role of nurse practitioners in providing care to patients requesting same day consultations. Generally patients consulting nurse practitioners were significantly more satisfied with their care than those of general practitioners.

Mundinger et al., (2000) conducted a study to compare the care given by nurse practitioners and physicians. This study utilized four community-based primary care clinics (17 physicians) and one primary care clinic (7 nurse practitioners) at an urban academic medical center to compare outcomes of patient care, follow-up and ongoing care after an urgent care visit. The nurse practitioners had the same authority, responsibilities, productivity, population, and administrative requirements as the physician group. Patients without a primary care provider were randomized from a local tertiary care facility into either the nurse practitioner practice or the physician practice. Data were collected about patient satisfaction and health status in addition to disease-specific physiological

measurements such as blood pressure for hypertensive patients, peak flow measurements for asthmatics and glycosylated hemoglobin's for diabetics. These measurements were performed at six-month and one-year intervals after the initial visit to one of the clinics. The researcher found no significant differences in patients' self-reported health status between the two groups. Additionally, no significant differences were found with physiological measurements for diabetic and asthmatic patients. The patients with hypertension in the nurse practitioner group had significantly lower diastolic blood pressures compared to those in the physician group. There were no significant differences in diabetic patient's glycosylated hemoglobin level between groups, nor were there significant differences found in satisfaction after the initial contact with the physicians or nurse practitioners. They did find a significant difference in provider attributes, such as personal manner, and time spent with the patient, which was rated higher for the physician group. This study indicated that care provided by the nurse practitioner, with the same authority, responsibilities, productivity and administrative requirements as the physician were comparable (Mundinger et al, 2000).

2.11 The relationship between hypertension and satisfaction

Education of patients with various diseases, including hypertension, usually occurs at an individual level through a patient's doctor as well as via various media campaigns, which also includes general community education. To evaluate their effects, the knowledge of 84 patients with hypertension was evaluated by a simple 13 question true/false questionnaire and the results compared with 58 normotensive subjects matched for sex, age and educational status. A significant difference in knowledge about hypertension could not be elicited between the two groups even when compared for sex or educational status. However, subjects > 70 years of age (hypertensive's and controls) demonstrated a lower

level of knowledge ($P < 0.05$). Further questioning of the hypertensive group elicited a high level of satisfaction with their doctor's educational skills (68%) and 57% were satisfied with their own knowledge. Nevertheless, 70% requested more information about their disease. These results suggest a reasonable level of knowledge within the general community presumably reflecting community education programs. While hypertensive patients were not more knowledgeable under the test conditions, they were reasonably satisfied with their knowledge which they stated came primarily from their doctor (CarneyS; Gillies A; Smith A; Taylor M, 1993).

Hypertension is a silent killer that has become a chronic medical condition confronting the world. Although the evidence recognizes the effectiveness of hypertension-lowering medications, they will not work unless patients adhere to the protocol. Research has found a low medication compliance rate among hypertensive patients, which leads to the lack of sufficient hypertension control and adverse consequences. Medication compliance requires ongoing efforts at an individual level. Based on the Health Belief Model, a set of individual beliefs including self-efficacy, perceived severity, perceived benefit, perceived barrier, perceived susceptibility, and cues to action, is predicted to have an impact on medication compliance. Importantly, we propose that the interrelationship between healthcare providers and patients such as trust and satisfaction have positive influence on medication compliance. While researchers have studied the effects of beliefs, trusts, and satisfaction on medication compliance, these constructs have never been examined simultaneously in one study. This research proposes a theoretical model that positions beliefs, trusts, and satisfaction as antecedents of medication compliance. We also propose trust as an antecedent to medication compliance is mediated by satisfaction.

We expect that this theoretical model can shed clearer light on the literature of medication compliance. Moreover, the empirical results of this model might provide some

implications on the need for a trusting and satisfied relationship between the healthcare providers and patients (Bron A, Baudouin C, Denis P, Nordmann JP, Renard JP, Rouland JF, Sellem E , 2008).

Hypertension is a growing health concern for American adults. In a study focused on community knowledge and satisfaction of hypertension education, researchers compared the knowledge and satisfaction of 84 hypertensive individuals with that of 54 normotensive subjects matched for age, gender and educational level. The results of a thirteen-question survey concluded no difference in the level of education of hypertension between the two groups. Additional questioning of individuals within the hypertensive group suggested a 68% level of reported satisfaction with the hypertension information obtained from their primary care physician and a 57% level of satisfaction with participants' knowledge of the disease. However, 70% of the participants requested additional education on the subject of hypertension as well as other health issues. As a result, researchers supported the need for community based health education programs, and attributed the lack of educational difference between the two groups as well as the high level of reported satisfaction to community based education (Carney et al, 1993).

The compliance of hypertensive patients and patients' knowledge and misconceptions about hypertension were investigated in a cross-sectional study of all hypertensive patients (190) attending four primary health care centers in Al-Khobar, Saudi Arabia. The mean age was 49.9 ± 11.7 years. The overall compliance rate was 34.2%; the rate was lower in those aged < 55 years than older patients (26.2% versus 48.5%; $P < 0.001$). It was also lower among educated than illiterate patients (30.4% and 38.1% respectively; $P < 0.001$). About 44% of patients thought that they should stop drug treatment once they achieved blood pressure control and 66.3% believed that emotional stress was the most important

etiological factor in hypertension. The findings indicate that there is a clear need for health education of hypertensive patients (L.S. Al-Sowielem and A.G. Elzubier , 1998).

Hypertension is a common disease and Community surveys in industrialized countries have shown a prevalence of 15%-38% in people aged 30 years (Burt VL et al. 1995). The disease continues to be a leading cause of morbidity and mortality of coronary artery disease and stroke (Selmer R.1992). Achieving and monitoring control of the disease is a problem that is shared by the patients and their physicians. An important issue in failure to control hypertension is low compliance with treatment, which remains a universal problem (Clark LT., 1991).

Compliance involves not only taking the prescribed medications but also adherence to follow-up appointments and maintaining the recommended lifestyle modifications. Furthermore, the patient should be an active participant in the plan of care. Patients' knowledge of hypertension and its complications is an important factor in achieving better compliance, and hence control. A study carried out in Al-Khobar showed a considerable lack of knowledge among patients with hypertension attending the cardiology and nephrology units in a teaching hospital (Al-Khadra A, Al-Muhana F, Ibrahim I., 1991).

High blood pressure is the leading risk factor for mortality around the world (Ezzati M, Lopex AD, Rodgers A, et al., 2002). Over a decade ago, the Canadian Heart Health Survey reported that 42% of Canadian adults with hypertension were unaware that they had the condition and that only 16% of cases were treated and controlled (Joffres MR, Ghadirian P, Fodor JG, et al., 1997). More recent studies in the United States Hajjar I, Kotchen TA. (2003) and England Primatesta P, Poulter NR.(2006) have reported improved awareness, treatment and control among adults with hypertension. In addition, increased initiation of hypertensive educations among elderly patients (Tu K, Campbell NR, Duong-Hua M,

et al., 2005), and increased use of polytherapy for treating hypertension have been reported (Campbell NR, McAlister FA, Duong-Hua M, et al., 2007). Given that blood pressure control has been shown to reduce mortality, one might expect that enhanced awareness and treatment of hypertension has led to improvements in mortality among patients with this condition. Greater survival of patients with hypertension would contribute to an overall increase in the prevalence of hypertension. In another article in the issue of CMAJ, they report that the prevalence of diagnosed hypertension among adults increased by 60% from 1995 to 2005, which greatly surpassed prior projections for the developed world (Tu K, Chen Z, Lipscombe LL., 2008).

Ethnicity plays a major risk factor in the development of hypertension. Jonathan D, et al. conducted a study to examine the association between skin color and blood pressure in 835 Egyptian adults (370 men and 465 women) participating in the National Hypertension Project, a national survey of hypertension prevalence and blood pressure– related complications conducted in Egypt during 1991–1993. Skin color was assessed by measuring the concentration of cutaneous melanin in an unexposed area with the use of reflectance spectrophotometry. Higher concentrations of melanin were associated with lower body mass index, less education, manual labor (among men), and a lower urinary sodium-to-potassium ratio (among women). In multivariate regression analyses adjusted for age, body mass index, and education, there was a significant nonlinear association between blood pressure and skin color among women; in the lower to intermediate range of skin pigmentation, both systolic and diastolic blood pressures were higher in women with greater concentrations of cutaneous melanin. In men, blood pressure was not associated with skin color. When we used a subjective assessment of skin color, there was no significant difference in blood pressure between black-skinned Egyptians (predominantly of Nubian descent) and fair-skinned Egyptians for either gender, While the

significant relationship in women appeared to be independent of known risk factors for hypertension, residual confounding may explain the association (Jonathan D. Mosley; Lawrence J. Appel; Zeinab Ashour; Paul K. Whelton; M. Mohsen Ibrahim , 2000).

Earlier studies have demonstrated significant associations between sociodemographic characteristics and patient satisfaction, suggesting that lower satisfaction is associated generally with being younger, female, and more educated (Khayat K, Salter B., 1994). Yet, the magnitudes of these associations are generally small, with correlations 0.14. Because healthcare institutions often use patient satisfaction with treatment as a benchmark for healthcare quality (Barr JK, Giannotti TE, Sofaer S, Duquette CE, Waters WJ, Petrillo MK., 2006).

2.12 Clients' satisfaction with care in different health care settings

Goupy, Gires and Massicot (1996) measured patient satisfaction in eight hospitals in France and compared the results from the year of 1989 to the year of 1995. Satisfaction was measured with four coding scale (very, enough, insufficiently, poorly). The results showed that in general, in 1995, for in-patient care, the study showed high satisfaction with the care received from physicians and nurse (77% and 82% of patients were "very satisfied"). Good satisfaction with cleanliness and comfort (64% and 55%) and moderate satisfaction for quietness and for time schedule and the quality of meals (47%, 47% and 37%). Also, they was reported for out- patient care, the study confirmed high satisfaction with the information given and the time spent by physicians and kindliness of personal (73%, 69% and 71% of patients were very satisfied) and moderate satisfaction with comfort and waiting time (39% and 31%). Time comparisons for six years interval showed decrease of satisfaction (3%-1%) except for nursing care and cleanliness. The possible

explanation could be increased patients demand and expectations (Goupy, Gires and Massicot, 1996).

Simic et al (1996) assessed the level of patient satisfaction in hospital in Belgrade. The study involved 298 patients discharged from hospital wards during two weeks period. A self-administrated questionnaire included 44 questions was distributed as postal survey. The overall response rate was 64.4%. The results showed a very high general satisfaction level (40.6% very and 51.3% mostly satisfied) (Simic et al, 1996).

Also Backhouse and Brown (2000) explored the patient satisfaction in a 26 bedded rehabilitation unit situated within a large general hospital. Most of the patients admitted are recovering from recent cerebrovascular accident. 67 questionnaires were sent out, of which 38 were returned. The finding showed that there was a quite a striking correlation between primary nurses, 76% of respondents satisfied from primary nursing care. Questions about satisfaction with information related mainly to information given about individual plans of care and progress towards recovery, 54% of respondents were satisfied with the information they received.

A study published in 1982 measured the level of satisfaction with maternity care, and to determine whether satisfaction was related to patterns of communication between patients and staff and to specific clinical procedures used in labor and birth. A questionnaire consisting of 60 structured questions was mailed to patients approximately 60 to 90 days postpartum. Although the results demonstrated widespread satisfaction with maternity care, 93% of the respondents were satisfied or very satisfied, there were 500 unsolicited comments on the questionnaires. Many of the women offering highly negative comments still checked off "satisfactory" in response to the question evaluating overall labor and delivery care. This apparent discrepancy emphasizes the importance of including open-

ended questions on a survey consisting mainly of forced- choice statements (Sulivan and Beeman, 1982).

Another researcher like Clark, Pokomy and Brown (1996) was assessed patient satisfaction with nursing care in a rural hospital emergency department. A total of 64 questionnaires were distributed. There were 52 usable questionnaires returned from subjects, for a return rate of 81%. Findings indicated that patients were satisfied with nursing care. No statistically significant effect of gender or education level on consumer satisfaction or on any subscale was detected, but African American consumers were less satisfied with discharge teaching than white consumers' holds implications for nursing practice. Nursing staff may need to spend more time with rural African consumers (Clark, Pokorny and Brown 1996).

Lieberman and Wysenbeek (1996) investigated clinical variable related to patient satisfaction in the out- patient clinic. Sixteen clinics were investigated according to the frequency of visits. The investigators assessed each clinic at three occasions, on different days of the week and at different hours. The following variables were assessed: waiting time, reception office, clinic secretary, medical and nursing quality as perceived by the patients, and the clinic's physical facilities (public areas, rest rooms etc). There were significant differences from "satisfied" and "unsatisfied" patients on the univariate analysis of the variables. On multiple regression, variables significantly related to patient satisfaction in descending order of statistical significance were, clinic secretary, waiting time, medical and nursing quality and reception office, while the clinic's physical facilities were not significantly related to patient satisfaction (Lieberman and Wysenbeek, 1996).

Some researchers assessed patients' satisfaction in out-patient and in-patient settings, such as, study conducted by Kersnik (2000) described the level of patient satisfaction with

family practice in Slovenia. The researcher used an internationally developed instrument for patients' evaluations of general practice care, 36 representative family practices settings were allocated. A total of 2160 questionnaires were distributed on the 60 consecutive selected patients in every practice to fill a self-administered questionnaire and by using the 5-point Likert Scale for the items in the questionnaire. The results showed that 58.2% of the respondents rated the level of care received as excellent. Participants were less satisfied with the perceived time during the consultation (51.6%) and with the connectional aspects of care; the feelings that family practitioners showed interest in their personal situation (46.5%); the feeling that family practitioners made it easy to explain problems (49.1 %). The poorest rating was with their satisfaction with the waiting time in the waiting room (26%). On the other hand, patients showed higher satisfaction with the confidentiality of medical records (77%); listening capacity of their family physicians (69.4%); being able to speak to the family practitioners on the phone (72%), so organizational changes to shorten waiting time in the waiting room and greater concentration to improve communication skills were reported (Kersnik, 2000).

Abu Saileek (2004) conducted a study aimed to assess the level of clients' satisfaction with nursing care provided at selected hospitals in Gaza Strip, and recognized the major domains regarding clients' satisfaction that related to some organizational and demographic variables. The study was established at the two major governmental hospitals in south of Gaza Strip, European Gaza hospital and Nasser hospital. The author was used across-sectional design with systematic randomized sample. Standardized structured questionnaire was developed. A total of 427 clients admitted to medical and surgical wards and receiving nursing care during hospitalization, 159 clients from European Gaza hospital and 268 clients from Nasser hospital. The response rate was 93.6%. SPSS was used to analyze data. The study identified six domains of satisfaction with nursing care including; information

and interaction, availability/attentiveness and openness, comfort and environment, nurses skills and professionalism, organizational culture, counseling and advising. The results showed that there is significant relationship between the service provider and satisfaction level. Overall satisfaction was 70.1% in both hospitals. The clients' in European Gaza hospital reported higher satisfaction 84.2% than the clients' in Nasser hospital 61.7%. The study concluded that the demographics, soci-economic variables including age, place of living, marital status, income, and education level showed a great influencing on the level of satisfaction. Also, the type of institution and organizational variables including the payment of medical care, referral source, previous hospitalization in other hospitals, admission days, medical diagnosis groups, and choosing the same hospital in the future showed a significant relationship on the level of client's satisfaction. On the other hand, gender, and the ward showed no significant relationship on the level of client's satisfaction with nursing care. Finally, the study provided some information to improve the quality of nursing care services that led to improve the level of clients' satisfaction with nursing care. (Abu Saileek, 2004)

Aldaabsa (1995) assessed patient expectation and satisfaction with health services, the study was conducted at Al-sareeh and Jordan University of Science and Technology Health Centers in Irbid city (north Jordan). A cross sectional survey of a convenient sample of 310 patients was carried out to assess the relationship between patients' satisfaction (PS) and expectation of health services which they receive. The study subjects were included in one exposure group. In order to measure patients' expectations, each patients was exposed to video clips of selected patient provider encounter i.e. privacy, confidentiality, respect, caring and concern about feeling, explaining medical problem, explaining medical procedure and treatment plan and thoroughness of the health provider. The video clips were prepared for this purpose. To measure patients' satisfaction at each group, a self

administered patient satisfaction questionnaire was distributed to patients. The study results showed that at both health centers, there were higher expectation levels among adolescent patients, female patients, patients with ten years or more of education and patients who had more frequent visits at the health center were found. However, family income was differently related to patient expectation at each center. At Al-Sareeh health center, patients with a monthly income less than JD250 had higher expectations than patients with higher monthly income and the opposite was true for the second health center. It was also found that at both health centers, there were lower satisfaction levels among adolescent patients , patients with ten years or more of education , patients with an income of JD 250 or more and with less frequent visits at the health centers . However, sex was differently related to PS at each center. At Al-Sareeh Health Center, males had higher satisfaction levels than females and the opposite was true to the second center. The study results also showed that the patient satisfaction and expectation were poorly inversely related with Person correlation coefficient of -0.29 to -0.366 but statistically significant (Aldaabsa, 1995).

A client satisfaction survey was undertaken on an adult psychiatric admission ward in Sheffield, England, being sent to all clients discharged from the ward over 12 months. The questionnaire consisted of a general satisfaction element, and two questions asking about satisfaction with nursing communication. The response rate was 81 from 199 forms sent. General satisfaction levels were lower than for a sample of 3120 mainly out-patient psychiatric clients in the USA. Satisfaction with nursing communication was significantly correlated with general satisfaction. The survey allowed the number of dissatisfied clients to be identified, and their views highlighted one aspect often reported by dissatisfied clients was a perceived lack of time from staff. The importance of nursing communication with respect to client satisfaction is highlighted by the study (Ricketts, 1996).

2.13 Client's satisfaction with health care services in Palestine

Massoud (1994) reported that there is general dissatisfaction among public and professional regarding quality of health care in Palestine. A study conducted by the department of quality of health care in Gaza and West Bank in Palestine in 1999 to evaluate clients satisfaction people with health care services and to assess the level of awareness of the Palestinian people with their rights in the health sector. The level of patient satisfaction with radiology services was assessed as a part of the study. The results revealed that only 13% of attendants showed high satisfaction with radiological services. There is 33.5% of the attendants did not use the radiology services (Massoud, 1994).

Also the study recommended further specific studies to assess the level of satisfaction with diagnostic services with more details, accuracy and depth. In addition to that it recommended studied to explore factors that may influence satisfaction of patients (Abu Dayyah, 2000).

Mousa (2000) investigated the level of clients' satisfaction with family planning services in Gaza Strip in Palestine. The researcher selected a random sample of 377 by systematic sampling technique. Self administered structure interviewed was used in this study. The response rate of clients' attending United Nation Relief and Works Agency (UNRWA) clinics was 96.5%, while the response rate of clients' attending MOH clinics was 79.6%. The researcher identified five dimensions of clients' satisfaction which are attitude and perception, information and counseling, communication and interaction, interpersonal relationships and mechanism and delivery of care. The overall satisfaction level of the family planning services provided by the two major provides (MOH and UNRWA) was 72%. Clients' attending UNRWA clinics were more satisfied of the services they received in comparison of the client attending MOH clinics. Whilst high satisfaction level was

found with the information and counseling process (8.9%), the least satisfaction level was with the process of communication and interaction (54%). Moreover, the findings reported that the younger clients' were more satisfied of the services they received than old age group, high educated clients' showed a higher level of dissatisfaction than clients' with lower level of education, clients living inside refugees camps more satisfied with family planning services than outside refuges (Mousa, 2000).

