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Faculty of Graduate Studies

Quality Assessment of Primary Health Care Delivered to Children Under 5 Years Old in North West-Bank / Palestine

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Dedication

For my husband, daughters Yumna and Sraa, parents, brothers, sisters and all nephews with love and gratefulness.

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الإقرار

أنا الموقعة اسمي أدناه مقدمة الرسالة التي تحمل العنوان:

Quality Assessment of Primary Health Care Delivered to Children under 5 Years Old in North West-Bank / Palestine

تقييم جودة خدمات الرعاية الصحية الأولية المقدمة للأطفال دون سن الخامسة في شمال الضفة الغربية / فلسطين

اقر بأن ما اشتملت عليه هذه الرسالة إنما هو نتاج جهدي الخاص، باستثناء ما تمت الإشارة إليه حيثما ورد، وان هذه الرسالة ككل، أو أي جزء منها لم يقدم من قبل لنيل أية درجة علمية أو بحث علمي أو بحثي لدى أية مؤسسة تعليمية أو بحثية أخرى.

Declaration

The work provided in this thesis, unless otherwise referenced, is there searcher's own work, and has not been submitted elsewhere for any other degree of qualification.

Student's name: **اسم الطالبة:**

Signature: **التوقيع:**

Date: **التاريخ:**

Abbreviations

HW: Health Worker.

IMCI: Integrated Management Program of Childhood Illness

MCH: Maternal and Child Health.

MOH: Ministry of Health.

NGOs: Non-Government Organizations

PHC: Primary Health Care

UNICEF: United Nations International Children's Emergency Fund.

UNRWA: United Nation Relief and Works Agency.

WB: West Bank

WHO: World Health Organization.

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Abstract

Background: In lower and middle-income countries, primary health care works as a first point of contact between population and health care system. Most of these countries concentrate on health care center size rather than quality of health services delivered, wherever, good health care system performance leads to good health indicators (8).

Study aim: this study aim to assess and evaluate the quality of primary health care delivered to children under 5 in North West Bank / Palestine, utilizing the IMCI as theoretical guideline for conducting this study.

Method: a cross sectional study was conducted in PHC clinics at three selected areas in North West Bank (Jenin, Tubas, Nablus). A close-ended questionnaire using likert scale consisted of three parts (caregiver, health worker, and clinic infrastructure part). All primary health care clinics distributed in (Jenin, Tubas, Nablus) were included in the study (83), convenient sample of health workers (216) and child caregivers (133).

Results: Place of living related significantly to perceptions of caregivers quality assessment in general satisfaction dimension only

(P<0.05), caregivers in villages were satisfied about health service. Whereas, caregivers education level was also related significantly with perceptions of caregivers quality assessment in general satisfaction and counseling dimensions (P<0.05). Caregiver-child relation, waiting time, and duration of receiving primary health care services were not related to the perceptions of caregivers in all dimensions (P>0.05).

Health workers' gender related significantly (P<0.05) on perceptions of health workers quality assessment in quality of administration and training dimensions; males were not in agree on quality assessment for primary health care clinics services in the two dimensions, contrary, females strongly agreed on the same dimensions. Relationship between HW educational level and his quality assessment was statistically significant on administration dimension only (P<0.05). HW experience and specialization was related significantly with his/her perceptions of quality assessment on administration, performance and training dimensions (P<0.05).

Quality assessment of primary health care clinics regarding to services**,** infrastructure**,** medical equipments**,** drug availability and cleanness of primary health care facility was positive at (P<0.05) in total score and all dimensions which means it was available. Primary health care clinic district was not related significantly with the quality of primary health care clinics regarding to services**,** infrastructure**,** medical equipments**,** drug availability and cleanness of the PHC facility.

Conclusion: Child caregivers, health workers perceptions showed positive attitude towards quality assessment of primary health care clinics services. Quality assessment of primary health care clinics regarding to services**,** infrastructure**,** medical equipments**,** drug availability and cleanness of the primary health care facility was significantly positive.

Chapter One

Introduction

Chapter One
Introduction

1.1 Background

Primary health care (PHC) was described in the declaration of Alma-Ata as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible through people's full participation and at a cost that the community and country can afford. It is the central function of the health system and its first level of contact, bringing health care as close as possible to where people live and work" (1).