Furthermore, another study done in Palestine by Al Hindi (2002) explored the clients' satisfaction with radiology services in Gaza Strip. The study assessed the level of satisfaction with radiology services at two major radiology centers. Al-Shifa Hospital represents governmental services and Gaza Diagnostic Center (GDC) represents the private sector. The researcher used random systematic sampling technique. A sample of 410 clients' was interviewed by used self-structured questionnaire. The response rate was 77.4% for Al-Shifa Hospital and 80% for GDC. The researcher identified these dimensions of the satisfaction as follow, organized culture, continuity and affordability, availability, communication and interaction, attitude and perception, comfort and privacy, and approach of care. The study findings showed that clients' reported a relatively high degree of satisfaction with radiology service (82.5%). The highest level of satisfaction was expressed toward comfort and privacy (90%) and the lowest level of satisfaction were reported toward communication and interaction (77.5%) and continuity/ affordability (75%). The finding showed no significant impact of gender, age, resident place and occupation on the level of clients' satisfaction. On the other hand, the study reported that the number of visits, waiting time and procedure time showed a great effect on the level of clients' satisfaction. The study recommended improving the organizational variables such as waiting time, level of cleanliness, communication and interaction, privacy and comfort and quality of service (Al Hindi, 2002).

Abu Shuaib (2005) conduct a study in governmental hospitals in Gaza strip to examine women's perceptions of childbirth services, the result showed that the overall perception level was 70% at the governmental hospitals. Abu Shuaib attributed the high level of perception to the social and cultural factors of the Palestinian society which made the women appraise the services even they were not satisfied, also due to the economical and political situation which lowered the level expectation of the Palestinian women (Abu Shuaib, 2005).

Chapter Three

Conceptual Framework

Chapter 3

Conceptual Framework

3.1 Theoretical Diagram of Conceptual Framework

Conceptual framework:

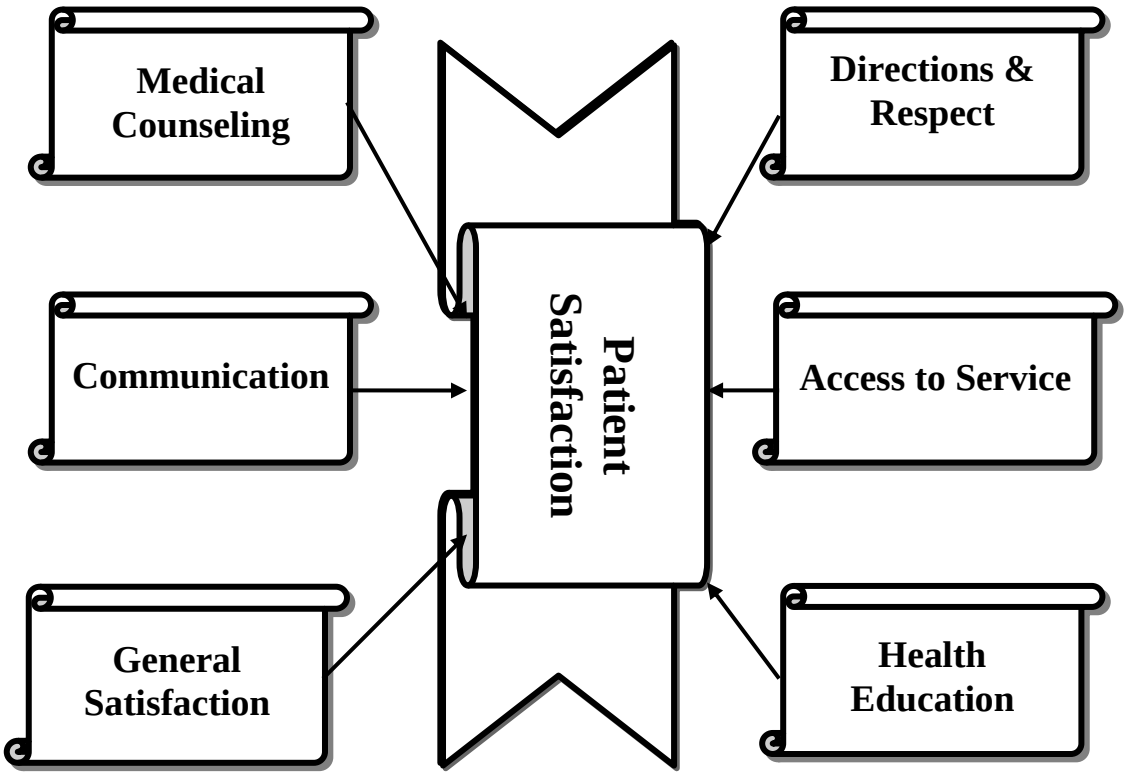

Figure No. (3.1): Hypertensive patient's satisfaction framework.

3.2 Overview

Multiple theories have been put forth to explain why patients with worse health are less satisfied. Patients who report lower satisfaction with medical care may simply be more dissatisfied with many aspects of their lives (Hall et al., 1990; Roberts, Pascoe, and Attkisson, 1983). In fact, some research suggests positive correlations between several dimensions of life satisfaction and health care satisfaction (Roberts, Pascoe, and Attkisson, 1983). Some researchers have asked whether lower satisfaction could actually lead to lower health status because patients who are less satisfied are less likely to comply with medical regimens. However, Covinsky et al. (1998) showed that it is the actual health status state and not the change in health status that is most closely related with satisfaction and Hall et al. found no evidence to suggest that satisfaction influences health status in causal models examining the relationships between health status and satisfaction (Hall, Milburn, and Epstein, 1993). Another theory showed that patients who are sicker are less well liked by their doctors, and therefore have lower satisfaction with their medical encounters (Hall, Milburn, and Epstein, 1993). Doctors may feel over whelmed by patients with problems that do not respond to treatment and could consciously or subconsciously display a negative affect toward sicker patients.

Perhaps the most frequently cited theories are patients whose symptoms or conditions do not respond fully to medical care may be less satisfied with their medical experience (Hall et al. 1990, 1998), and that patients with worse health status may have needs that the health system can-not or does not entirely meet (Greenley,Young, and Schoenherr1982; Hall et al., 1990). Clinicians may not have time to address multiple problems in short visits or to fully explore the needs of patients with multiple severe medical problems are negatively affecting patient satisfaction. Clinicians may also minimize social conversation

during visits where multiple problems need to be addressed (Hall et al., 1998) and involve patients less in decision making (Kaplan et al., 1995).

Measures of patient satisfaction have become important standards for comparing health plans, groups of providers, and even individual providers (Gold and Wooldridge, 1995). Organizations that use satisfaction performance in comparisons rarely adjust for the characteristics of the populations being compared. Studies have found that some sociodemographic Characteristics influence satisfaction (Linn and Greenfield, 1982; Zaslavskyet al., 2000) and that adjusting for these may change plan ratings (Fiscella and Franks 2001; Zaslavsky et al., 2000). Similarly, several studies have found that patients with worse health report lower levels of satisfaction (Hall et al., 1990; Linn and Greenfield, 1982). While adjusting from any sociodemographic characteristics requires little data beyond what health care organizations already have available, adjusting satisfaction scores for health status would require a great deal more data collection and cost.

To identify the relationship between dependent and independent variables in our study, we design our own model which included that :-

3.3 Health education

Education for health begins with people. It hopes to motivate them with whatever interests they may have in improving their living conditions. It aims to develop in them a sense of responsibility for health conditions for themselves as individuals, members of families, and communities. In disease control and management, health education commonly includes an appraisal of what is known by a population about a disease, an assessment of habits and

attitudes of the people as they relate to spread and frequency of the disease (Bundy, D., Guya, H.L., 1996).

3.4 Patients' general satisfaction

Good communication between doctors and their patients is an essential part of a medical care and the expression of patient needs is an essential dimension of the Findings from communication process (Salmon P, Sharma N, Valori R, Bellenger N., 1994). patient-centered research can help us to improve our understanding of problems in health care. Understanding patients' expectations and evaluations in everyday life promises to elucidate doctors' problems. Relationship occurs when the doctor has a clear understanding of a patient needs (Strasser R.,1992). Consumer satisfaction is generally considered the extent to which consumers feel that their needs and expectations are being met by the services provided. Meeting or failing to supply the care patients hoped for is an important predictor of patient satisfaction (Mckinley RK, Stevenson K, Adams S, Manku-Scott TK., 2002).

3.5 Directions and respect

The General Medical Council, Information Commissioner and the Department of Health have agreed this joint statement to ensure that all those who have access to patient information in the course of their work are clear about what is expected of them. The Department of Health has strongly supported the Information Commissioner's call for stronger penalties to apply where individuals obtain information unlawfully, and the law is to be changed to provide the possibility of a custodial sentence for those found guilty.

3.6 Medical counseling

Health risk behaviors are increasingly linked to preventable morbidity and mortality (Holtzman, Powell- Griner, Bolen, & Rhodes, 2000). Changing risk behavior can be an effective way to prevent diseases and to improve the overall health of the population. Health care providers are in the unique position to motivate and assist patients in initiating risk behavior change and in maintaining healthy habits. However, counseling that targets health behavior change is not routinely provided during patient encounters (Bergman-Evans & Walker, 1996; Ewing, Selassie, Lopez, & McCutcheon, 1999; Coodwin, Flocke, Borawski, Zyzanski, & Stange, 1999) due to a number of barriers, such as lack of time, lack of reimbursement, lack of adequate clinician training, and lack of support services (Kottke, Brekke, & Solberg, 1993; Stange, Flocke, & Goodwin, 1998).

3.7 Accessibility to Health Service

Socioeconomic and cultural factors have long been thought to influence an individual's health access to health care. Accessibility to health service remains a major challenge in the context of health. Economic, social, political, administrative, geographic and cultural factors all converge to influence health seeking behavior and access to health services. Unaffordable health care costs represent the most important barrier for poor people to access health services. These include also so-called “hidden costs” such as transport, lost working time, the costs of having to buy materials or drugs that aren’t available at health facilities or even under-the-table-payments (SDC’s Social Development Division, 2008).

Cultural acceptability also determines a person’s health seeking behavior. In many settings, “modern” and “traditional” health services still compete with each other especially poor population groups are more likely to turn to traditional ways of medicine.

Key factors determining access to appropriate health care services are the social and economic conditions of a household. Health behavior within a household is a dynamic process which depends on knowledge, resources, information, skills and available technologies and services. Lack of adequate education, cultural reasons and gender inequalities especially prevent women from accessing basic medical services. Besides gender differences, disparities in access to health care are even more accentuated by old age and poor economic status. The relationship between poverty and access to health care can be seen as part of a larger vicious cycle, whereby poverty leads to ill health, and ill health reinforces and further entrenches poverty. There is no universal explanation that can be applied across different country settings as the cultural, socio-economic and political context varies considerably. However, access to health care for the poor is determined by several key factors:

- **Financial accessibility:** prices of services vs. ability and willingness to pay
- **Geographical accessibility:** costs related to travel and waiting time and income losses
- **Cultural acceptability:** social and cultural expectations vs. responsiveness of health care providers (SDC's Social Development Division, 2008)

3.8 Methods of cmmunication and iformation povided

In health care, listening is one of the most important skills we have. We listen to our patients and the communities we serve. The bond of trust between the patient and the physician is vital to the diagnostic and therapeutic process. It forms the basis for the physician-patient relationship. In order for the physician to make accurate diagnoses and provide optimal treatment recommendations, the patient must be able to communicate all relevant information about an illness or injury. Physicians are obliged to refrain from

divulging confidential information. Physicians do not have to provide medical services in opposition to their personal beliefs. In addition, it is acceptable to have a nonjudgmental discussion with a patient regarding her need for the service and to ensure that the patient understands alternative forms of therapy (Heisler, M., et al., 2002).

There may be many barriers to effective physician-patient communication. Patients may feel that they are wasting the physician's valuable time; omit details of their history which they deem unimportant; be embarrassed to mention things they think will place them in an unfavorable light; not understand medical terminology; or believe the physician has not really listened and, therefore, does not have the information needed to make good treatment decisions (Heisler, M., et al., 2002).

Chapter Four

Methodology

Chapter 4

Methodology

4.1 Overview

This chapter presents the study methodology which includes, study design, study population, study setting, sample size, sampling method, eligibility criteria and data collection as will as validity and reliability of the study instrument. In addition, also the method of data analysis, limitations of the study and ethical matters.

4.2 Study design

In this study, we used descriptive analytical cross - sectional design. It describes the status of compliance of the hypertensive patients with their management regime in the PHCs in Gaza strip with the management regime and not only the drug therapy prescribed, as well as it measures specific indicators which reflect the daily practices of the patients and their compliance with the management regime that they deal with a lone. The cross sectional design was chosen because it is useful for descriptive analysis due to its criteria of less expensive and enables the researcher to meet the study objectives in short time period and mostly for one time.

4.3 Study population

The study population in this research was the hypertensive patients who were registered in the chronic disease clinics in Remal and Rafah at MOH .The number of target population was (3180) patients 2484 in Rafah and 696 subjects in Rimal clinic. All cases treated in both clinics at this period of time considered from our study population.

4.4 Sample Size and sampling

An estimated sample of 70 from Remal and 300 from Rafah clinics- were drawn from the target population. The researcher used the statistical calculator of the Epi-Info to determine a scientifically based sample accidental sampling method were used in this study to select the patients. The data and interviewed were done inside chronic department in the clinic. The data collectors were university students trained to collect data from patient with training course for three days to unify there method to collect data. The response rate was high 100 % because the researchers catch every patient who came to take his treatment and follow up.

4.5 Setting of the study

The study was conducted at two major chronic disease clinics service provides by (MOH) in Remal and Rafah clinics in Gaza strip. It's worth nothing that the various types of chronic disease services were available in both places offer a chance to compare and contrast between factors that might contribute to clients' satisfaction with chronic disease services.

4.6 Period of the study

The study was conducted in September 2008 and data collection started in January 2009. and finsh in march 2009.

4.7 Questionnaire Design

Self reported structural interviewed was distributed for the hypertensive patients. It consumed about 20 minutes to complete the questionnaire. It includes several domains such as general patient satisfaction, directions and respect, Medical counseling,

accessibility to health service, health education, methods of communication and information provided. The instrument used in this study was a structured questionnaire. The researcher constructed the satisfaction questionnaire based on his review of the literature. The instrument was built in English and Arabic Language and the interviewed in Arabic to prevent Language barriers. The data was collected by the researcher and trained assistants. The assistants were qualified they prepared well on how to approach and interview the patients in the same way as the researcher .

4.8 Pilot Study

The pilot study consisted of 15 subjects. They interviewed to examine the clarity and suitability of the questions included in the instrument before starting data collection and to fined the weakness areas in the instrument domains. The pilot subjects were excluded from the study population to prevent bias and some modifications of the questionnaire were done after piloting.

4.9 Ethical consideration

a. An official letter was obtained from the MOH to conduces and study.

b. Consent form was obtained from the participants to participate in the study and

the patients have aright to accept or refuses to participate in the study.

4.10 Eligibility criteria

4.10.1 Inclusion criteria

The study included all hypertensive patients with history of other diseases who are registered at Rimal and Rafah primary health care clinics.

4.10.2 Exclusion criteria

- Patients refused to participate.
- Emergency cases.

4.11 Data entry

Over viewing of the questionnaires was the first step prior to data entry. The useable number of questionnaires was (370). This step was followed by designing an entry model using the computer software Statistical Package for Social Sciences (SPSS). The coded questionnaires were entered into the computer by the researcher. Data cleaning was done through checking out a random number of questionnaires and through exploring descriptive statistics frequencies for all variables.

4.12 Validity

Validity of an instrument is considered to be an important issue that have been discussed and stressed out by many researchers. Validity is defined as "the extent to which a measuring instrument measures what it is supposed to measure" (mark, 1996). In fact, when instruments measure what they are designed for, this considered to be of great importance for their reliability, and this start with conceptual relevance and simplicity of instrument (fagerstrom, 2000). Three types of validity evidence were used in this study. They are content, criterion and construct-related validity evidence.

4.13 Content validity

Content validity is defined as the extent to which a test reflects the variable it seeks to measure (Holm and Liewehyn, 1986). Content validity conducted before data collection and measured in the form of expert estimates of the relevance, and completeness.

Therefore, content validity is subjective estimate of measurement rather than statistical analysis, and applied to all relevant parts of the measured area. In order to validate the instrument of this study, the researcher sent the instrument including items, dimensions and operational definitions to (10) different experts including researchers, managers, supervisors, physicians, and health workers and asked them to estimate the relevance, clarity completeness of each item. A criteria of (85%) acceptance among experts were used. As a result, some questions were modified, others were omitted and the rest showed relevance and adequacy. A total of (92) items were reported to reflect the construct being measured.

4.14 Construct validity

Construct validity examines the fit between the conceptual definitions and operational definitions of variables (Burns and Groves, 1997). In other words, construct validity describes how well the instrument is operationalized and quantified (Fagerstorm, 2000), so from construct point of view, the valid instrument has the ability to measure the hypothetical construct. (Polit and Hungler, 1999).

As a result of six factors were emerged and included General Satisfaction, Health Education, Accessibility, Direction Respect, Medical Counseling, and Communication. These factors represented (55.8%) of the total amount of variance. More detailed discussion about that will be presented in the next chapter.

4.15 Reliability

The technique of measuring variables must be reliable as this reflects the extent to which an operational definition, questionnaire, test, interview schedule or other instruments is stable and consistent (Mark, 1996). In other words, a measure is reliable if it gives the

same results each time the situation or the factor is measured. In this study, the statistical test used for the internal consistency was Cronbachs, Alpha coefficient. The reliability coefficient for the study instrument as a whole was high as (0.760) Cronbachs, alpha is considered the most general form of reliability estimates and also, it concerned with the homogeneity of items compromising the scale (Polit and Hungler, 1999). In addition to the whole instrument reliability, Cronbaches, Alpha was computed for the instrument's subscales. Reliability estimates ranged from moderate to high (table 4.1).

Table No. (4.1)
Factors sub-scales reliability estimates

No.	Domain	No. of questions	A
1.	General Satisfaction	19	0.710
2.	Satisfaction of health education	4	0.840
3.	Satisfaction of Accessibility	2	0.894
4.	Satisfaction of Direction respect	6	0.733
5.	Satisfaction of Medical counseling	17	0.701
6.	Satisfaction of Communication and inf. provided	5	0.772
7.	All Satisfaction	53	0.760

4.16 Response rate

Response rate was 100 % . No missed or delete questionnaires**.**

4.17 Limitation of the study

1. Subjects were selected by anon probability convenience sample method which is one of the weakness form of sampling.

2. The war hinders and postponed data collection.

3. The unusual political situation and time limitation.

4. Lack of relevant resources as references.

5. The bad socio-economic condition of the patients during the implementation of the study might have some effects on their satisfaction level on general.

6. Transfer of patients to receive treatment in the governmental clinic to UNRWA clinic, because of treatment free.

4.18 Summary

This chapter aimed to describe the methodology for carrying out the present study. A general description of the setting, population, and sample was presented, along with information regarding the manager groups utilized for the survey. The instrument utilized and the data collection processes were discussed as to their development and validity. Lastly, the statistical processes selected for analyzing the data were presented.

Chapter Five

Results & Discussion

Chapter 5

Results & Discussion

5.1 Introduction

The study was conduct to assess the level of client satisfaction with the care given to hypertensive patient in primary health care center in two localities of Gaza strip (Rimal and Rafah), and to identify the domains of satisfaction affect it. Also this study aims to high light the areas that lead to increase the satisfaction with health care in primary health care centers. When the quality of services improves, patient will feel reassured to seek health services with in the primary health care services. It is crucial to view the results of this study as an over all evaluation of their performance and as reminder that patient – driven service standard are important for the production of quality care must be better understood.

In this study the researcher attempts to interpret and discuss the findings. The major domains of clients satisfaction with health care - that were extracted from the study reflected the meaning-full dimension of client satisfaction about health care provided at primary health care centers. It is good to remind the readers that six factors were appeared and label by the researcher as following: The total satisfaction score reflect all subscale score, dimension of patient satisfaction, and satisfaction of primary health care center. They were General satisfaction, health education, accessibility, direction response, medical counsel and communication**.**

In this chapter the researcher presents the main results of the study of statistical analysis of the data, descriptive analysis present, the variables and responds of the sample. The study sample was (370) clients attending primary health care center in two different localities of

Gaza strip. They are Rimal Martyrs primary health center (present north of Gaza strip, the number of participants was 70) and Rafah Martyrs clinic (number of participants was 300), the sample were collected according to the number of hypertensive patients registered in the two clinics and estimated according to Epi-info statistical package. More over factor analysis identify the major six dimension of hypertensive patient's satisfaction with the health care services introduce to them, they were**,** general patient satisfaction, health education, accessibility to health service, directions and respect, medical counseling, methods of communication and information provided. Also the researcher represents the deference between the selected variables and general satisfaction score with subscales were exploring by using different analytical statistical test.

5.2 Descriptive analysis

5.2.1 Characteristics of study population:

Table (5.1) shows the back ground characteristics of total population, male subject (215) represent (58.1 %), female subject (155) represent (41.9%).

Table (5.1): Distribution of the study sample by gender

Gender	Frequency	%
Male	215	58.1
Female	155	41.9
Total	370	100.0

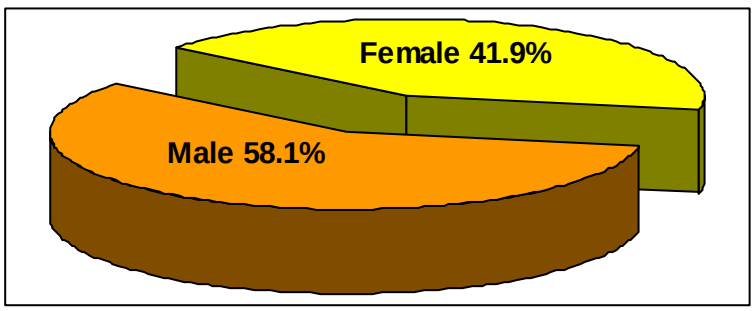

Figure (5.1) Distribution of the study sample by gender

Table (5.2) shows the distribution of study sample by age, the age range from 35 years to 70 years. The majority of clients from 41 – 50 was (124) represent (33.5 %) and the age from 50 – 60 was (98) represent (26.5 %) and the age from 60 years and over was (106) represent (28.6 %). The mean age was (54.4) years standard deviation (1.3).

Table (5.2): Distribution of the study sample by age group

Age group	Frequency	%
40 Yrs and less	42	11.4
From 41 to 50 Years	124	33.5
From 50 to 60 Years	98	26.5
More than 60 Years	106	28.6
Total	370	100.0

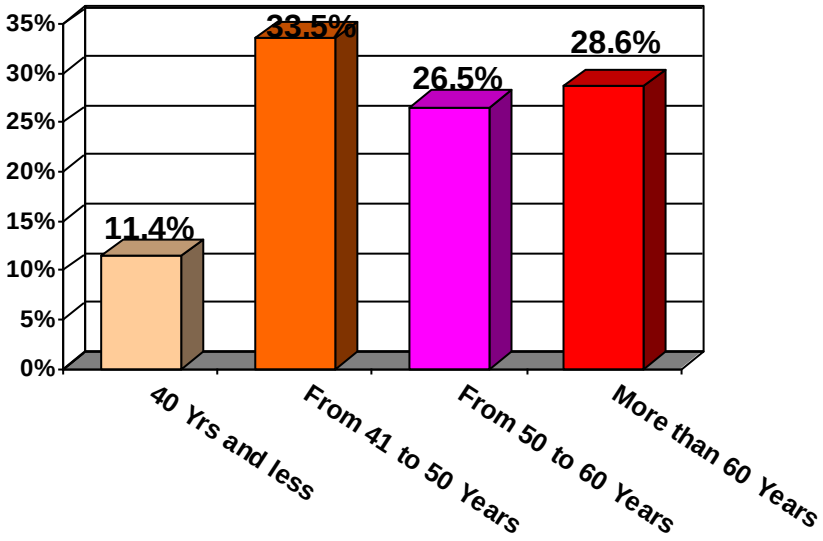

Figure (5.2) Distribution of the study sample by age group

5.2.2 Distribution of study sample by residency:

Table (5.3) regarding residency shows that the majority of clients lived in city (257) represented (69.5%) while (92) represented (24.9 %) lived in camps and small percentage (21) represent (5.7%) lived in villages.

Table (5.3): Distribution of the study sample by residency

Address	Frequency	%
City	257	69.5
Camp	92	24.9
Village	21	5.7
Total	370	100.0

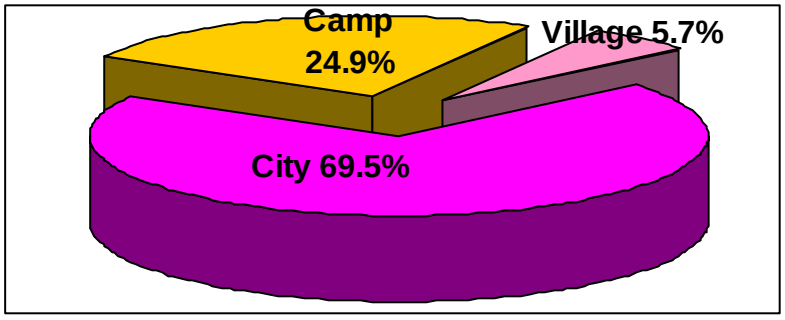

Figure (5.3) Distribution of the study sample by residency

5.2.3 Distribution of study sample by Housing type:

Table (5.4) regarding to the housing type shows that the majority of client live owned housing (254) represent (68.6 %) while living in rent house (116) represent (31.4 %).

Table (5.4): Distribution in patient's satisfaction by Housing type

Housing type	Frequency	%
Owned	254	68.6
Rent	116	31.4
Total	370	100.0

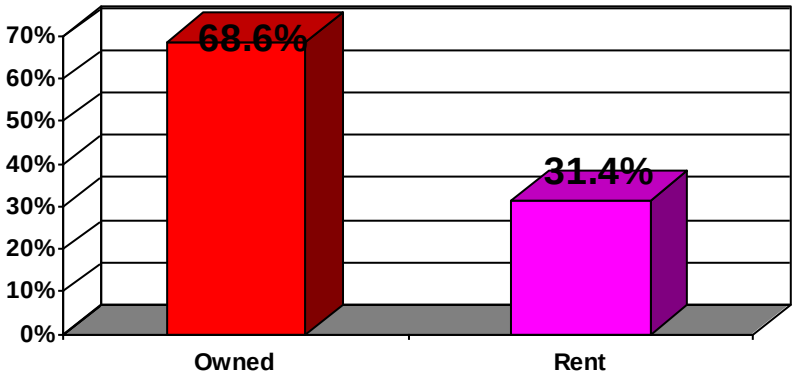

Figure (5.4) Distribution in patient's satisfaction by housing type

5.2.4 Distribution of study sample by health center:

Table (5.5) regarding to health center shows that (79.5%) from the subject get there health in Rafah Martyrs clinic and (20.5%) in Remal Martyrs clinic.

Table (5.5): Distribution of the study sample by health center

Where do you get your health services	Frequency	%
Rafah Martyrs clinic	294	79.5
Al Rimal Martyrs clinic	76	20.5
Total	370	100.0

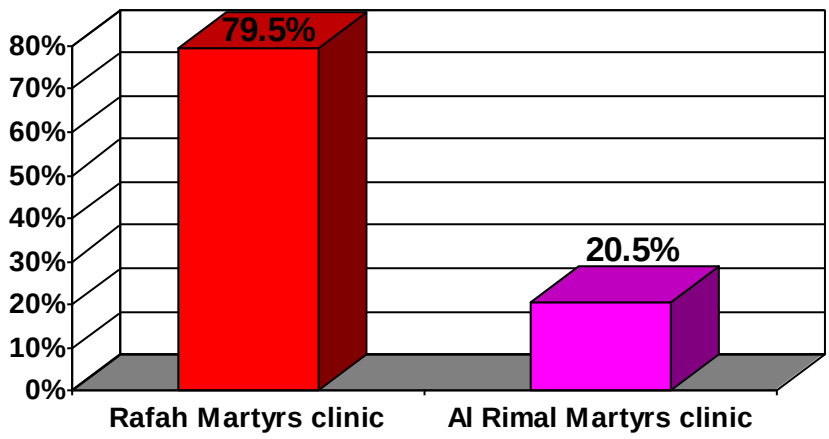

Figure (5.5) Distribution of the study sample by health center

5.2.5 Distribution of study sample by health type of insurance:

Table (5.6) shows that the types of insurance for the subject were voluntary (2.2%), social affaire (29.2%) worker (37.8%), contract (7.3%) municipalities (1.6%), Governmental Employee (16.5%), free (1.6%), retired (3.8%).

Table (5.6): Distribution of the study sample by health insurance

Type of health insurance	Frequency	%
Voluntary	8	2.2
Social affairs	108	29.2
Workers Syndicates	27	37.8
Contract	140	7.3
Municipalities	6	1.6
Gov. Employee	61	16.5
Free	6	1.6
Retired	14	3.8
Total	370	100.0

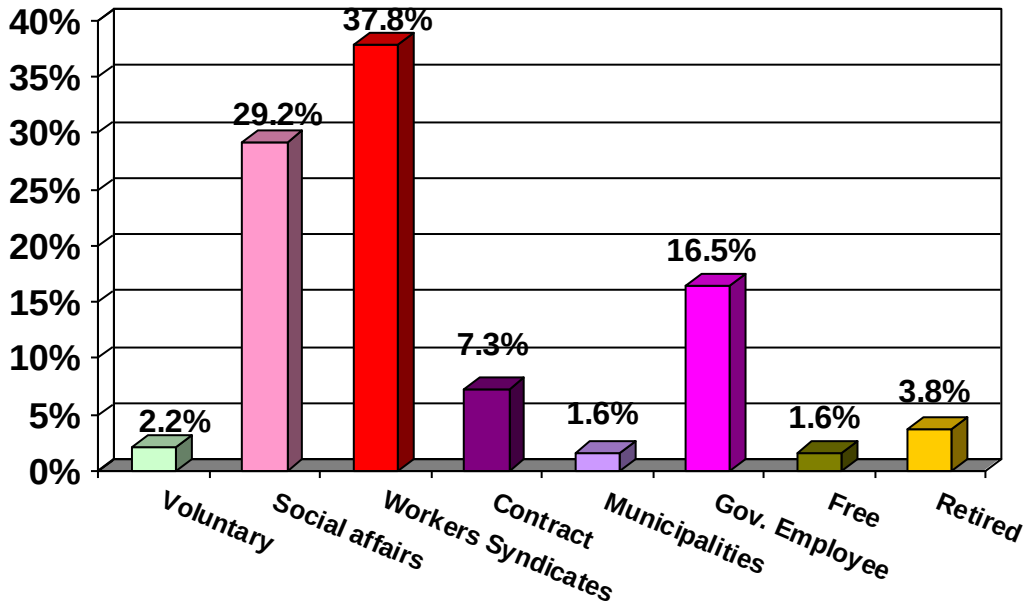

Figure (5.6) Distribution of the study sample by health insurance

5.2.6 Distribution of study sample by marital status:

Table (5.7) indicated that most of the participants were married (75.9%), single (4.1%), widow (15.9%), and divorced (4.1%).

Table (5.7): Differences in patient's satisfaction by marital status

Marital status	Frequency	%
Married	281	75.9
Single	15	4.1
Widow	59	15.9
Divorced	15	4.1
Total	370	100.0

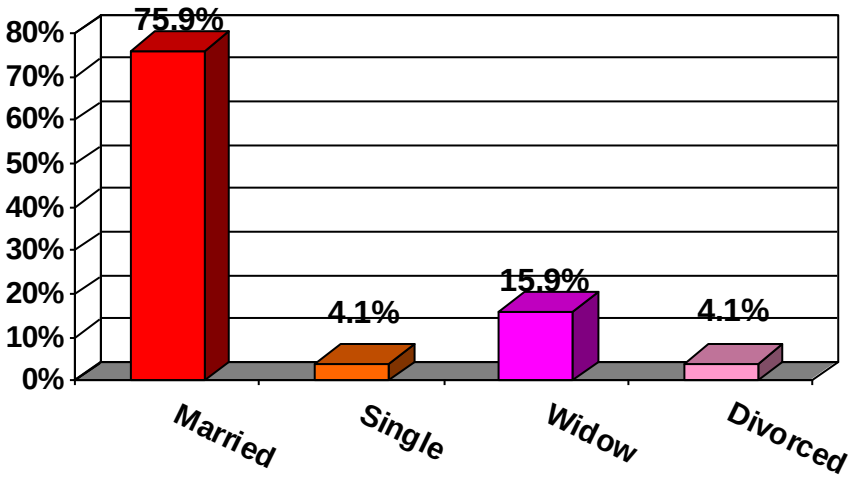

Figure (5.7) Differences in patient's satisfaction by marital status

5.2.7 Distribution of study sample by Family members:

Table (5.8) shows that the family members of 5 and less represented (41.8%) of the study sample, from 6 – 9 members represented (48.1%) and more than 9 members represented (10.2%).

Table (5.8): Differences in patient's satisfaction by family members

Number of family members	Frequency	%
5 and less	154	41.8
From 6 to 9	177	48.1
More than 9	39	10.2
Total	370	100.0

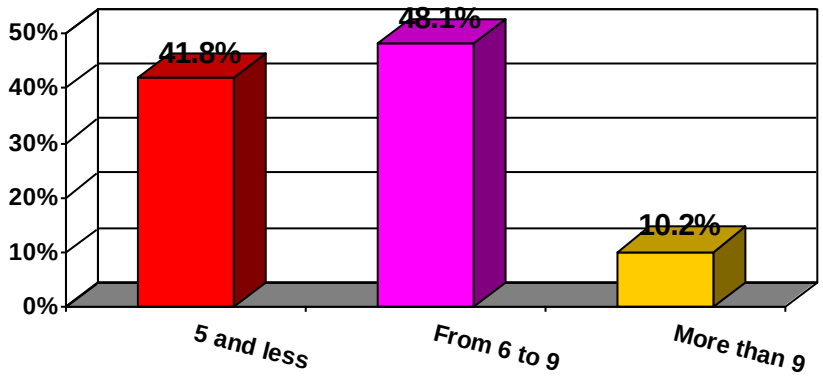

Figure (5.8) Differences in patient's satisfaction by family members

5.2.8 Distribution of study sample by Educational level:

According to table (5.9), the educational level of subjects in the study population was distributed as follow, illiterate (19.6%), preparatory (37.6%), secondary (27.5%), diploma (10.4%), bachelor (4.9%).

Table (5.9): Distribution of the study sample by educational level

Education	Frequency	%
Illiterate	73	19.6
Preparatory	138	37.6
Secondary	101	27.5
Diploma	39	10.4
Bachelor	19	4.9
Total	370	100.0

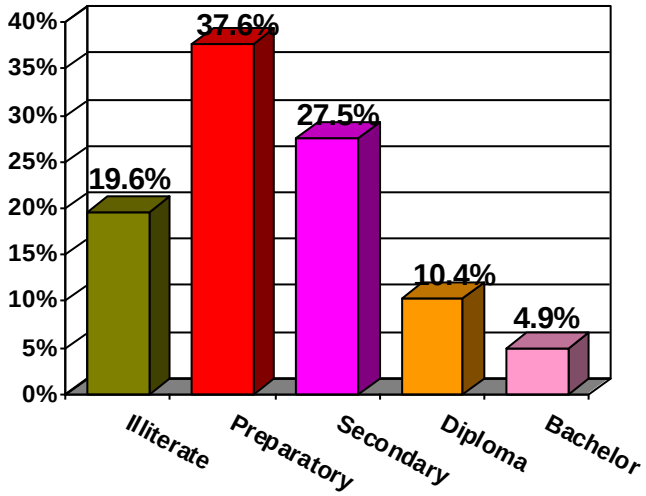

Figure (5.9) Distribution of the study sample by educational level

5.2.9 Distribution of study sample by current employment status:

Table (5.10) shows that the current employment status of the study sample as follow, employed were (58.1%) and (41.9%) were unemployed.

Table (5.10): Differences in patient's satisfaction by current employment status

Work	Frequency	%
Yes	215	58.1
No	155	41.9
Total	370	100.0

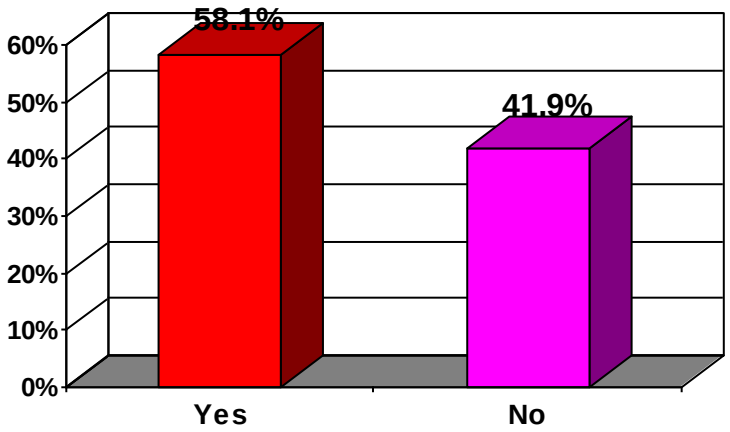

Figure (5.10) Differences in patient's satisfaction by current employment status

5.2.10 Distribution of study sample by current types of works:

According to table (5.11), the types of work of the study sample were Office worker (26.5%), Bricklayer (14.0%), Salesman (27.0%), Driver (19.1%), other (13.5%).

Table (5.11) Differences in patient's satisfaction by current types of works

Kind of work	Frequency	%
Office Worker	57	26.5
Bricklayer	30	14.0
Salesman	58	27.0
Driver	41	19.1
Other	29	13.5
Total	215	26.5

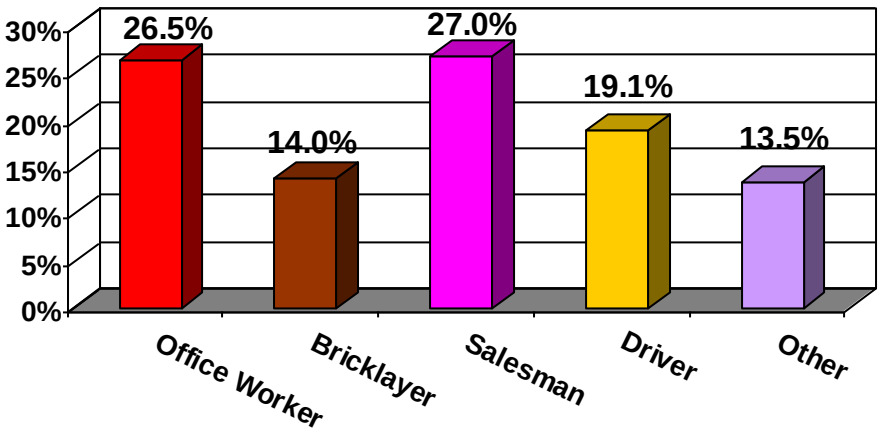

Figure (5.11) Differences in patient's satisfaction by current types of works

5.3 History of diseases and health care characteristics

5.3.1 Distribution of study sample by the history of suffering from HBP:

Table (5.12) shows the distribution of study sample by the history of suffering from HBP, Less than 5 years was (131) represent (36.3%). From 6 to 10 years was (148) represent (41.0%) and more than 10 years was 82 represent (22.7%).