Primary health care services in Palestine are variable for all people with different ages. There are general practitioners' clinics, specialists (pediatric, obstetric, internal medicine, skin and venereal), maternal and child health, health education activities, emergency services as well as laboratory services in the clinics of level two and above. Moreover, physiotherapy services in some of clinics of level four are there (2).

Palestinian population is considered as one of the young communities where those who are under 15 years consist a 47% out of the total population of 4,048,4 (3), and the probability of dying before 5^{th} birthday is 25.4 per 1000 (2). PHC services delivered for children are considered the most targeted group around the world. Each year over 10 million children in low and middle income countries die before the age of 5 years old, and about half of those deaths are due to pneumonia, diarrhea,

malaria and measles. In addition, malnutrition contributes to about 50% of those deaths (4, 5, 6).

The primary health care clinics, have to play their role effectively and efficiently; which starts with diagnosis, treatment, and extends to include health promotion, health prevention, support and rehabilitation, and all that could achieve client's satisfaction, which is defined by Locker and Dunt as: "the extent of an individuals experience compared with his or her expectations"(7).

The role of primary health care is to improve quality of health; an outcome could be enhanced by implicating a comprehensive guideline like the “Integrated Management Program of Childhood Illness (IMCI),” which is developed by WHO, UNICEF, and other technical partners to reduce mortality and morbidity among children around the world (4).

In lower and middle income countries, primary health care works as a first point of contact between population and health care system, in most of these countries do concentrate on the size of health care centers not on type or quality of delivered services, wherever, good health care system performance leads to good health indicators (8).

The importance of quality which is the core of health system is rising up; the quality which makes the health sector able to improve and promote health that directly affects and enhances patients’ satisfaction. Thus, quality demands optimizing material inputs and practitioner skill to produce health.

As the Institution of Medicine in Washington (2001) defined it, quality of health is "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (9).

Referring to the health related literature, Donabedian developed the conceptual framework for quality assessment and systems monitoring; a framework that consists of three main perspectives (10, 11, 12):

1. Structure: this involves assessing the adequacy of facilities and equipment, administrative process, quality and quantity of health personnel in terms of their medical training.

2. Process: this includes adherence to good medical care; clinical history, physical examination, diagnostic tests, justifications of diagnosis and therapy, technical competence, evidence of preventative management, co-ordination and continuity of care, acceptability of care to the recipient. At community level, this includes the quality of performance of health personnel concerning managing acute problems such as acute respiratory infections and diarrhea in the case of children.

3. Outcome- considers whether a change in a person’s current and future health status can be attributed to health care reception. Measuring of infant mortality and maternal mortality or quality of health are other means of reflecting the impact of the health system on community health.

1.2 The scope of primary health care

Primary health care provides immediate and often continuing care for children, adults, or families, and considered as their point of entry to the formal health care system. In developing countries, public health posts and health centers often provide this care through nurses and mid-level health workers. Ideally, doctors are available for support, training, and referrals (13).

Primary health care serves several unique and essential purposes (13):

- The first point of contact with health system for many individuals
- Handle a wide range of basic health condition
- Provide follow – up services, where patients are followed over time by the same primary care providers
- Coordination with higher levels of health system that can provide more specialized care when needed
- Reach out to marginalized and underserved groups, who may not otherwise seek or receive health care.

1.3 Quality of primary health care

The quality of primary health care services delivered to clients should achieve its ultimatum goal in case to achieve the scope of primary health care.

Good quality of primary health care is described in terms of access to care, effectiveness of care, with including, both clinical as well as interpersonal aspects of the process.

By access, the good accessibility for primary health care services resides in prenatal care, vaccination programs, screening and treatment of epidemic diseases, programs targeting chronic illnesses, specialist care, and access to health education. Further beyond, in order to improve access to services, primary health care centers should establish appointment systems, registers, and follow-up systems (14).

When it refers to effectiveness, primary health care is effective when clinical decisions are reported in terms of prescribing patterns and diagnostic and referral practices. In addition, the effectiveness of PHC has to: reduces disease burden, produces economic savings, and assures greater equity (15).

The very fact that primary health care includes the provision of many services that some might consider "common place" heightens the importance of assessing and assuring its quality. It's all too easy to assume that the lower need for advanced technology in primary health care implies a lower need for quality standards. On the contrary, the very simplicity of main primary health care activities mean that they are subject to faulty performance, for instance, ignoring health promotion activities for the caregiver may increase child morbidity in short as well as in long term (16).