Table (5.12) Distribution of the study sample by history of suffering from HBP

Since when discover you suffer from HBP	Frequency	%
Less than 5 Years	134	36.3
From 6 to 10 Years	151	41.0
More than 10 Years	85	22.7
Total	370	100.0

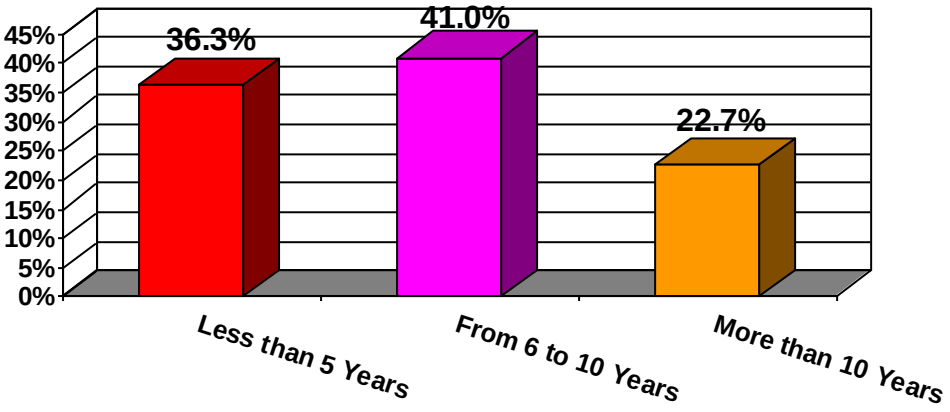

Figure (5.12) Distribution of the study sample by history of suffering from HBP

5.3.2 Distribution of study sample by used to measure BP before discovered:

According to table (5.13), the participants who used to measuring BP before discovered was 164 (44.3 %) and who did not use 206 (55.7 %).

Table (5.13) Distribution of the study sample by measuring BP before discovered

Used to measure your BP before discovered	Frequency	%
Yes	164	44.3
No	206	55.7
Total	370	100.0

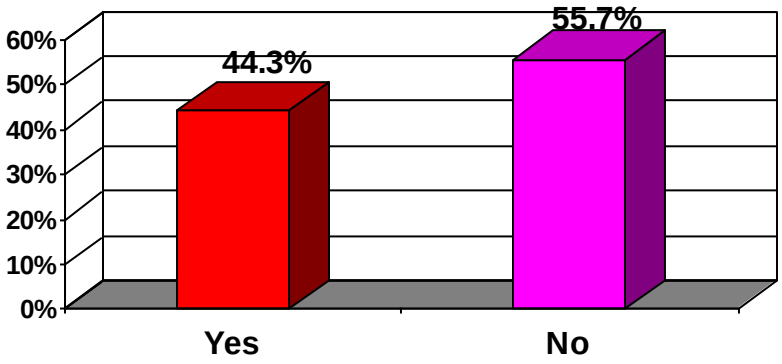

Figure (5.13) Distribution of the study sample by measuring BP before discovered

5.3.3 Distribution of study sample by the period of measuring BP before discovered:

Table (5.14) indicated that the period of measuring BP before discovered was 21 (12.8%) weekly, 34 (20.7%) monthly and 109 (66.5%) irregularly.

Table (5.14): Differences in patient's satisfaction by the period to test BP before discovered

If yes specify	Frequency	%
Weekly	21	12.8
Monthly	34	20.7
Irregular	109	66.5
Total	164	100.0

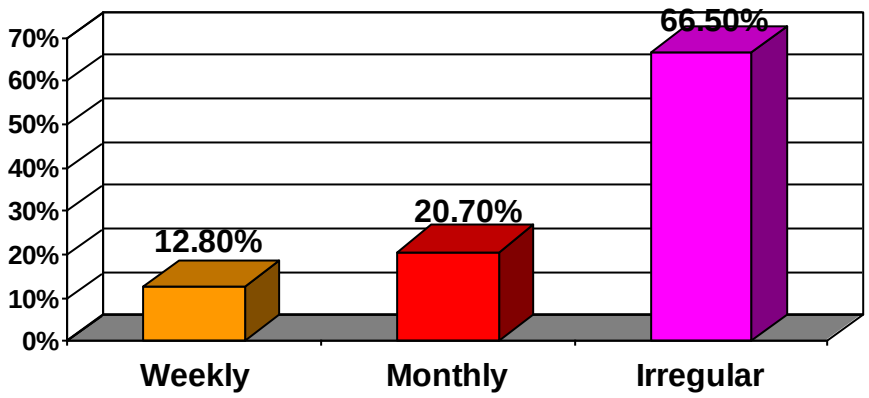

Figure (5.14) Differences in patient's satisfaction by the period to test BP before discovered

5.3.4 Distribution of study sample by Admitted to hospital before attend to the PHC:

As shown in table (5.15), the number of participants who admitted to the hospital before attended to the PHC was 73 (19.7%) and 297 (80.3%) did not admitted to hospital before attend to the PHC.

Table (5.15): Differences in patient's satisfaction by Admitted to hospital before attend to the PHC

Admitted to hospital before you attend to the PHC	Frequency	%
Yes	73	19.7
No	297	80.3
Total	370	100.0

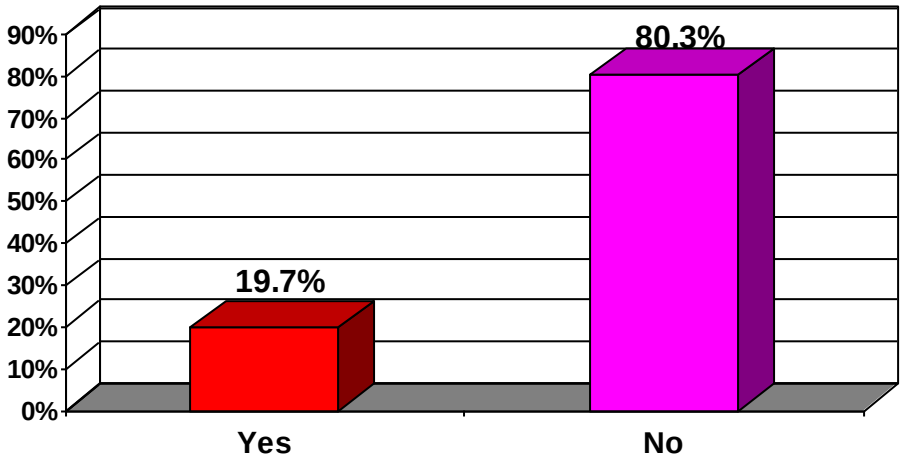

Figure (5.15) Differences in patient's satisfaction by Admitted to hospital before attend to the PHC

5.3.5 Distribution of study sample by suffering from previous diseases:

Table (5.16) indicated that the percentage of the participants who suffered from history of other diseases was 35.9%, and 64.1% did not suffer from history of other diseases.

Table (5.16): Distribution of the study sample by suffering from history of other diseases

Suffering from any diseases	Frequency	%
Yes	133	35.9
No	237	64.1
Total	370	100.0

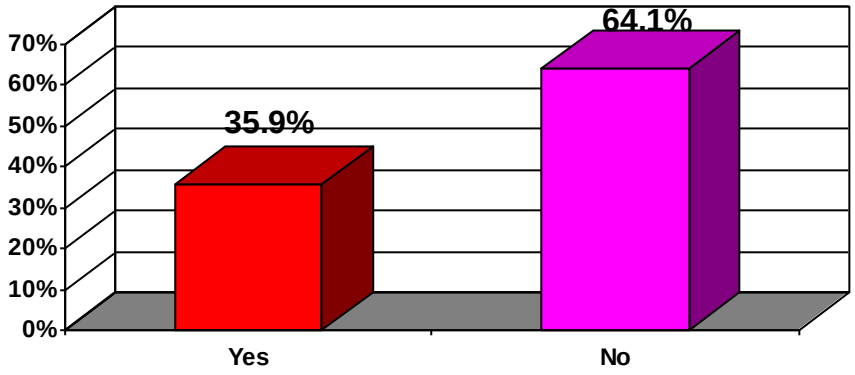

Figure (5.16) Distribution of the study sample by suffering from history of other diseases

5.3.6 Distribution of study sample by types of history of other diseases:

Table (5.17) indicated that the frequency and percentage of the participants who suffered from history of diabetes was 89 (66.9 %), 29 (21.8 %) was cardiac diseases, 3 (2.3%) was Kidney diseases and 12 (9.0%) was asthmatic diseases.

Table (5.17): Distribution of the study sample by types of history of other diseases

If yes	Frequency	%
Diabetes	89	66.9
Cardiac	29	21.8
Kidney	3	2.3
Asthma	12	9.0
Total	133	100.0

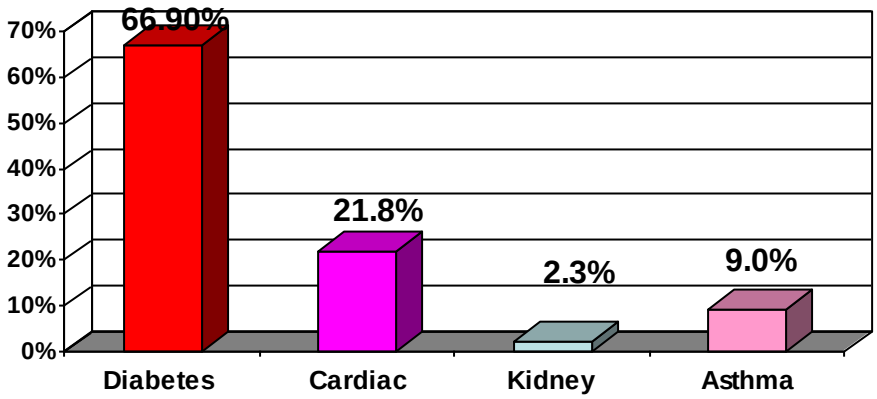

Figure (5.17) Distribution of the study sample by types of history of other diseases

5.3.7 Distribution of study sample by physical activity:

As shown in table (5.18), 106 (28.6 %) of the participants practice some types of physical activity such as walking, jogging, sports, etc., and 264 (71.4%) did not practice any types of physical activity.

Table (5.18): Distribution of the study sample by practice of physical activity

Do you practice body Exercise	Frequency	%
Yes	106	28.6%
No	264	71.4%
Total	370	100.0

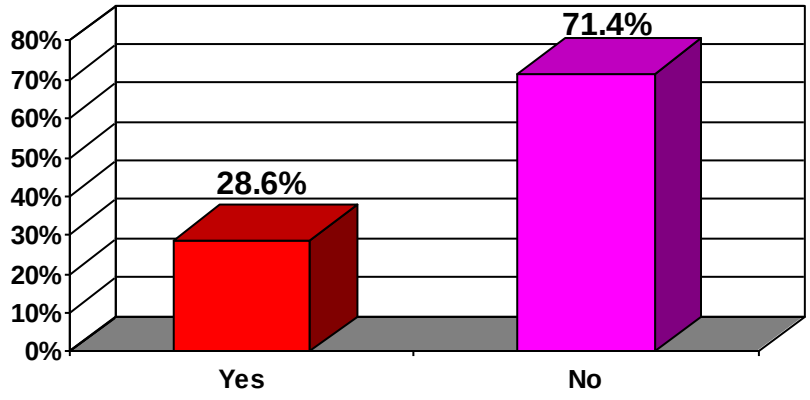

Figure (5.18) Distribution of the study sample by practice of physical activity

5.3.8 Distribution of study sample by regular follow up:

Table (5.19) shows that 154 (42.3%) of the participants maintain regular follow up health care and 210 (57.7) did not do so.

Table (5.19): Distribution of the study population by follow up

Follow up specified nutritional system	Frequency	%
Yes	157	42.3%
No	213	57.7%
Total	370	100.0

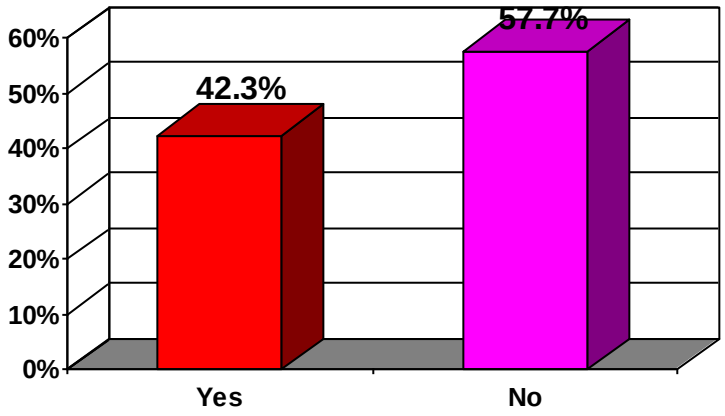

Figure (5.19) Distribution of the study population by follow up health care

5.3.9 Distribution of study sample by smoking:

As shown in table (5.20), more than two thirds of the study participants (74.3%) were smokers, 80 (21.6%) were not smokers and 15 (4.1%) were stop smoking.

Table (5.20): Distribution of the study sample by smoking

Are you smoker	Frequency	%
Yes	275	74.3%
No	80	21.6%
Stop smoking.	15	4.1%
Total	370	100.0

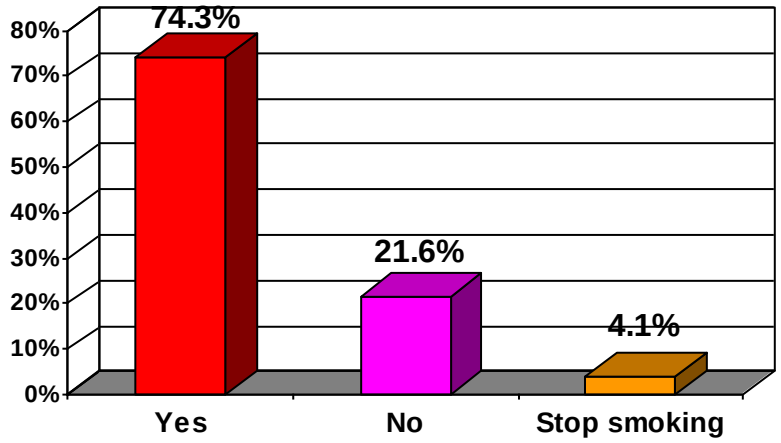

Figure (5.20) Distribution of the study sample by smoking

5.3.10 Distribution of the study sample by types of smoking:

Table (5.21) shows that the majority of the smokers' participants (77.9%) used to smoke cigarettes and the rest (22.1%) used to smoke Hubble Bubble.

Table (5.21): Differences in patient's satisfaction by type of smoking

If yes type of tobacco	Frequency	%
Cigarettes	214	77.9%
Hubble Bubble	61	22.1%
Total	275	100.0

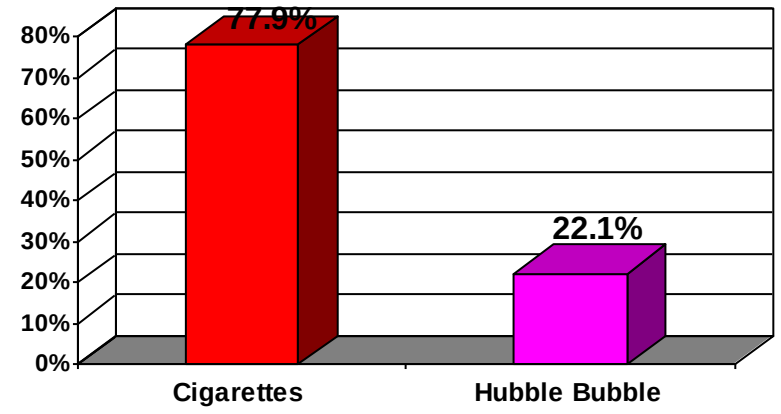

Figure (5.21) Differences in patient's satisfaction by type of smoking

5.3.11 Distribution of study sample by family history of HBP:

Table (5.22) indicated that 141 (38.1%) of the study participants have family history of hypertension and the majority of the study participants 229 (61.9%) did not have family history of hypertension.

Table (5.22): Distribution of the study sample by family history of HBP

Family history of HBP	Frequency	%
Yes	141	38.1
No	229	61.9
Total	370	100.0

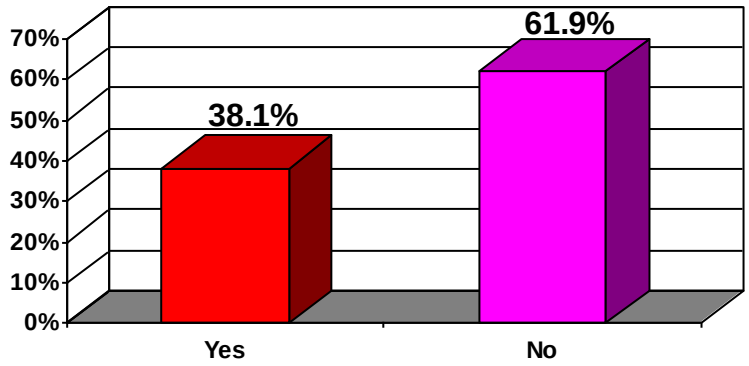

Figure (5.22) Distribution of the study sample by family history of HBP

5.4 Domains of patient's satisfaction

Table (5.23): Domains labels, Means, Standard Deviations and Variances

No.	Domains name	Mean	%	Std	Variance
1.	**General Satisfaction**	**3.3**	68.6	0.5	0.710
2.	**Satisfaction of health education**	**2.5**	25.1	1.1	0.840
3.	**Satisfaction of Accessibility**	**3.5**	53.2	1.1	0.894
4.	**Satisfaction of Direction respect**	**4.1**	75.9	0.7	0.733
5.	**Satisfaction of Medical counseling**	**3.4**	70.0	0.4	0.701
6.	**Satisfaction of Communication And inf. provided**	**2.4**	19.7	0.7	0.772
7.	**All Satisfaction**	**3.4**	56.5	0.4	0.760

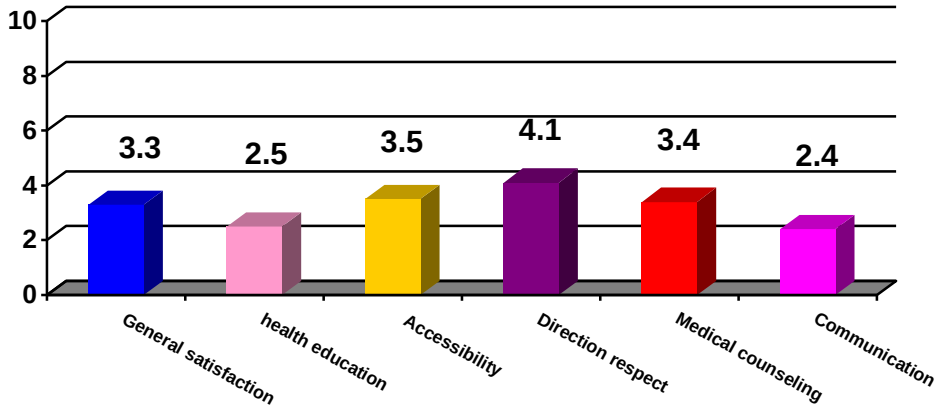

Figure (5.23): Domains labels, Means, Standard Deviations and Variances

As shown in Table (5.22), there are six dimensions of satisfaction domain, these domains might reflect the Palestinian client satisfaction with health care at primary health care centers. The satisfaction level of these domain were varied as the following: general satisfaction was (68.6%) with mean (3.3), satisfaction of health education was low (25.1%) with mean (2.5), satisfaction of accessibility was (53.2%), with mean (3.5), satisfaction of direction respect (75.9%) with mean (4.2), satisfaction of medical counseling was (70%) with mean (3.4), and satisfaction of communication and interaction was (19.7%) with mean (2.4), all satisfaction represent (56.5%) with mean (3.4).

The following paragraphs present the interpretation of these domains and explain what behind these scores:

5.4.1 General satisfaction:

General satisfaction is the first factors and included 30 items, this dimension reflect client satisfaction as a whole with the services offered to the primary health care, also it refers to the patient satisfaction toward health team and health facility. As expressed by the mean,

general satisfaction was (3.3) which mean that (68.6%) of study population were satisfied with the care they received, in contrast (31.4%) of population were dissatisfied.

The result was consistent with Al Hindi (2002) who conducted a study in Gaza to assess the degree of satisfaction among clients seeking radiology services at Al_Shifa hospital and at Gaza Diagnostic center, the researcher reported that the overall satisfaction level was (82.5%) as expressed by the clients who used radiology services. Al Hindi attributed this result of satisfaction to the difficult political and socioeconomic situation of the Palestinian people which might reflect their expectations and have resulted in a high satisfaction level (Al Hindi, 2002)

Also the result was consistent with Abu Shuaib (2005) study which conducted in governmental hospital in Gaza strip to examine women's perceptions of childbirth services; the result revealed that the overall perception level was (70%) at the governmental hospital. Abu Shuaib attributed the high level of perception to the social and cultural factors of the Palestinian society which made the women appraise the services even when they were not satisfied, also due to the economical and political situation which lowered the level of expectation of the Palestinian women (Abu Shuaib, 2005).

In addition, the result was consistent with the result revealed with Abu Saileek (2004) study which was conducted in Gaza strip to measure the level of clients' satisfaction with nursing care in the two major and biggest governmental hospital in the south of Gaza strip, European Gaza Hospital (EGH) and Nasser Hospital in Khanyounis Governorate, the result showed that the satisfaction level was (70.1%) in both hospitals, Abu Saileek attributed the high level of satisfaction to the cultural and political factors, which might have an impact on their expectations and have resulted in the revealed the level of satisfaction. (Abu Saileek, 2004).

Abu Dayya (2000) conducted a study in the GS and WB, which investigated the Palestinian's satisfaction with health services provided by MOH, the findings showed that (61.9%) of the clients' showed high level of satisfaction with health services as overall. Abu Dayya attributed the high level of satisfaction of Palestinian people to the low expectations with regard to the difficult political and socioeconomic situation of the Palestinian National Authority in general and MOH specifically. The study concludes that governmental health service in Palestine is improving in comparison with health services in several Arab countries (Abu Dayya, 2000).

Mousa (2000) conducted a study in the Gaza strip to assess the level of client's satisfaction with family planning services at UNRWA and MOH clinics, the researcher reported that overall satisfaction as expressed by the Palestinian woman (72%). Mousa attributed the result to the lack of knowledge of the workload of the family planning staff, also to the in _ built bias, which predisposed some clients to express satisfaction with family planning they received (Mousa, 2000).

Andaleeb (2001) conducted a study in Bangladesh to assess the service quality perceptions and patient satisfaction. The researcher reported that the satisfaction level was (67%) as expressed by the population of Dhaka who had utilized hospital services. Andaleeb (2001) attributed the low level of satisfaction to the lack of patient confidence. Al asad and Ahmad (2003) conducted a study to examine patients' satisfaction with nursing care at a major teaching hospital in Jordan. Patients' satisfaction was examined in the medical, surgical and gynecological wards of the hospital in relation to patient's gender, age, class of admission, level of education, length of stay in the hospital, operation status, having other diseases and health insurance. The researcher reported that the satisfaction level as expressed by the patients was (77%).

Al Doghather (2004) conducted a study to evaluate inpatient satisfaction with physician at King Khalid University Hospital in Riyadh; the result showed that the overall satisfaction was (66.2%). Al Doghauther attributed the low level of satisfaction to the majority of people from non - Arabic speaking countries and because of cultural and social differences, fluent communication with patients was sometimes difficult. Another study was conducted in Turkey with Yildiz and Erdogmus (2004) developed a reliable and valid instrument to measure patient satisfaction of the quality of health care in Turkey, the result revealed that the satisfaction level was (76.6%). They attributed the result to the low education and culture level .

Ricketts (1996) claimed that high level of satisfaction that is usually reported by many studies is considered meaningless when it is result of a single measurement. Therefore, repeated measurements or comparisons with other health centers are necessary (Ricketts, 1996). In general and in spite of the quality concerns of the health care services as Massoud reported in his situational analysis about health care in Palestine (Massoud, 1994).The findings from this study indicate that patient's high degree of perspective with hospital services (78%). The political, economical and social factors of the population in Gaza Strip made the patients accept the health services even they were not satisfy with it. Furthermore, in my opinion the expectations of the Palestinian patients were low due to the closure (siege) of Gaza Strip and the Israeli sanctions against the civil population living there. Moreover, the people want to support the elected government against the attacks of the Israeli occupation.

5.4.2 Health education:

This dimension included 4 item's which reflect to the knowledge and advice given to the client during his visits to clinic. It also reflect to the degree of explanation given to the

client. The information and interaction dimension reflected the extent of clients' satisfaction with health team answers; in addition their satisfaction with health team concerns to keep the clients' and families informed about the clients' health conditions. Also, it reflects the extent of clients' satisfaction with the amount of time which health team spent with their clients'. The information and interaction domain reported satisfaction level as 25.1%. Clients' complain of the health team work-load and that the health teams have very little time to set and talk with their clients (Kaplan and Ware, 1995; Wilson, 1992). Moreover, other researchers stated that "health care is fundamentally interaction", they expressed their vision as "every patient is the only patient". They concluded that interaction is important in several areas including informing the patients about their care, respecting their physical, emotional, cultural and spiritual needs, also provide the care without delay and not in separate from their family or friends. Informing patients about their care is an issue that has been stressed by several studies, conducted to analysis the patients experience with hospitals care in five countries. The reported result were that information and education as expressed by the respondents were in Germany 79.6, %,Sewed 76.6 %, Switzerland land 83.8 %, united Kindom 71,3 % and united state 74.8% (Kaplan and Ware, 1995; Wilson, 1992).

Kaplan and Ware (1995) urged that informed patients feel better than those who were less informed about their care. Moreover, the information provided by services helps in changing' behaviors of the patients in ways that positively influence their health.

The importance of information and interaction as one of the satisfaction domains was emphasized by several studies. For example, a study conducted by Thornhill and Stevens (1998) revealed that interaction skills of health worker were important factor affecting the attendance of clients' (Thornhill and Stevens, 1998). Health team could improve the

process of information and interaction through dealing with each client.. This enhances the relationship between the clients and the health team and accordingly will increase the level of clients' satisfaction with health care. Improving information and interaction could be achieved by providing training courses to the health team in therapeutic interaction including (therapeutic communication) listening skills, silence, information material, reducing distance, acknowledgement, seeking clarification, focusing and summarizing (Kaplan and Ware, 1995).

The result is consistent with Mousa (2000) who conducted a study about client satisfaction with family planning services in GS and showed that communication and interaction were reported to have the lowest degree of satisfaction, only 54%.

The result is inconsistent with study by Abu Saileek (2004), who examined the client's satisfaction with nursing care provided at selected hospitals in Gaza Strip his result showed that 67.4% of the clients were satisfied with information and interaction dimension. Also the result is inconsistent with Abu Shuaib (2005), who which assess women perception and experience of childbirth services at governmental hospitals in Gaza Strip, he reported that information and communication as expressed by Palestinian women was 78.1 %. Also Al Hindi (2002), he reported that communication and interaction as expressed by Palestinian clients was 77.5% satisfied and 22.5% dissatisfied.

5.4.3 Accessibility:

This dimension included 2 items, this reflects to the easy reach of the client to the health services and the present of delay inside the car center.

The level of satisfaction was reported with accessibility (53.2%). The finding showed that the services provided in the clinic take a long way from reaching of the client to the center

to his leave, this study were concerned with the comfort of the clients and easy reach and facilitate his care inside the clinic . Availability of the services considered as one important quality measure. In this study, availability reflects to which extent the service providers ensure that the various investigations and various medications and materials are available. In addition, it reflects the vitality of the services in term of availability. Clients reported moderate degree of satisfaction with the accessibility of the services are consistent and support the finding that revealed by Massoud (1994) who demonstrated that Palestinian national input into health care is high. Health providers are investing more in spite of scarce of resources. This might be attributed to difficult socio-economic situation in Gaza Strip which led to low expectation level and accordingly enhanced the level of satisfaction with the availability. The challenge is to continue investment in order to provide further new services that meet client's needs. The result is consistent with Mousa (2000) who revealed that in his result conducted to examine women satisfaction with family planning services that 23% of the interviewed women expressed dissatisfaction, 25.7% of the interviewed women said that is not easy to rich to the clinic site, also he identified that 63.7% of the respondent were pleased with the mechanism of care of family planning services, he suggest some strategy for reducing long waiting times.

Also Timothy Williams and other (1996) in eight Latin American and Caribbean countries in their study they found that client were highly satisfied with family planning services they received, more than 95%, but 20% expressed dissatisfaction from waiting hours and 15% of client found difficulties to get the clinic site.

5.4.4 Direction and respect:

This dimension included 7 items, this refer to satisfaction of the client with primary health care clinic staff and the respect shown by them to the patient. It also refers to the patient

satisfaction toward confidence to the staff and their relationships with him. Direction and respect is the highest satisfaction score (75.9%) which is considered as one of the important quality dimension. This domain reflects to which extent the health team available when clients needed help and the rapidness to respond to client's request, moreover, awareness and participation of clients needs and allowed some freedom and privacy to the client in the clinic. On top of that the health team must treat the client with humor and humanity. These results are consistent with Abu saileek (2004) who revealed that attentiveness and openness domain reported level of satisfaction (70.7%). In my opinion to improve client satisfaction regarding this domain the health team may need to increase attentions and concerns toward client worries. Also health team may need more attention to psychological support of the client and deals with client as human. Also dealing with client friendly and give him some degree of freedom. Al Hindi (2002) showed that clients reported higher level of satisfaction (90%) with comfort and privacy and her results showed that health team may need more concern with the comfort of the clients and keeping their privacy in the investigation room (Al Hindi, 2002).

5.4.5 Medical counseling:

This dimension included 17 items this refer to satisfaction of the patient with medical examination and treatment regime shown from the health team to the patient, it also reflect the decision of health status between the patient and health team in the primary health care clinic. In contrast to the above-mentioned domains, interviewed clients expressed a high level of satisfaction with the process of information and counseling. The result of this study showed that (70%) of clients were satisfied with the medical counseling. The variables included in this domain were "proper health education, accurate explanation about hypertension and the availability of information booklet". Counseling is important part of ensuring that clients make informed-choices. Face to face meeting between a client

and provider may be the only chance to the client to ask questions, expresses concern and learns about different methods from someone who is knowledgeable and concerned. A successful interaction will build between the provider and the client, thereby encouraging the client to return if more help is needed (Family Health International, 1991).

The results of this study are consistent with the study of Mousa (2000) who showed that (83.9%) of the respondent were satisfied with the health education program. About (82%) of women agreed that field-workers give accurate and relevant information on the accepted contraceptive method regarding how to use, advantages, what to do if side effects occur, when and where to return and re-supply procedures. Findings also revealed that written materials are available on contraceptive methods at clinics as expressed by (79.4%) of the responding clients. Also, clients responded positively to the re-supply procedures where (93%) of them mentioned that they could obtain supplies of the used contraceptive method easily. The lowest satisfaction level was found with the information clients' received about the explanation of what the fieldworker are doing when taking care of them, only (70.8%) of women were satisfied of this process of care. In an overall, (89.7%) of women were satisfied with birth spacing consultative services they received from service delivery point staff (Mousa, 2000).

When done well, counseling can have a significant impact on users' satisfaction. A study in Gambia found that women who reported that they were inadequately counseled were more than three times as likely to stop contraceptive method as those who felt they were received sufficient information about side effect. To improve the shortcomings of information and counseling domain, the field- workers should create a climate so that the client feels accepted, non-defensive, and able to talk freely about herself and her feeling. The staff should use the elements of counseling, the GATHER (is drawn from the initials

of the following words) method, which includes; Greeting the clients, Ask clients about herself, Tell clients about the topics, Help the clients to participate in discussion of the topics, Explain how to get benefit from the topics and Return for evaluation and follow up. By doing so, the clients is therefore had given the opportunity to freely choose the suitable method for herself. To empower family planning's staff, training courses should be conducted in active listening, communication skills, questioning skills, problem solving and decision making. Also, information materials such as pamphlets, posters and booklets are important to teach clients about family planning, health providers have to work in cooperation to issue such materials. Those education materials should be communicated to clients at clinics, school health setting for preparatory and secondary girls' schools. Mass Media should be involved in raising the public awareness on this regard (Family Health International, 1991).

Also Abu saileek (2004) revealed that counseling and advising domain reflects that nurses teaching their clients' some thing related to health condition, also it reflects that nurses explain to their clients' how to deal with his problem at home, and allow client/family participation in decisions related to client care. The lowest level of satisfaction was expressed by the clients' toward the counseling and advising domain (59.5%). Also, the results showed that there are real differences between EGH clients' and Nasser Hospital clients, regarding the satisfaction level with counseling and advising domain. The EGH clients' reported (68.3%) of satisfaction level, while Nasser Hospital reported only (54.3%) of satisfaction level regarding counseling and advising domain. The counseling process should be an interactive one; whenever possible, providers should ask clients to state what they have heard in their own words to ensure that they understand the information being provided. Counseling and Advising are an important part of quality nursing care (Mousa, 2000).

5.4.6 Communication:

These include 5 items this reflects to the interaction and communication between his staff and the client. The important of client satisfaction with health care has been recognizing for it is many values. Primary health care services such as non communicable care need to be evaluated and client choose and response of the service to the client need and core important consideration. Research gives 3 mean reasons why measure patient satisfaction should be put in consideration severally. The problem area highlighted by this study is that the process of communication and interaction, elicited the lowest scores and only (19.7%) of the respondents were satisfied. For this domain, it is important to study the content of this satisfaction factor to point the areas of shortcoming and to recommend for health providers the need to improve the services. The contents of communication and interaction "Listening to clients, improper explanation of the needed information, respect of clients, long waiting time, privacy and expectations" which did not meet the acceptable performance standard.

The importance of keeping a good communication and interpersonal relations and the failure of the service delivery point staff to carry out this vital aspect of care has been a major theme in the literature. Henderson (1966), drew attention to this problem over 34 years ago, he posted that: "Acceptable communication makes clients feel worthwhile, valued and able to go on. Good communication creates a trustful relationship which makes clients responds to main messages".

1- There is convincing evidence that it is an important out core measure it is thought to be related to the improvement of health statues and complain to influence where patient re attend for treatment

2- It is useful tool with assessment consultation and communication and the give information involving patient decision about their care and being reassured in this category.
3- Information on satisfaction can provide evidence for the need to change the organization and provision of the health care services (Fitzpatrik, 1991)

This domain composed of communication, interaction and in formativeness aspects of service features. It reflects the extent of client's satisfaction with staff's answers and their response in case the clients inquire about some health related issues. This study revealed a lower degree of satisfaction with communication and interaction domain in comparable to other domains (19.7%). the researcher may attribute this results to client's complains of the communication and interaction , such as the staff's workload, their unfairness in dealing with different clients and their lack of concern with the psychological aspect of the clients. In fact, the sociable nature of Palestine people made clients aware of communication and interaction aspect of service. Clients expected higher level of communication from staff compared to the service they had actually received. This led them to complain and has result in dissatisfaction.

The literature emphasizes communication skills as an area in which quality improvement is required (Kersnik, 2000). The result of this study recommended the training of the staff to improve their skills to deal and interact with clients.

Professionals could improve the process of communication and interaction through dealing with each client as he/she is only patient. They could, give him/her the maximum care, meet their needs and respect her/his right to privacy and confidentiality. This enhances the relations between the clients and the staff and accordingly will increase the levels of client's satisfaction. Improving communication and interaction could be achieved by

providing training courses in communication including listening skills, silence, reducing distance, acknowledgment, seeking clarification, focusing and summarizing. In congruence with AI-Hindi (2002) study, which was conducted in Gaza Strip and investigated clients' satisfaction with radiology services, the researcher reported that the communication and interaction as expressed by the Palestinian clients' was (77.5%) satisfied and only (22.5%) dissatisfied. The result of this study is inconsistent with the result of our study due to different sample, design, number of sample and setting.

Another study conducted by Mousa (2000) who examined the clients' satisfaction with family planning services in Gaza Strip and showed that communication and interaction were reported the lowest degree of satisfaction, only (54%) of the respondents were satisfied with regard to the communication and interaction part of the service. The main actions that family planning service providers took to improve the process of communication and interaction through proper communication process that recognizes each client as an individual, with individual needs and respects of their rights to privacy, confidentiality and an opinion. Good communication of potential clients helps to ensure that these needs are satisfied and reduces unnecessary returns to the clinic or discontinuation due to misunderstandings about the method chosen. This could be attained by measures, such as providing core-fresher courses in communication (listening skills, information material) for clinics' staff and hiring a female doctor experienced in providing family planning in all clinics. Moreover, encouraging primary health care clinic's staff to provide and build a trustful relationship with clients through showing them that we care about them. We can apply that by understanding the client's feelings, respect clients friendly and polite and honesty, by telling the truth and not to hold back information that client wants (Mousa, 2000).

Similar findings revealed by Abu Shuaib (2005) study, which assess women perception and experience of childbirth services at governmental hospitals in Gaza Strip. The researcher reported that information and communication as expressed by Palestinian women was (78.1%). Another study conducted by Abu Saileek (2004), who examined the client's satisfaction with nursing care provided at selected hospitals in Gaza Strip showed that (67.4%) of the clients were satisfied with information and interaction dimension. Al Hindi (2002) conducted a study, which investigated c1ient's satisfaction with radiology services. The researcher reported that communication and interaction as expressed by Palestinian clients was (77.5%) satisfied and (22.5%) dissatisfied.

Andaleeb (2001) conducted a study, which evaluated the service quality perceptions and patient satisfaction in Bangladesh. Andaleeb reported that communication as expressed by Bangladesh clients was (69.1%) satisfied. Coulter and Cleary (2001) conducted a study, which analysis the patients' experiences with hospital care in five countries. The researchers reported that information and education as expressed by the respondents were in Germany (79.6%), Sweden (76.6%), Switzerland (83.3%), United Kingdom (71.3%) and United State (74.8%).