1.4 Quality of primary health care in developing countries

While it has long been thought that the assessment and assurance of quality is a luxury confined to the more developed countries, many now believe that quality is not the domain of the richer countries alone, quality assurance could be applied effectively in developing countries (17).

Quality assurance holds a great potential for improving quality of care, even in the most resource constrained health care systems, since it focuses on the process of health care delivery. Great sensitivity and caution should be exerted, however, to adapt quality assurance methods to the prevailing cultural norms and values, the availability of resources and local priorities, thus, avoiding mere replication of western methodology (18).

In many developing countries the studies do emphasize that there is poor child health care delivered by health professionals in PHC level, and as it is described in those studies, the most concern areas are; incorrect diagnosis, un obligation as the IMCI guideline elements require, long waiting time, inappropriate prescription of drugs; especially the antibiotics (19). For that, the need to focus on improving primary health care delivery is that much necessary in developing countries through the improvement of PHC personnel performance, utilization of global guidelines like the IMCI which is one of most accessible one in developing countries.

1.4.1 Integrated Management Program of Childhood Illness-(IMCI) definition aims and development

The role of primary health care is to improve quality of health; an outcome could be enhanced by implicating a comprehensive guideline like the “Integrated Management Program of Childhood Illness (IMCI),” which is developed by WHO, UNICEF, and other technical partners to reduce mortality and morbidity among children around the world (4).

Integrated Management of Childhood Illness (IMCI) is a systematic approach to children's health which focuses on the whole child. This means not only focusing on curative care but also on prevention of disease (20).

The main aims of IMCI is to develop and improve health system, improve skills of health workers, improve knowledge and practices of families in relation to their young children, decrease in mortality and morbidity ratios among under five years children (21).

Furthermore, the IMCI combines prevention and treatment of common childhood illnesses in a simple guidelines and messages for use in first-level health facilities and communities. Primary health care alone may be not sufficient for improving health equity (22,23), polices that emphasize a primary health care strategy can potentially worsen health inequalities temporarily, mainly because new public health intervention programs tend to reach those of higher socioeconomic status first and later those of lower socioeconomic ones (24,25).

1.4.2 Main challenges interface IMCI implementation

Beyond the main goals of IMCI, there are more challenges that face its implementation, the most well recognized are (6):

1. Delivering existing, effective interventions that are part of IMCI to those who need them most in the community, especially the most vulnerable.

2. Accelerate implementation to reach maximum coverage while sustaining the achievements made and keeping the quality of interventions.

3. Make resources available to support implementation.

1.4.3 Children under five years old

Over two thirds of under 5 years child deaths are due to diseases that are preventable and treatable through simple and affordable interventions. enhancing health systems to provide such effective interventions to all children will protect many young lives. About 20 million children around the world suffer from severe acute malnutrition, which exposed them to serious illness and early death. Globally, in 2010, an estimated 171 million children below five years of age, were stunted and 104 million were underweight. Optimal breastfeeding and complementary feeding help prevent malnutrition and can save about a million child lives (26).

1.5 Health care in Palestine

Most Palestinians have easy access to health services, but this is mostly because of the short distances in the Palestinian territories. Gaza

Strip and West Bank have independent health care systems, causing duplication of services and increased costs (27).

Hardship upon Palestinian territory has caused a deterioration of the primary health care network. UNRWA has since 2007 increased its activities to meet the need of Palestinians for health services (27). A restriction on movement represents hardship for many in West Bank, those not living immediately near a health station or hospital.

1.5.1 Primary health care services in Palestine

The Palestinian Ministry of Health-MOH is considered the main provider of primary health services in Palestine. There are 416 primary health care centers owned and supervised by Palestinian MOH. These centers are distributed as 57 centers in the Gaza Strip and 359 centers in the west bank (28).

The most popular NGOs operating health care in Palestine are Red Crescent Societies, the Patient's Friends Societies, Women's Union Societies, Medical Relief Committees and Islamic Zakat Charitable Fund.

NGOs had 187 PHC centers, 57 centers in Gaza strip, and 130 centers in West Bank (29).