5.5 patient's characteristics and satisfaction

5.5.1 Differences in patient's satisfaction by Gender:

Table (5.24) Differences in patient's satisfaction by Gender

Dep. Var. " patient's satisfaction"	Indep. Var. "Gender"	N	Mean	SD	t	Sig.
General Satisfaction	Male	215	60.9	8.9	-2.650	0.008
	Female	155	63.3	8.1		
Satisfaction of health education	Male	215	9.3	4.0	-3.919	0.000
	Female	155	11.0	4.4		
Satisfaction of Accessibility	Male	215	6.8	2.3	-0.822	0.412
	Female	155	7.0	2.1		
Satisfaction of Direction respect	Male	215	24.5	4.6	-0.974	0.330
	Female	155	25.0	3.5		
Satisfaction of Medical counseling	Male	215	57.1	7.1	-2.928	0.004
	Female	155	59.1	5.4		
Satisfaction of Communication	Male	215	11.6	3.3	-2.908	0.004
	Female	155	12.7	4.0		

An independent t-test used to compare the means of satisfaction scores in regard to the gender. Table (5.23) showed that there are statistical differences between sex and general satisfaction. Female are satisfied more than male as the mean shows that (63.3) for female and (60.9) for male, and the significance is (t = -2.650, P value = 0.008). There are statistical differences between sex and health education. Female are satisfied more than male as the mean shows that (11.0) for female and (9.3) for male and the significance is (t = -3.919, P value = 0.000). There are no statistical differences between sex and accessibility, the significance is (t = -0.822, P value = 0.412). There are no statistical differences between sex and direction respect, the significance is (t = -0.974, P value = 0.330). There are statistical differences between sex and Medical counseling. Female are satisfied more than male as the mean shows that (59.1) for female and (57.1) for male and the significance is (t = -0.928, P value = 0.004). There are statistical differences between

sex and Communication. Female are satisfied more than male as the mean shows that (12.7) for female and (11.6) for male and the significance is (t = -2.908, P value = 0.004).

In this part of discussion the researcher dominate the relationship between dimension of patient satisfaction and demographic variables in order to understand these relations. The results show the satisfaction level was higher in females mean scores (63.3) were higher that men mean score (60.9), in general an all subscale dimensions the results identify the females were higher in the level of general satisfaction and its dimension and recording of statistically difference were present between males and females except in accessibility (P value = 0.412) and direction and respect (P value = 0.330). This result is consistent with Abu saileek (2004) who examined client satisfaction with nursing care provided at selected hospitals in Gaza Strip and identified that females were represented higher percent (52.2 %) while male percentage was (47.8%), also the statistical significant are no differences between males and females in their level of satisfaction regarding nursing care. our result is inconsistent with al Hindi (2002) results who identified that, there were no significant relationship between males and females regarding satisfaction level.

5.5.2 Differences in patient's satisfaction by Age group:

Table (5.25) Differences in patient's satisfaction by Age group

Dep. Var. " patient's satisfaction"	Indep. Var. "Age"	N	Mean	SD	F	Sig.
General Satisfaction	40 Yrs and less	42	60.8	9.4	7.370	0.000
	From 41 to 50 Yrs	124	60.3	8.1		
	From 51 to 60 Yrs	98	60.8	8.2		
	More than 60 Yrs	106	65.1	8.6		
	Total	370	61.9	8.6		
Satisfaction of health education	40 Yrs and less	42	10.6	4.3	0.293	0.830
	From 41 to 50 Yrs	124	10.0	4.5		
	From 51 to 60 Yrs	98	9.9	4.1		
	More than 60 Yrs	106	9.9	4.1		
	Total	370	10.0	4.2		
Satisfaction of Accessibility	40 Yrs and less	42	6.6	2.0	5.099	0.002
	From 41 to 50 Yrs	124	6.4	2.4		
	From 51 to 60 Yrs	98	7.1	2.0		
	More than 60 Yrs	106	7.5	2.2		
	Total	370	6.9	2.2		
Satisfaction of Direction respect	40 Yrs and less	42	25.9	3.9	6.167	0.000
	From 41 to 50 Yrs	124	24.6	3.8		
	From 51 to 60 Yrs	98	23.4	4.9		
	More than 60 Yrs	106	25.6	3.8		
	Total	370	24.7	4.2		
Satisfaction of Medical counseling	40 Yrs and less	42	58.4	5.9	6.656	0.000
	From 41 to 50 Yrs	124	56.9	6.4		
	From 51 to 60 Yrs	98	56.6	6.6		
	More than 60 Yrs	106	60.1	6.3		
	Total	370	57.9	6.5		
Satisfaction of Communication	40 Yrs and less	42	12.5	4.5	0.454	0.714
	From 41 to 50 Yrs	124	11.8	3.4		
	From 51 to 60 Yrs	98	12.1	3.9		
	More than 60 Yrs	106	12.1	3.3		
	Total	370	12.0	3.6		

As shown in Table (5.24), One way ANOVA was used to assess the differences between patient's satisfaction and the age groups of study population. The results revealed that there are statistical differences between age group and general satisfaction. The interval "more than 60 Yrs" are satisfied more than the others age groups as the mean shows that (65.1), and the significance is (P value = 0.000).There are no statistical differences between age group and health education, the significance is (P value = 0.830).There are statistical

differences between age group and Accessibility. The interval "more than 60 Yrs" are satisfied more than the others ages group as the mean shows that (7.5), and the significance is (P value = 0.000).There are statistical differences between age group and direction respect. The interval "40 Yrs and less" are satisfied more than the others ages group as the mean shows that (25.9), followed by the interval more than 60 Yrs with mean (25.6) the significance is (P value = 0.000).There are statistical differences between age group and medical counseling. The interval "more than 60 Yrs" are satisfied more than the others ages group as the mean shows that (60.1), and the significance is (P value = 0.000).There are no statistical differences between age group and communication, the significance is (P value = 0.714). In this study the age of the respondents rang from 37 – 70 the results revealed statistical significant difference between the age of the patient and general satisfaction (P value = 0.000), accessibility (P value = 0.002), direction and respect (P value =0.000), medical counseling (P value = 0.000) and no statistical significant between age of patient and health education (P value = 0.830) and communication (P value = 0.714). These finding showed that patient over 60 years of age have higher scores of satisfaction while age from 41- 50 lowest score of satisfaction. This result could be to the more exposing of health care by the old ages who visited the clinics more than the other so a full concern is needed to be directed to the younger age. This result is consistent with a study conduct by Abu saileek (2004) who found statistical significant difference between age group regarding satisfaction level, also older age reported higher level of satisfaction. Also this result is consistent with Abu Shuaib (2005) who identifies significant difference with women age. The results are inconsistent with another study done in Gaza Stripe Mousa (2000) he found that the all satisfaction was decrease as the age was increased.He concluded that the old people in Palestine tended to be less satisfaction

of the younger. Another study conducted by Al Hindi (2002) found that no statistical significant difference between age and satisfaction level.

5.5.3 Differences in patient's satisfaction by place of living:

Table (5.26) Differences in patient's satisfaction by place of living

Dep. Var. " patient's satisfaction"	Indep. Var. "Living Place"	N	Mean	SD	F	Sig.
General Satisfaction	City	257	62.0	8.5	0.200	0.819
	Camp	92	61.5	9.1		
	Village	21	62.7	9.1		
	Total	370	61.9	8.6		
Satisfaction of health education	City	257	10.1	4.3	3.066	0.048
	Camp	92	9.3	4.0		
	Village	21	11.8	4.1		
	Total	370	10.0	4.2		
Satisfaction of Accessibility	City	257	6.9	2.3	0.071	0.932
	Camp	92	7.0	2.2		
	Village	21	6.9	1.8		
	Total	370	6.9	2.2		
Satisfaction of Direction respect	City	257	25.0	3.7	6.581	0.002
	Camp	92	23.5	5.5		
	Village	21	26.6	2.7		
	Total	370	24.7	4.2		
Satisfaction of Medical counseling	City	257	57.8	6.2	0.312	0.732
	Camp	92	58.0	7.2		
	Village	21	59.0	7.1		
	Total	370	57.9	6.5		
Satisfaction of Communication	City	257	12.2	3.7	0.985	0.374
	Camp	92	11.6	3.6		
	Village	21	11.8	2.9		
	Total	370	12.0	3.6		

As shown in Table (5.25), One way ANOVA was used to assess the differences between the living places (City, Village, and Camp) of the respondents regarding the level of satisfaction. The results showed that, there are no statistical differences between place of living and general satisfaction, the significance is (P value = 0.819). There are statistical differences between place of living and health education. The persons who live in villages more satisfaction than the persons who lived in city or camps as the mean shows (11.8), the

significance is (P value = 0.048).There are no statistical differences between place of living and accessibility, the significance is (P value = 0.932).There are statistical differences between place of living and direction respect. The persons who live in villages more satisfaction than the persons who live in city or camps as the mean shows (26.6), the significance is (P value = 0.002).There are no statistical differences between place of living and medical counseling, the significance is (P value = 0.732). There are no statistical differences between place of living and communication. The significance is (P value = 0.374). With regard to residency place the results indicated that there was statistical significant difference between satisfaction, direction and respect and place of living, direction and respect, and no statistical significant difference between satisfaction and health education (P value = 0.048). Also patient who live in the camp have higher score of satisfaction than the other, this revealed that accessible and feasible of clinic to the patient is easier for the camp than the city and the village. The clinic in the study was situated in the central of the city. This result is consistent with Al Hindi (2002) she identified the residence tend to be more satisfied with communication and approach of care. Another fact influencing this result that people living in camp seek their care by the UNRWA health sector. Also this result is consistent with study done by Abu saileek (2004), he found that the client who were living in cities represent higher level of satisfaction 48% than who were living in camp. This result is inconsistent with Mousa (2002) who reported higher satisfaction of population living in refuges camp in Gaza Strip. On the other hand the result not consistent with Abu shuaib (2005) he found that the women living in villages reported higher score of perception with child birth services than who were living in cities.

5.5.4 Differences in patient's satisfaction by marital status:

Table (5.27) Differences in patient's satisfaction by marital status

Dep. Var. " patient's satisfaction"	Indep. Var. "Marital Status"	N	Mean	SD	F	Sig.
General Satisfaction	Married	281	61.8	8.5	0.888	0.447
	Single	15	59.4	10.2		
	Widow	59	63.1	9.3		
	Divorced	15	60.8	7.4		
	Total	370	61.9	8.6		
Satisfaction of health education	Married	281	10.3	4.3	3.222	0.023
	Single	15	9.0	4.4		
	Widow	59	8.6	3.5		
	Divorced	15	10.4	4.1		
	Total	370	10.0	4.2		
Satisfaction of Accessibility	Married	281	6.8	2.3	5.917	0.001
	Single	15	5.4	1.7		
	Widow	59	7.6	2.0		
	Divorced	15	8.0	1.5		
	Total	370	6.9	2.2		
Satisfaction of Direction respect	Married	281	24.7	3.9	0.226	0.879
	Single	15	24.0	4.8		
	Widow	59	25.0	5.3		
	Divorced	15	24.6	4.6		
	Total	370	24.7	4.2		
Satisfaction of Medical counseling	Married	281	58.0	6.5	0.392	0.759
	Single	15	56.4	6.7		
	Widow	59	57.7	7.4		
	Divorced	15	58.8	2.6		
	Total	370	57.9	6.5		
Satisfaction of Communication	Married	281	12.2	3.7	1.300	0.274
	Single	15	12.2	4.2		
	Widow	59	11.3	3.2		
	Divorced	15	11.2	3.2		
	Total	370	12.0	3.6		
All Satisfaction	Married	281	178.8	20.6	0.599	0.616
	Single	15	171.4	23.7		
	Widow	59	178.1	22.4		
	Divorced	15	178.5	12.9		
	Total	370	178.4	20.8		

As shown in Table (5.26), One way ANOVA was used to assess the differences between patient's satisfaction and marital status of study population. The results showed that, there

are no statistical differences between marital status and general satisfaction, the significance is (P value = 0.447).There are statistical differences between marital status and health education. Divorced patients are more satisfied more than the others, as the mean shows (10.4) followed by married with mean (10.3), the significance is (P value = 0.023).There are statistical differences between marital status and Accessibility. Divorced patients are more satisfaction more than the others as the mean shows (8.0), the significance is (P value = 0.001).There are no statistical differences between marital status and direction respect, the significance is (P value = 0.879).There are no statistical differences between marital status and medical counseling, the significance is (P value = 0.759).There are no statistical differences between marital status and communication, the significance is (P value = 0.616).

With regard to marital statues the results revealed that no statistical significant between marital statues and general satisfaction and no statistical difference between marital statues and direction and respect (P value = 0.879), medical counseling (P value = 0.759), communication (P value = 0.274), general satisfaction (P value = 0.447) and married client reveal higher level of satisfaction than the other group, while statistical difference between marital statues and health education (P value = 0.023, accessibility (P value = 0.001). The result might indicate that married patient have less satisfaction with direction respect, medical counseling. It might be due to married patient have more responsibilities at home. This finding was consistent with Al-Doghauther (2004) study which reveled that married people were more satisfied than the single people, also this result consistent with Abu saileek (2004) who reveled that the respondent people who were married showed higher percentage (65.3%) while the un married 34.8 %.The finding reported that there are significant difference in satisfaction level between married and unmarried clients. The married respondent reported higher level of satisfaction.

5.5.5 Differences in patient's satisfaction by level of education:

Table (5.28) Differences in patient's satisfaction by level of education

Dep. Var. " patient's satisfaction"	**Indep. Var.** "Education Level"	**N**	**Mean**	**SD**	**F**	**Sig.**
General Satisfaction	Illiterate	72	63.5	8.8	3.481	0.008
	Preparatory	138	62.7	8.6		
	Secondary	101	60.4	8.4		
	Diploma	38	62.2	8.6		
	Bachelor	18	56.7	8.6		
	Total	367	61.9	8.7		
Satisfaction of health education	Illiterate	72	9.9	4.1	9.449	0.000
	Preparatory	138	9.0	4.0		
	Secondary	101	10.0	4.1		
	Diploma	38	12.8	4.1		
	Bachelor	18	13.2	4.4		
	Total	367	10.0	4.3		
Satisfaction of Accessibility	Illiterate	72	6.7	2.1	4.830	0.001
	Preparatory	138	7.3	2.5		
	Secondary	101	7.1	2.0		
	Diploma	38	6.8	1.9		
	Bachelor	18	5.0	1.7		
	Total	367	6.9	2.2		
Satisfaction of Direction respect	Illiterate	72	25.3	3.4	1.091	0.361
	Preparatory	138	24.2	4.7		
	Secondary	101	24.9	4.1		
	Diploma	38	25.3	4.0		
	Bachelor	18	25.0	4.2		
	Total	367	24.8	4.2		
Satisfaction of Medical counseling	Illiterate	72	58.4	6.8	1.567	0.182
	Preparatory	138	57.1	5.9		
	Secondary	101	58.4	7.4		
	Diploma	38	59.6	4.5		
	Bachelor	18	56.7	6.9		
	Total	367	58.0	6.5		
Satisfaction of Communication	Illiterate	72	12.3	3.3	10.806	0.000
	Preparatory	138	10.8	3.5		
	Secondary	101	12.1	3.6		
	Diploma	38	13.8	3.4		
	Bachelor	18	15.3	3.2		
	Total	367	12.0	3.7		

As shown in Table (5.27), One way ANOVA was used to assess the differences between patient's satisfaction and level of education of study population. The results showed that, there are statistical differences between education and general satisfaction. Illiterate are satisfied more than other educational levels as the mean shows that (63.5) and the significance is (P value = 0.008).There are statistical differences between education and health education. Bachelor are satisfied more than the other educational levels as the mean shows that (13.2) and the significance is (P value = 0.000).There are statistical differences between education and Accessibility. Secondary are satisfied more than other educational levels, the significance is (P value = 0.001).There are no statistical differences between education and Direction respect, the significance is (P value = 0.361).There are no statistical differences between education and medical counseling, the significance is (P value = 0.182). There are statistical differences between education and Communication. Bachelor are satisfied more than other educational levels as the mean shows that (15.3), and the significance is (P value = 0.000). Regarding to the educational level, the result revealed that there is a real difference between satisfaction and health education (P value = 0.000), accessibility (P value = 0.001), communication (P value = 0.000), general satisfaction (P value = 0.008), while no significant different between satisfaction and direction and respect (P value = 0.361), medical counseling (P value = 0.182). This finding was consistent with Al Hindi (2002) she revealed that population of higher level of education reported a higher satisfaction level, also Mousa (2000) study revealed that the highly satisfied group is the higher educated, also Abu shuaib (2005) identified that no statistical significant differences between educational level and over all perspective, the results could be attribute either to difference to expectation or to attitude of the health team. Also educated patient tend to make comparison between the services they received in the past and services received now.

5.5.6 Differences in patient's satisfaction by current employment status:

Table (5.29) Differences in patient's satisfaction by current employment status

Dep. Var. " patient's satisfaction"	**Indep. Var.** "Employment status"	**N**	**Mean**	**Std**	**t**	**Sig.**
General Satisfaction	Yes	215	60.7	8.5	-3.103	0.002
	No	155	63.5	8.6		
Satisfaction of health education	Yes	215	10.1	4.3	0.446	0.656
	No	155	9.9	4.2		
Satisfaction of Accessibility	Yes	215	6.8	2.2	-1.058	0.291
	No	155	7.1	2.2		
Satisfaction of Direction respect	Yes	215	24.7	3.9	-0.147	0.883
	No	155	24.8	4.6		
Satisfaction of Medical counseling	Yes	215	57.6	6.3	-1.151	0.250
	No	155	58.4	6.8		
Satisfaction of Communication	Yes	215	11.9	3.8	-1.027	0.305
	No	155	12.2	3.4		

Another independent t-test used to compare the means of satisfaction scores in regard to employment status. Table (5.28) showed that there are statistical differences between working and general satisfaction domain. The patients who were not working are satisfied more than the patients who were working as the mean shows that 63.5 and the significance is (t = -3.103, P value = 0.002). There are no statistical differences between working and health education, (the significance is (t = 0.446, P value = 0.656), no statistical differences between working and Accessibility,(the significance is t = -1.058, P value = 0.291), no statistical differences between working and direction respect, (the significance is t = -0.147, P value = 0.883), no statistical differences between working and medical counseling, (the significance is t = -1.151, P value = 0.250), and no statistical differences between working and communication, (as the mean shows that (12.2), the significance is (t = -1.027, P value = 0.305). Regarding to the employment status the result reveled that there are statistical significant difference between working and general satisfaction (P value = 0.002) the patient who were not working are satisfied more than the patient who

were working. There are no statistical significant difference between working and other domains, working and health education (P value = 0.656), working and accessibility (P value = 0.291), direction and respect (P value = 0.883), medical counseling (P value = 0.250), communication (P value = 0.305).

This result is consistent with Abu shuaib (2005) who revealed that no statistical difference between employment with perspective, also this results consistent with Mousa (2000) study who revealed no statistical significant difference between economic status and satisfaction. More over Al Hindi (2002) identify that respondents with higher financial status tend to be more satisfied than respondent with lower financial status. The patients who have higher income tend to have higher expectation than patient who have lower income or unemployed tend to have lower expectation.