United Nation Relief and Works Agency-UNRWA health program focuses on comprehensive preventive and primary health care. Services are covering medical care, family health, disease control and prevention, and health education. These services are provided directly and at no cost to

Palestinian refugees through the agency's network of 53 primary health care facilities that are located both inside and outside refugee camps; 18 in Gaza strip and 35 in West Bank (30).

Palestinian MOH provides PHC services at four levels of facilities(3):

First level: *Health Post* (cover less than 1,000 populations): Provides preventive health services (hygiene, sanitation, and MCH services) and keeps records. In addition, health post provides curative services such as first aid.

Second level: *Health Clinic* (covers 1000-3000 populations): staffed by a general practitioner and nurses. It provides all preventive and general curative services throughout the week.

Third level: *Health Centre* (covers 3000-10000 populations): provides the same services as the health clinic plus the routine laboratory tests and preventive dentistry.

Fourth level: *Comprehensive Health Centre* (covers 10,000-25,000 populations): offers the same preventive services as the health centre. Comprehensive health centre provides extra curative services such as general medicine, specialized consultations, and emergency care.

1.5.2 Utilization of PHC centers in Palestine

According to Palestinian MOH there are two PHC centers per 10,000 populations in Palestine. 4,273,820 visits reported to the public PHC clinics

in 2004 with average of 1.64 visits per person in Gaza Strip and 0.88 visits per person in the West Bank per year. About 1.17 visits seen by general practitioner per year, 0.25 visits seen by nurses per person, and 0.10 visits per person for specialist clinic (2).

There are 2.41 general practitioners per 10,000 populations working in PHC, while there are 0.84 specialist, 0.77 dentist, 0.70 pharmacist, 4.42 nurses, 0.72 midwives, 0.72 health workers and 3.8 paramedics per 10,000 populations in Palestine (2).

1.5.3 Integrated Management of Childhood Illness in Palestine

According to the WHO implementation of IMCI, it involves three phases (31):

- The introductory phase: to ensure that key persons in MOH and other health services providers understand IMCI strategy, to establish a management structure and to build national capacity.

- The early implementation phase: to plan and prepare for IMCI implementation, including adaptation of the generic IMCI clinical guidelines, selection of a limited number of districts for initial implementation, and to build national and district capacity to implement IMCI activities.

- The expansion phase: includes efforts to increase access and to broaden the range of IMCI interventions. Problems identified during the early

implementation phase are addressed, priorities agreed, and strategies for expanding access while maintaining quality are developed.

In early implementation phase; health facilities implement IMCI since 2005 started with 100 (16.1%) out of 619 PHC facilities. This rate refers to PHC facilities with at least a physician trained in IMCI (32).

1.6 Study significance

Primary health care have the largest attendance and performance to improve the maternal and child health care, where their health is considered as one of the major indicators which evaluate the health of society and could help in improving the socioeconomic status of the country, like infant mortality rate (IMR), under 5 mortality rate (U5MR), maternal mortality ratio (MMR), and neonatal mortality rate (NMR).

Highlighting such subject will enhance better performance for health system. Also, PHC as the first point of contact between population and health care system bringing health service as close as possible to where people live, make it more important for such study, where the literature survey indicates lack of related studies in Palestine.

The importance of this study is that it will add beneficial information to child caregiver, as well as health workers. Moreover, the results will be also significant for the decision makers, who work in the area of health care at level of primary care.

1.7 Study goal and objectives

1.7.1 Main goal

The main goal is to assess the quality of primary health care delivered to children in North West Bank/Palestine districts (Tubas, Nablus and Jenin) as perceived by health workers and child caregivers in addition to assess the PHC clinic infrastructure.

1.7.2 Specific objectives

1- To assess the quality of primary health care delivered to children according to child caregivers.

2- To assess the quality of primary health care delivered to children according to primary health care workers.

3- To identify the quality of primary health care delivered to children based on primary health care facility (services**,** infrastructure**,** medical equipments**,** drug availability and cleanness of the PHC facility).

1.8 Study questions

- What is the quality assessment of PHC clinics services according to children's caregiver?
- What is the quality assessment of PHC according to PHC workers?
- What is the quality assessment of PHC clinics regarding the PHC services**,** infrastructure**,** medical equipments, drug availability and cleanness of the PHC facility?