5.5.7 Differences in patient's satisfaction by period of disease discovery:

Table (5.30) Differences in patient's satisfaction by period of disease discovery

Dep. Var. " patient's satisfaction"	**Indep. Var.** " period of disease discovery "	**N**	**Mean**	**SD**	**F**	**Sig.**
General Satisfaction	Less than 5 Yrs	131	60.0	8.6	12.749	0.000
	From 6 to 10 Yrs	148	61.6	7.6		
	More than 10 yrs	82	65.8	8.8		
	Total	361	61.9	8.5		
Satisfaction of health education	Less than 5 Yrs	131	9.8	4.3	0.051	0.951
	From 6 to 10 Yrs	148	9.9	4.2		
	More than 10 yrs	82	10.0	4.2		
	Total	361	9.9	4.2		
Satisfaction of Accessibility	Less than 5 Yrs	131	6.6	2.0	20.991	0.000
	From 6 to 10 Yrs	148	6.5	2.4		
	More than 10 yrs	82	8.3	1.5		
	Total	361	7.0	2.2		
Satisfaction of Direction respect	Less than 5 Yrs	131	24.3	4.7	6.346	0.002
	From 6 to 10 Yrs	148	24.2	4.0		
	More than 10 yrs	82	26.1	3.4		
	Total	361	24.7	4.2		
Satisfaction of Medical counseling	Less than 5 Yrs	131	57.2	7.0	6.444	0.002
	From 6 to 10 Yrs	148	57.4	6.5		
	More than 10 yrs	82	60.2	5.6		
	Total	361	58.0	6.6		
Satisfaction of Communication	Less than 5 Yrs	131	11.7	3.5	0.814	0.444
	From 6 to 10 Yrs	148	12.3	3.7		
	More than 10 yrs	82	11.9	3.8		
	Total	361	12.0	3.7		

As shown in Table (5.29), One way ANOVA was used to assess the differences between patient's satisfaction by period of disease discovery of study population. The results showed that, There are statistical differences between discover of suffering from HBP and general satisfaction. The interval "more than 10 Yrs" are satisfied more than the others as the mean shows that (65.8) and the significance is (P value = 0.000). There are no statistical differences between discover of suffering from HBP and health education, the significance is (P value = 0.951). There are statistical differences between discover of

suffering from HBP and Accessibility. The interval "more than 10 Yrs" are satisfied more than the others as the mean shows that 8.3 and the significance is (P value = 0.000). There are statistical differences between discover of suffering from HBP and direction respect. The interval "more than 10 Years" are satisfied more than the others as the mean shows that (26.1), the significance is (P value = 0.002). There are statistical differences between discover of suffering from HBP and medical counseling. The interval "more than 10 Yrs" are satisfied more than the others as the mean shows that (60.2) and the significance is (P value = 0.002).There are no statistical differences between discover of suffering from HBP and communication. The significance is (P value = 0.444). Regarding to the period of discovery of the disease and satisfaction there are statistical difference between the period of discovery of hypertension and general satisfaction. The interval more then 10 years are satisfied more than the others, (P value = 0.000) and also statistical significant between period of suffering from hypertension and accessibility (P value = 0.000), statistical differences between period of suffering from hypertension and direction respect (p value = 0.002) and statistical differences between period of suffering hypertension and medical counseling while no statistical significant between period of suffering from hypertension and health education (P value = 0.951) and communication (p value = 0.444). This result is consistent with Abu saileek (2004), he revealed that client who spent 4 - 12 days in the hospital more satisfied with nursing care than the client who spent fewer days. On the other hand the result is inconsistent with Abu shuaib (2005) who found that the women who spent one day in the hospital were have higher positive perspectives with child birth services than the women who spend more than 3 days .

5.5.8 Differences in patient's satisfaction with Exercise:

Table (5.31) Differences in patient's satisfaction and Exercise

Dep. Var. " patient's satisfaction"	Indep. Var. " Exercise"	N	Mean	Std	t	Sig.
General Satisfaction	Yes	106	59.4	8.8	-3.476	0.001
	No	264	62.8	8.4		
Satisfaction of health education	Yes	106	10.6	4.5	1.628	0.104
	No	264	9.8	4.1		
Satisfaction of Accessibility	Yes	106	5.7	2.0	-7.190	0.000
	No	264	7.4	2.1		
Satisfaction of Direction respect	Yes	106	24.7	4.2	0.018	0.986
	No	264	24.7	4.2		
Satisfaction of Medical counseling	Yes	106	57.1	6.5	-1.552	0.122
	No	264	58.2	6.5		
Satisfaction of Communication	Yes	106	12.5	3.8	1.751	0.081
	No	264	11.8	3.6		
All Satisfaction	Yes	106	174.9	21.7	-2.012	0.045
	No	264	179.7	20.3		

An independent t-test used to compare the means of satisfaction scores in regard to the exercise. Table (5.30) showed there are statistical differences between exercise and general satisfaction. The patients who did not do exercises are satisfied more than the patients who did as the mean shows that (62.8) and the significance is (t = 0.3476, P value = 0.001).There are no statistical differences between doing exercises and health education, the significance is (t = 1.628, P value = 0.104).There are statistical differences between doing exercises and Accessibility. The patients who did no do exercises are satisfied more than the patients who did as the mean shows that (7.4) and the significance is (t = -7.190, P value = 0.000). There are no statistical differences between doing exercises and direction respect, the significance is (t = 0.018, P value = 0.986).There are no statistical differences between doing exercises and medical counseling and the significance is (t = -1.552, P value = 0.122).There are no statistical differences between doing exercises and communication and the significance is (t = 1.751, P value = 0.081).

5.5.9 Differences in patient's satisfaction by Smoking:

Table (5.32) Differences in patient's satisfaction and Smoking

Dep. Var. " patient's satisfaction"	Indep. Var. "Smoking"	N	Mean	Std	t	Sig.
General Satisfaction	Yes	275	62.7	8.6	2.721	0.007
	No	80	59.8	8.1		
Satisfaction of health education	Yes	275	10.4	4.4	3.489	0.001
	No	80	8.6	3.6		
Satisfaction of Accessibility	Yes	275	6.8	2.2	-2.856	0.005
	No	80	7.6	2.2		
Satisfaction of Direction respect	Yes	275	24.9	4.2	1.227	0.220
	No	80	24.3	3.8		
Satisfaction of Medical counseling	Yes	275	57.9	6.9	-0.426	0.670
	No	80	58.3	4.6		
Satisfaction of Communication	Yes	275	12.4	3.7	4.329	0.000
	No	80	10.5	3.3		
All Satisfaction	Yes	275	180.1	21.7	2.958	0.004
	No	80	173.8	15.2		

Another independent t-test used to compare the means of satisfaction scores in regard to smoking habits. Table (5.31) showed there are statistical differences between smoking and general satisfaction. The patients who smoke are satisfied more than the patients who did not as evidence by the mean (62.7) and the significance is (t = 2.721, P value = 0.007). There are statistical differences between smoking and health education. The patients who smoke are satisfied more than the patients who did not as evidence by the mean (10.4) and the significance is (t = 3.489, P value = 0.001).There are statistical differences between smoking and Accessibility. The patients who did not smoke are satisfied more than the patients who did as evidence by mean 7.6 and significance is (t = -2.856, P value = 0.005). There are no statistical differences between smoking and direction respect. The significance is (t = 1.227, P value = 0.220).There are statistical differences between smoking and Medical counseling. And the significance is (t = -0.426, P value = 0.670). There are statistical differences between smoking and communication. The patients who

smoke are satisfied more than the patients who did not as evidence by mean 12.4 and the significance is (t = 4.329, P value = 0.000). In regarding to smoking there is statistical significant between smoking and general satisfaction the patient who smoke are satisfied more than the patient who did not smoke (P value = 0.007), and there is also statistical significant between smoking and health education (P value = 0.001), statistical significant between smoking and accessibility (P value = 0.005), statistical significant between smoking and communication (P value = 0.000). On the other hand, there is no statistical significant differences between smoking and direction as evidence by (P value = 0.220), no statistical significant differences between smoking and medical counseling as evidence by (P value = 0.670).

Chapter Six

Conclusion and recommendations

Chapter Six

Conclusion and recommendation

6.1 Conclusion

In an attempt to assess the level of clients satisfaction with health care given to hypertensive patients in Gaza Strip, this study was conducted at two primary health centers, Al Rimal clinic in the north and Rafah central clinic in the south of Gaza. These two places could roughly present the care given to the hypertensive patients' in Gaza Strip.

The study findings might help in improving the quality of non communicable disease health services in Gaza Strip by providing some satisfaction indicators to improve the care given to these patients. Rafah clinic clients represent (79.5%) while Al Rimal clinic represents (20.5%) of study population. Males clients represent (58.1%) while female were (41.9%). The mean age for the study population was (54.4) years, with high percentage of age group 41- 60 years (60%). The majority of the respondents were living in city (69.5%). Financial status of the population seems mostly moderate of poor because more than (58%) of the respondents were not working. The majority of the population has free health insurance more than (68%). This reflected the difficult socioeconomic status that most Palestinian people suffered at this time, (65.9%) of studied population were married, and (58.3%) were had 6 members or more in the families. Majority of studied population were had low certificate- secondary or less (74.7%).

Majority of studied sample were not practiced body exercise (71.4%). Further more around (57.7%) were not practice nutritional system. Most of the population practice smoking habits (74.39%). This reflects the lack of health education sessions in regarding to chronic

diseases and the presence of smoking in these patients may be risk factor for other complications. Also most of the population studied had another disease associated with hypertension (66.9%) had diabetes with hypertension. Overall satisfaction level was reported at (56.5%). The domains of satisfaction with health services introduced to hypertensive patients are extracted to include general satisfaction (68.6%), health education (25.1%) accessibility (53.2%), communication and interaction (19.7%). The highest level of satisfaction was expressed toward direction respect (75.9%) which is reflecting client trust toward providers.

Also the clients reported high (70%) satisfaction score toward medical counseling. This positively affects client's health status and encourages them to cope good with their health and health team and to be aware of coming back and compliance to their treatment regimen. Moderate satisfaction score were reported with accessibility (53.2%) which system and the long time stay in the center and the complex management routine. Also the lowest satisfaction score were reported with health education (25.1%) and communication (19.7%). This reflects the lack of health education sessions in the clinic and in the media. Also the short time the doctor spent with the client also the lack of communication skills and interaction between client and health team.

Also this could be attributed to that most of them didn't informed about the services and lack of advices from their doctors. Therefore improving the quality of services encourages the clients to continuing attending the service provider and to avoid their turn over to other places to self care. On the other hand, poor communication and interaction were led to dissatisfaction because dealing with patients openly and in formativeness helps in changing patients' behaviors which positively affect their health care. Improving communication skills by training the staff improve their ability to deal with the clients and to inform them

about issues related to their health. It is of great value to consider all factors that might affect satisfaction. On the other hand this study showed some significant impact of demographic variables on satisfaction. There were strong correlation between client satisfaction and sex that females showed more satisfaction than males also old ages were satisfied more than young ages. Also people with low educational level are more satisfied than high educational level. This may attributed to the high expectation material of educated people from health teams.

There were statistical differences between working and general satisfaction domain. The patients who were not working are satisfied more than the patients who were working as the mean shows that 63.5 and the significance is (t = -3.103, P value = 0.002). There are no statistical differences between working and health education, the significance is (t = 0.446, P value = 0.656), no statistical differences between working and Accessibility, the significance is t = -1.058, P value = 0.291), no statistical differences between working and direction respect, the significance is t = -0.147, P value = 0.883), no statistical differences between working and medical counseling, the significance is (t = -1.151, P value = 0.250), and no statistical differences between working and communication, (as the mean shows that (12.2), the significance is (t = -1.027, P value = 0.305). Organizational variables showed great impact on satisfaction, the clients reported higher scores when the discovery of the diseases more than 10 years in comparison with the clients who discovered the disease earlier. This reflects those clients who discover disease before got more experience and more attitudes towards the health service have low level of satisfaction. Moreover it is worth for the organization to work more on scheduling and introduce the appointment system to decrease the waiting time to increase satisfaction with the care offered. Also increasing the contact time between client and his health team, listening carefully to him and his complains, and giving full information will improve

patients’ satisfaction as well, so there is a great necessity to make some changes in the health services and environment including shorting waiting time, offering some pleasant physical environment and improving communication skills. These factors might increase client satisfaction. The study showed no significant correlation between living place and satisfaction.

6.2 Recommendations

The study results had helped me to develop an in depth understanding of the problem and to address its causes. Therefore, it led me to put tentative recommendations based on the findings which might help health care providers, managers and professionals to set priorities, effective problem solving and quality improvement. Recommendations directed to improve organizational factors that may influence clients' satisfaction, and to improve the physical facilities

- Preventive strategies should be established on the basis for community that promotes healthy life styles by improving dietary habits, decrease smoking and increase physical activity.
- Primary health care managers and policy makers in health care institutions should improve the client's satisfaction level according to the global domains of clients to increase clients' satisfaction level.
- Encourages continuous education and training programs that will positively influence the health professional and competent. Provision of training the staff including physicians, technicians and the in front office personnel to improve their communication skills.
- Increasing the awareness of the health professionals about the importance of increasing the patient- doctor contact time in which it had a great impact on increasing the level of clients' satisfaction. Supporting strategies that appreciate the role of in formativeness of

the clients about their health related issues. The health provider's behaviors should inform patients about their health to help them in changing their behaviors in ways that positively influence their health.

- Health managers should utilize an appointment system through booking to reduce the waiting time which is one of the core factors that enhance clients' satisfaction and improve the quality of services.
- Health managers and health teams need to concentrate on the weakness domains of client satisfaction to develop their ability especially in communication and interaction and health education because better communication and interaction should increase client satisfaction.
- Health teams need to support effective strategies to provide the client all information about their diagnosis and plans of treatment and participation in their plans, this participation might lead to better client satisfaction.
- Improving physical environment of waiting area by providing adequate number of seats, also, by enhancing the level of cleanliness and decreasing the sources of noise.
- Directing efforts on a wide scale towards public awareness and education about their health rights. Also, supporting and guiding them to acquire knowledge and skills in dealing and presenting themselves to health providers.

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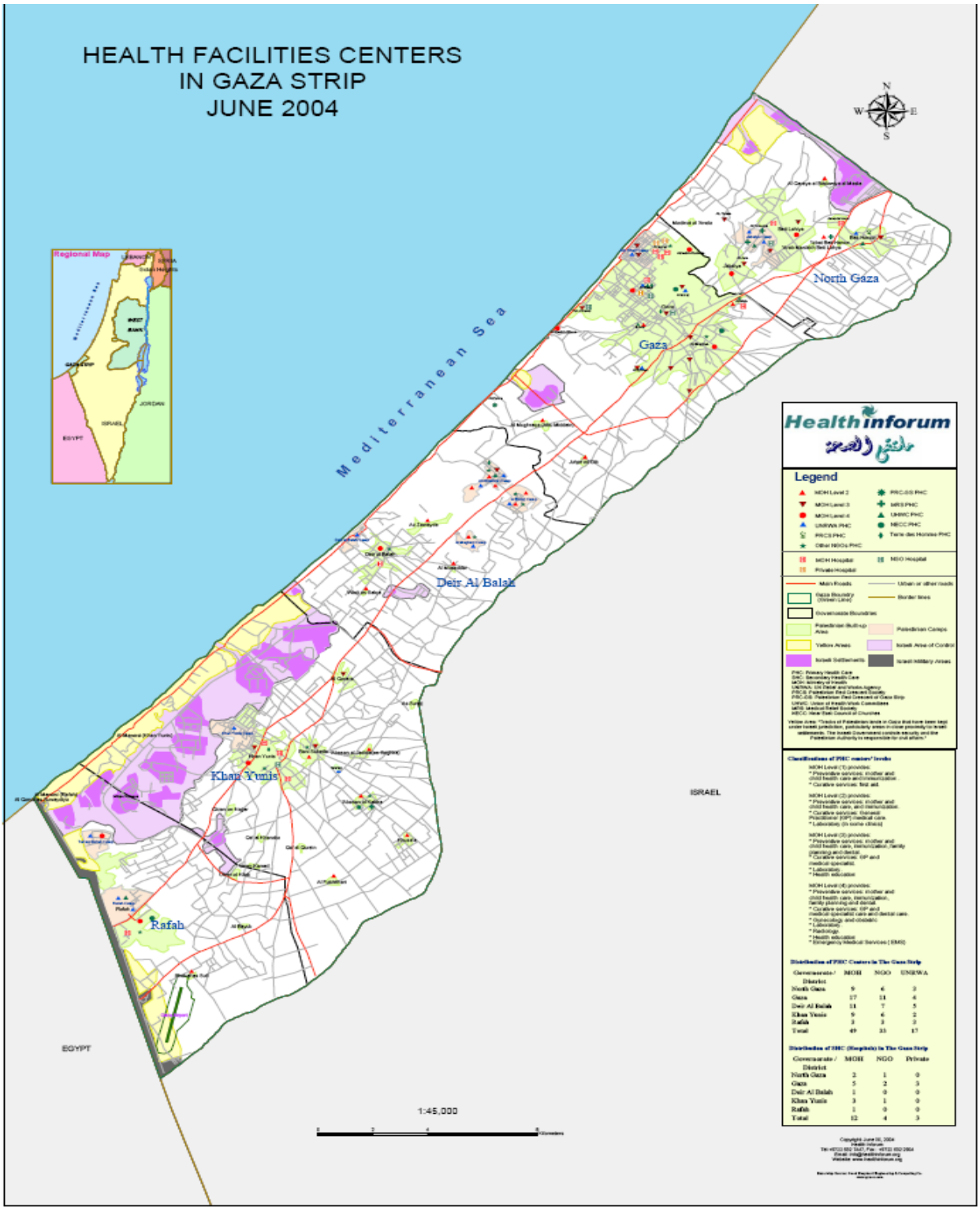
Annexes

Annex No. (1)

GAZA STRIP



Annex No. (2)

Agreement of Ministry of Health

Al-Quds University
Jerusalem
School of Public Health

جامعة القدس
القدس
كلية الصحة العامة

2008/12/21

الأخ الدكتور / فؤاد العيسوي المحترم
مدير عام الرعاية الأولية بوزارة الصحة
تحية طيبة وبعد،،،

الموضوع: مساعدة الطالب ياسر نصر الله إبراهيم

يقوم الطالب المذكور أعلاه بإجراء بحث بعنوان:

"Hypertensive Patients' satisfaction with services Provided at Gaza Governmental Primary Health Care Centers"

كمتطلب للحصول على درجة الماجستير في الصحة العامة-مسار إدارة صحية و عليه نرجو التكرم للإيعاز لمن تروونه مناسب لتسهيل مهمة الطالب في جمع البيانات اللازمة من مراكز الرعاية الأولية التابعة لدائرتكم الموقرة. علماً بأن المعلومات ستكون متوفرة لدى الباحث و الجامعة فقط و سنطلعكم على النتائج في حينه.

و اقبلوا فائق التحية و الاحترام،،،

د. بسام أبو حمد
منسق عام برامج الصحة العامة

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Annex No. (3)

The Cover letter of the Questionnaire

دعوة للمشاركة

في دراسة

"رضا مرضى ضغط الدم المرتفع عن الخدمات المقدمة من قبل مراكز الرعاية الصحية الأولية الحكومية في غزة"

أخي / أختي المراجعة :

يسعدني جداً مشاركتكم الفاعلة في هذا البحث الذي هو جزء من رسالة الماجستير في كلية الصحة العامة – جامعة القدس.

إن الغرض من هذه الدراسة هو تقدير مستوى " رضا مرضى ضغط الدم المرتفع عن الخدمات المقدمة من قبل مراكز الرعاية الصحية الأولية الحكومية في غزة ".

هذه الاستبانة أداة تعكس رأيكم الذي نأمل أن يعود بالفائدة للنهوض بمستوى و جودة الخدمات الصحية المقدمة في وزارة الصحة.

السرية التامة مكفولة، و لا حاجة لذكر اسمك.

يرجى الإجابة عن الأسئلة كافة وفق ما تراه مناسباً، حيث لا توجد إجابات أو آراء صحيحة وأخرى خاطئة.

الإجابة عما ورد في هذه الاستبانة قد يستغرق 20 دقيقة تقريباً.

رغم أنى أرحب بمشاركتك إلا أنه من حقك عدم المشاركة إذا أردت ذلك.