1.9 Study hypotheses

This study includes the following null hypotheses:

1) There are no statistically significant differences at ($P < 0.05$) for quality assessment of PHC clinics as perceived by caregivers of children under 5 years old according to; place of living, child relation, waiting time to receive PHC service, duration of receiving PHC services and education level of caregivers.

2) There are no statistically significant differences at ($P < 0.05$) for quality assessment of PHC clinics as perceived by PHC clinic workers according to; gender, educational level, experience, and specialization.

3) There are no statistically significant differences at ($P < 0.05$) for quality assessment of PHC clinics regarding the PHC services**,** infrastructure**,** medical equipments**,** drug availability and cleanness according to clinic district (Nablus, Jenin and Tubas).

1.10 Definitions

Caregiver: An individual, such as a parent, foster parent, or head of a household, who attends to the needs of a child or dependent adult (33).

Health Service: the organization that runs all the medical services of a country which available to the public (33).

IMR: Infant Mortality Rate, the number of children dying under a year of age divided by the number of live births that year. The infant mortality rate is also called the infant death rate (33).

MMR: Maternal Mortality Rate, the number of maternal deaths related to childbearing divided by the number of live births (or by the number of live births plus fetal deaths) in that year (33).

Morbidity: is a term that refers to the diseased state or a state of substandard health that results from any number of causes. This term can be used to refer to the existence of the disease in a portion of a population (33).

Mortality: A fatal outcome or, in one word, death. The word "mortality" is derived from "mortal" which came from the Latin "mors" (death) (33).

PHC: Primary Health Care, basic level of health care that includes programs directed at the promotion of health, early diagnosis of disease or disability, and prevention of disease (33).

1.11 Chapter summary

This chapter aimed at giving a clear description of PHC delivered for children in perception of HW, child caregiver, and PHC facility. Moreover, defining the problem statement of this study and to clearly define its objectives.

Chapter Two

Literature review

Chapter Two
Literature review

2.1 Introductions

The aim of this chapter is to review and summarize the literature about quality assessment of PHC services delivered to children under 5 years old including IMCI at global, regional and national level as perceived by caregiver, health workers and health facilities available for children health care.

2.2 Primary health care

From many perceptions primary health care is accepted as the model for delivering basic health care to low income populations in developing countries (34). The different views of PHC today reflect differing experiences with the concept and its implementation since 1978. In developed countries like Australia; PHC performance at the national level is seen as an important part of the health sector, at least for rural health, but views on what it is vary. Best Practice in PHC has been an integral part of Australian PHC strategy, with national and state health departments and their research agendas, and the literature, continuing to emphasize the need for more effective PHC research evaluation to occur. Also increasingly emphasized is the importance of chronic and complex care programs and the need for better prevention components in these programs (35).

At the WHO beginning, primary health care was started as “an idea whose time had come” (36) and achieving “Health for All by the Year

2000" program was the golden goal. Yet at the beginning of the 21st century perceptions of its success were mixed from the perception of different countries (37).

Hall and Taylor discussed the reasons for the "demise of the Alma-Ata Declaration and primary health care in developing countries", PHC did not achieve its goals for several reasons, including the refusal of experts and politicians in developed countries to accept the principle that communities should plan and implement their own healthcare services (38). An editorial by Cueto focused on the "promise of primary health care", and how it could increase and enhance the health of poor people (39). Practitioners such as Keleher argued for the importance of primary care to health systems and health, with some talking about PHC and primary care interchangeably and others were distinguishing PHC from primary care (35).

2.3 The roots of primary health care

To understand modern PHC it helps to have a sense of its origins. PHC had its roots in world events leading up to the 1970s. Post-World War two; organizations such as the United Nations, the WHO, and the World Bank, were established with mandates to 'make a difference' to the disadvantaged world. By the mid-1960s, the majority of colonized countries in Africa and Asia had become politically, but not economically, independent. Social scientists were increasingly questioning the massive investments in so-called 'development' programs, the effects of which had

not ‘trickled down’ to the rural sectors of ‘developing’ countries as anticipated, but had in fact led to a very ‘specific distorted development’ (40).