ولكم جزيل الشكر،،،

الباحث / ياسر الشاعر
كلية الصحة العامة
جامعة القدس

Annex No. (4)

Questionnaire in Arabic language

أولاً : معلومات أساسية:

1) الاسم ..... :العمر..... :
2) الجنس : 1- ذكر 2- أنثى
3) مكان السكن : 1- مدينة 2- مخيم 3- قرية أو ريف
4) نوع السكن : 1- ملك 2- إيجار 3- غير ذلك
5) أين تتلقى خدماتك الصحية .....
6) هل يوجد تأمين صحي؟ 1- نعم 2- لا
7) ما هو نوع التأمين الصحي (إذا كان موجود)؟

1- اختياري 2- شئون اجتماعية 3- نقابات العمال 4- عمال إسرائيل 5- عقود
6- بلديات 7- موظف حكومة 8- مجاني 9- متقاعد 10-أخرى.....

8) الحالة الاجتماعية:

1 -متزوج 2- أعزب 3- أرمل 4- مطلق

9) عدد أفراد الأسرة يشمل الوالدين _____فرد :

1- (5) أو أقل 2- (9 – 6) أفراد 3- أكثر من 9 أفراد

10) التعليم:

1- أمي 2- إعدادي 3- ثانوي 4- دبلوم 5- جامعي فأعلى

11) هل تعمل؟ 1- نعم 2- لا
12) ما طبيعة عملك؟ عامل مكتب، عامل بناء، بائع، سائق، أخرى.....
13) منذ متى اكتشفت أنك تعاني من ضغط الدم المرتفع.....
14) هل كنت تقيس ضغط الدم قبل اكتشاف أنك تعاني من ضغط الدم؟ 1- نعم 2- لا
15) إذا كان نعم، حدد المدة: 1- يومياً 2- أسبوعيا 3- شهرياً 4- غير منتظم
16) متوسط الضغط في الأسبوع الأخير .....
17) ما هي الأعراض التي شكوت أو تشكو منها .....
18) هل سبق وأن أُدخلت المستشفى قبل بدء المتابعة مع مركز الرعاية الصحية الأولية؟

1- نعم 2- لا

19) إذا كانت الإجابة نعم فلماذا؟ .....
20) هل تعاني من أمراض أخرى؟ 1- نعم 2- لا
21) إذا كانت الإجابة نعم، حدد نوعها: سكر، قلب، كلى، ربو... الخ
22) الوزن .....
23) الطول .....
24) كتلة الجسم (تحسب بواسطة الباحث)
25) هل تمارس الرياضة؟ 1- نعم 2- لا

26) ما نوع الرياضة التي تمارسها؟ .....

27) هل تتبع نظام غذائي محدد؟ 1- نعم 2- لا

28) هل أنت مدخن؟ 1- غير مدخن 2- مدخن 3- مدخن سابق

29) ما النوع الذي تدخنه؟ 1- السجائر 2- الأرجيلة

30) إذا كنت مدخن سجائر كم عدد السجائر التي تستهلكها في اليوم؟ .....

31) هل يعاني أحد أقاربك من الضغط المرتفع؟ 1- نعم 2- لا

32) إذا كان نعم، حدد صلة القرابة: .....

ثانياً :الرضا العام:

33) هل توجد خدمات للأمراض المزمنة في المركز؟

1- نعم 2- لا

34) هل أنت راضٍ عن وقت الانتظار قبل معاينة الطبيب لك؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

35) هل أنت راضي عن الطريقة التي يتعامل بها الطاقم الصحي في مركز الرعاية الأولية؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

36) هل أنت راضي عن الكشف الطبي الذي تم لك ومتابعة حالتك الصحية أثناء زيارتك للمركز؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

37) هل أنت راضي عن مستوى الخبرة التي يتمتع بها مقدمو الخدمات الصحية في هذا المركز؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

38) هل أنت راضي عن الوقت الذي تقضيه خلال الزيارة/المراجعة للطبيب؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

39) هل أنت راضي عن المدة الزمنية التي استغرقتها منذ دخلت العيادة وحتى دخولك للطبيب؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

40) هل أنت راضي عن المدة التي تمكثها مع الطبيب؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

41) هل عملت فحوصات طبية؟

1- نعم 2 - لا

42) هل أنت راضي عن المدة التي استغرقتها في إجراء فحوصات مثل فحص الدم –الأشعة – الخ؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

43) هل أنت راضي عن المدة الزمنية التي استغرقتها في صرف الدواء من الصيدلية؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

44) هل أنت راضي عن الفحوصات المخبرية المتوفرة في المركز الصحي الذي تراجع فيه؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

45) هل أنت راضي عن نوع العلاج "الأدوية " التي تستخدمها؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

46) هل أنت راضي عن التحسن في حالتك الصحية؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

47) هل أنت راضي عن توفر الأدوية في الوقت المناسب؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

48) هل أنت راض عن الخدمات المقدمة لك من قبل الطبيب؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

49) هل أنت راض عن الخدمات المقدمة لك من قبل التمريض؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

50) هل أنت راض عن الخدمات المقدمة لك من قبل المختبر؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

51) هل أنت راضي عن الخدمات المقدمة لك من قبل الصيدلة؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

52) هل أنت راضي عن الخدمات المقدمة لك من قبل الإداريين؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

53) هل أنت راضي عن الاهتمام بوضعك الصحي؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

ثالثاً: التثقيف الصحي:

54) هل يتم تقديم خدمات تثقيفية في المركز؟

1- نعم 2- لا

55) هل أنت راضي عن تزويدك بمواد تثقيفية حول ضغط الدم المرتفع من قبل مراكز الرعاية الصحية الأولية؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

56) هل أنت راضي عن التوعية من قبل الأطباء بخصوص مرضى ضغط الدم المرتفع؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

57) هل أنت راضي عن التوعية عبر الصحف أو التلفزيون او الراديو بخصوص مرضى ضغط الدم المرتفع؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

58) هل أنت راضي عن النشرات التي تصدرها الوزارة حول ضغط الدم المرتفع؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

رابعاً: إمكانية الوصول للخدمة:

59) هل هناك خدمة المواعيد المحددة في المركز؟

1- نعم 2- لا

60) كم مرة زرت العيادة آخر مرة بما فيها هذه الزيارة؟ عدد المرات

1- منذ أقل من شهر. (_____)

2- من (1- 6) شهور. (_____)

3- من (6- 12) شهر. (_____)

61) هل أنت راضي عن المدة التي استغرقتها في الوصول للعيادة؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

62) هل أنت راضي عن التنقل داخل المركز الصحي؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

خامساً: التوجيهات الاحترام:

63) هل أنت راضي عن الطاقم الذي يتعامل معك؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

64) هل أنت راضي عن طريقة الشرح التي يقوم بها الطاقم الطبي؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

65) هل أنت راضي عن احترام مقدمي الخدمات الصحية لك؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

66) هل أنت راضي عن مستوى احترام الطبيب عند مقابلته لك؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

67) هل أنت راضي عن احترام الممرض عند مقابلته لك؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

68) هل أنت راضي عن احترام فني المختبر عند مقابلته لك؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

69) هل أنت راضي عن احترام موظف الإداري عند مقابلته لك؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

سادساً: الاستشارة الصحية:

70) هل أنت راضي عن سلوك وتصرفات الطبيب العام في العيادة ؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

71) هل أنت راضي عن وصف العلاج من خلال المحادثة؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

72) هل أنت راضي عن الاستعانة بالمختبرات والأشعة في التشخيص؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

73) هل أنت راضي عن وصف الدواء /كتابة وصفات طبية للعلاج؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

74) هل أنت راضي عن الوقت الذي استغرقته في الاستشارة؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

75) هل أنت راضي عن طريقة إخبار الطبيب عن مشاكلك؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

76) هل أنت راضي عن مشاركتك في اتخاذ القرارات التي تخص رعايتك الطبية؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

77) هل أنت راضي عن طريقة استماع الطبيب إلى مشاكلك؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

78) هل تأخذ علاجات أخرى من خارج المركز؟

1- نعم 2- لا

79) هل أنت راضي عن المحافظة عن سرية سجلاتك وبياناتك؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

80) هل أنت راضي عن مساعدته لك على الشعور بالتحسن الذي يجعلك تستطيع القيام بنشاطاتك اليومية العادية؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

81) هل أنت راضي عن الفحوصات التي يقوم بها الفريق الصحي لجسمك؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

82) هل يتم إرشادك عن المضاعفات التي تترتب على المرض؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

83) هل أنت راضي عن شرح الغرض من الفحوصات والعلاج؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

84) هل أنت راضي عن إخبلوك عما تريد معرفته حول الأعراض أو الأمراض؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

85) هل أنت راضي عن مساعدته في التعامل مع المشاكل الانفعالية /العاطفية المتعلقة بوضعك الصحي؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

86) هل أنت راضي عن مساعدتك في فهم أهمية إتباع نصائحه؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

87) هل أنت راضي عن المساعدة الكاملة من الطاقم عدا الطبيب؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

سابعاً: طرق الاتصال والمعلومات المقدمة

88) هل أنت راضي عن إعطاءك الموعد الذي يناسبك؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

89) هل أنت راضي عن التواصل معك عبر التليفون؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

90) هل أنت راضي عن القدرة على التحدث مع الطبيب عبر الهاتف؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

91) هل أنت راضي عن زمن الانتظار في غرفة الانتظار؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

92) هل أنت راضي عن الخدمات المقدمة في حال حدوث وضع طارئ لك؟

1- راضي جداً 2- راضي 3- لا رأي لي 4- غير راضي 5- غير راضي جداً

Annex No. (5)

Questionnaire in English language

First: Basic Information:

1) Age……

2) Sex: 1. Male 2. Female

3) Address : 1.City 2.Camp 3.Village/ Countryside

4) Housing Type : 1.Owned 2.Rent 3.Other

5) Where do you get your health services? .....

6) Do you have a health insurance? 1.Yes 2.No

7) What type of health insurance do you have? (If yes)

1. Voluntary 2.Social Affairs 3.Workers Syndicates 4.Israel Laborers

5. Contracts 6.Municipalities 7.Gov.Employee 8.Free 9.Retired 10.Other

8) Marital Status:

1. Married 2.Single 3.Widow 4.Divorced

9) No. of family members including the parents……..members:

1. (5) or less 2. (6-9) members 3. More than 9 members

10) Education:

1. Illiterate 2.Preparatory 3.Secondary 4.Diploma 5.University and more

11) Do you Work? 1. Yes 2.No

12) Kind of Work? Office Worker, Bricklayer, Salesman, Driver, Other……

13) Since when did you discover you suffer from High Blood Pressure? .....

14) Have you measured your Blood Pressure before you discover you suffer from High Blood Pressure? 1. Yes 2.No

15) If Yes, Specify the period: 1. Daily 2.Weekly 3.Monthly 4.Irregular

16) Average blood pressure in the last week……

17) What Symptoms did/do you complain? .....

18) Have you ever been admitted to the hospital before you attend to the P H C center?

1. Yes 2. No

19) If the answer is yes, why? .....

20) Do you suffer from any other diseases? 1. Yes 2.No

21) If the answer is yes, Specify kind of disease: D M, Cardiac, Kidney, Asthma….etc.

22) Weight…….

23) Height……..

24) Body mass (To be assessed by the Researcher)……

25) Do you practice sport? 1. Yes 2.No

26) Kind of sport do you practice? .....

27) Do you follow a specified diet regimen? 1. Yes 2.No

28) Are you a smoker? 1. Not Smoking 2. Smoker 3. Ex Smoker

29) What type of tobacco? 1. Cigarette 2. Hubble-Bubble

30) If you are a cigarette smoker, how many cigarettes do you smoke a day ?.....

31) Does any of your relatives suffer from high Blood Pressure? 1. Yes 2.No

32) If Yes, specify the kind of relation: ……

Second: General Satisfaction:

33) Are there health services for the chronic diseases in the health center ?

1. Yes 2. No

34) Are you satisfied with the waiting time before the physician examines you?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

35) Are you satisfied with the way the health staff is dealing with in the P H C Center?

1. Very Satisfied 2. Satisfied 3. No opinion 4. Unsatisfied 5. Very Unsatisfied

36) Are you satisfied with the medical examination and follow up to your health status that you have during your attendance to the center?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

37) Are you satisfied with the level of experience the health providers have in this center?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

38) Are you satisfied with the time you spend during your attendance/ medical checking?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

39) Are you satisfied with the time since you came in the center till see the physician?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

40) Are you satisfied with the time you spend with the physician ?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

41) Did you have any medical examinations? 1. Yes 2. No

42) Are you satisfied with the time spent on the necessary tests e.g. blood tests, X-ray?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

43) Are you satisfied with the time spent on getting the medicines from the pharmacy?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

44) Are you satisfied with the laboratory tests provided in the center that you attend?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

45) Are you satisfied with the type of drugs/medicines which you use?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

46) Are you satisfied with the improvement in your health status ?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

47) Are you satisfied with availability of the drugs on the right time?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

48) Are you satisfied with the health services provided by the Physician?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

49) Are you satisfied with the health services provided by the nursing staff?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

50) Are you satisfied with the health services provided by the Laboratory staff?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

51) Are you satisfied with the health services provided by the pharmacy staff?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

52) Are you satisfied with the health services provided by the administrative staff?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

53. Are you satisfied with the way your health status is taken care of?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

Third: Health Education:

54) Are there any health education services provided in the health center?

1. Yes 2.No

55) Are you satisfied with the health education materials about high BP in PHC center?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

56) Are you satisfied with the health education awareness provided by the physicians about high blood pressure patients?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

57) Are you satisfied with the health education awareness provided by the newspapers, and/or media (TV & Radio) regarding the high blood pressure patients?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

58) Are you satisfied with the health education awareness brochures and booklets issued by the Ministry of Health about high blood pressure?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

Fourth: Accessibility to Health Service:

59) Is there an appointment service system in the health center?

1. Yes 2. No

60) How many times have you attended to the health clinic including this time ?

1. Since less than one month (_____ times)

2. (1-6) months (_____ times)

3. (6-12) months (_____ times)

61) Are you satisfied with the period of time spent on accessing the health clinic?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

62) Are you satisfied with mobility between the departments of the health center?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

Fifth: Directions / Respect:

63) Are you satisfied with the health staff that takes care of you?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

64) Are you satisfied with the way the procedure is explained by the medical staff?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

65) Are you satisfied with the level of respect expressed by the health services providers?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

66) Are you satisfied with level of respect expressed by the physician when seeing you?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

67) Are you satisfied with the level of respect expressed to you by the nurse?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

68) Are you satisfied with the level of respect expressed by the laboratory technician?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

69) Are you satisfied with the level of respect expressed by the administrative official?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

Sixth: The Medical Counseling

70) Are you satisfied with the actions and behaviors of the general physician in the clinic?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

71) Are you satisfied with prescribing the medicines through the conversation with you?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

72) Are you satisfied with the use of laboratory and X-Ray in the diagnostic process?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

73) Are you satisfied with the drug prescription / writing prescription for treatment?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

74) Are you satisfied with the period of time spent on the consultation?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

75) Are you satisfied with the way of telling the physician about your health problems?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

76) Are you satisfied with participating in making decisions related to your medical care?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

77) Are you satisfied with the way the physician is listening to your problems?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

78) Are you taking any other medications outside the health center?

1. Yes 2. No

79) Are you satisfied with maintaining the privacy of your health records and data?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

80) Are you satisfied with the physician's helping you to feel better enough to do your regular daily activities?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

81) Are you satisfied with the medical tests made for your body by the health team?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

82) Are you clearly directed about the medical complications resulted from your illness?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

83) Are you satisfied with the explanation for the purpose of medical tests and treatment?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

84) Are you satisfied with informing you about what you need to know regarding the symptoms or the diseases?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

85) Are you satisfied with the physician's way of helping you to deal with the emotional/ psychological problems related to your health status?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

86) Are you satisfied with helping you in understanding the importance of following the physician' advices?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

87) Are you satisfied with the help of all the health team except the physician?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

Seventh: Methods of Communication and Information Provided :

88) Are you satisfied with giving you the appointment suitable for you?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

89) Are you satisfied with communication with you by the telephone?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

90) Are you satisfied with your ability to talk to the physician by the telephone?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

91) Are you satisfied with the waiting time length at the waiting room?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

92) Are you satisfied with health services provided in case of emergency you may have?

1. Very satisfied 2. Satisfied 3. No Opinion 4. Unsatisfied 5. Very Unsatisfied

Annex No. (6)

ملخص الدراسة

"رضا مرضى ضغط الدم المرتفع عن الخدمات المقدمة من قبل مراكز الرعاية الصحية الأولية الحكومية في غزة"

لا يستطيع أحد أن ينكر أن رضا المرضى ذو أهمية مركزية في تقييم جودة الخدمات الصحية المقدمة, وقد إزدادت هذه الأهمية في الوقت الحالي وستزداد في المستقبل.

وكذلك يعتبر الرضا للمرضى مؤشر مهم لتحسين جودة الخدمات الصحية, وهذه الدراسة هدفت إلى معرفة وتقييم رضا مرضى ضغط الدم عن الخدمات المقدمة لهم في مراكز الرعاية الصحية الأولية الحكومية, وقد إستخدم الباحث دراسة وصفية مقطعية من خلال إختيار العينة بالطريقة الفجائية أي بمقابلة من يحضر من المرضى .

وقد تم صياغة أداة البحث وهي عبارة عن إستبيان تم توزيعه على المرضى اللذين يرتادون مركز شهداء رفح الصحي ومركز شهداء الرمال الصحي للعلاج والمتابعة.

وقد كانت العينة عبارة عن 370 مريض منهم 300 مريض في عيادة شهداء رفح و 70 مريض في عيادة شهداء الرمال, وكانت نسبة الإستجابة 100%.

وقد إستخدم الباحث طرق تحليلية وعدة إختبارات لفحص النتائج ومقدار الثبات والمصداقية وقد كانت كرونباخ ألفا (0.760). وقد أظهرت الدراسة 6 محددات للرضا وهي كالتالي:

الرضا العام, التثقيف الصحي, إمكانية الوصول للخدمة, التوجيهات والاحترام, الإستشارة الطبية, طرق الإتصال والمعلومات.

وقد أظهرت النتائج أن نسبة الرضا العام (68.6%), ونسبة الرضا عن التثقيف الصحي (25.1%), الرضا عن الإتصال والحصول على المعلومات (19.7%), الرضا عن سهولة الوصول للخدمة

(53.2%), الرضا عن الإستشارة الطبية (70%), وكانت أعلى نسبة من الرضا هي الرضا عن التوجيهات والاحترام (75.9%).

وقد أظهرت النتائج أيضاً بعض المتغيرات الأخرى مثل, نسبة الرضا عند النساء, وكبار السن , والقرويين, والمطلقين, وإنخفاض المستوى التعليمي, واللذين لايعملون, واللذين لا يقومون بنشاطات رياضية, والمدخنين, قد أظهروا مستوى عالي من الرضا.

والرجال, الأعمار الأخرى, سكان المدينة, المتزوجين, المتعلمين , الموظفين, واللذين يقومون بنشاطات رياضية, و الغير مدخنين, قد أظهروا نسبة منخفضة من الرضا.

ومن نتائج البحث أن هناك أهمية للإتصال والتواصل وبرامج التثقيف الصحي في مراكز الرعاية الصحية الأولية حيث أن هذان العاملان لهما تأثير كبير على رضا المرضى , وأكثر من ذلك أعطت الدراسة نافذة للمسؤلين وواضعي السياسات الصحية في وزارة الصحة لإستخدام نتائج هذا البحث والعوامل المؤثرة على رضا المرضى والعمل على تطوير البرامج والآليات لزيادة الرضا لدى المرضى.