The WHO and UNICEF supported the push for basic health services in the 1960s and early 1970s, which started with governments establishing networks of peripheral health facilities. These were to provide curative and preventive services to the 80% of population living in socially and geographically remote regions - ‘health for the people’, rather than the continual investment in hospitals, providing secondary and tertiary care in urban areas to 20% of the population and consuming over 80% of the budget (41). Developing countries were also involved in vertical programs such as malaria and smallpox eradication, which influenced their initial PHC strategies and contributed to the selective versus comprehensive PHC debate that began almost before the ink had dried on the Alma-Ata Declaration (42).

In the early 1970s and in the world events the situation was that countries had “not demonstrated convincingly” that they would be able to solve their problems in a finite period of time (43). However at this time there were signs that ‘health by the people’ programs, in a range of settings as diverse as Cuba, China, Tanzania, India, Bangladesh, Niger and Guatemala, where there was active participation of communities in their own care, were impacting favorably on those communities (44).

The Declaration of Alma-Ata was adopted at the International Conference on Primary Health Care (PHC), Almaty (formerly Alma-Ata), currently in Kazakhstan, 6-12 September 1978. It expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world. It was the first international declaration underlining the importance of primary health care. The primary health care approach has since then been accepted by member countries of WHO as the key to achieving the goal of "Health for All" (45).

The Declaration of Alma-Ata introduced PHC, “health for all by the year 2000” (HFA2000), to an international audience. This was only the beginning of the Declaration. It went on to state that PHC is the first level of contact that individuals and families have with the national health system, and this is often the limited view that many have of it. However, the declaration was very clear that it is an integral part of an integrated system of comprehensive health care encompassing the preventive, promotive, curative and rehabilitative continuum. It was also clear about the need for inter-sectoral cooperation; and that there is a set of activities or elements that make up PHC practice (46).

2.4 Quality assessment of primary health care

As it was mentioned above PHC defined as: the central function of the health system and its first level of contact, bringing health care as close as possible to where people live and work. So through the PHC services

we can achieve quality of health which is defined as: the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Number of studies have examined the quality of PHC.

In developed countries and in Britain; Hudson and other researcher asked the question about the quality assessment: is the Focus on Providers or on Patients?

Most studies of ambulatory care quality are based on chart reviews of episodes of care in single settings, rather than on care received by a patient over time and across settings. The purpose of this study was to compare ambulatory care quality scores based on information from the usual source of care to scores based on information from all providers seen during a year. The quality of well child care for 55 two-year-olds and asthma care for 70 children and adults continuously enrolled in the Maryland Medicaid program was assessed **.**

Combining data from multiple providers changed quality scores in both directions. For well child care, quality scores generally improved because of an increased opportunity to perform desirable actions, such as lead screening. However, quality scores for asthma care generally decreased because undesirable clinician actions, such as the failure to document follow-up plans, increased as more problems were uncovered. Thus, the findings of quality assessments differ according to whether the focus is on care delivered by individual providers or on care received by

patients. The direction of the difference will depend upon whether the indicators of quality represent omission of recommended care or commission of improper care (47).

A cross sectional study in Bandar Abbas Iran found that quality of health services section is very important because its role in health maintenance and care of community. Researchers tried to assess quality of PHC from women's perceptions of current situation in health centers. A total of 400, filled out a questionnaire, which had been designed according to servqual instrument (service quality framework to measure the gape between perceived and expected services) for measuring their perceptions and expectations about services quality. This instrument consisted of five dimensions including tangibles, reliability, responsiveness, assurance and empathy. They found that the majority of participants (64%) assessed the quality of services as moderate. The best dimension of service quality was assurance, followed by reliability, responsiveness and tangibles with empathy being the worst. The study found significant differences in women's perceptions and expectations in all of the five dimensions which was statistically meaningful ($P<0.01$) (48).

A cross sectional study in Nigeria aimed to assess the quality of child health services in PHC clinics, in Calabar, data collected through interviews, structured observations, self-administered questionnaires and focus group discussions. As a result, it was found that these clinics did well in diarrhea management and immunization but did not achieve the expected

performance for PHC services, including management of acute respiratory infection, common problem of children, inadequate supply of essential drugs, and mothers complained from long waiting time, lack of drugs and behaviors of health worker. Weak infrastructure and structure, omission to obligate with government protocols lead to these outcomes. To deal with such a situation, it was suggested that avoiding concentration on recourse intensive structure, but also on cheap, cost effective measures that address actual delivery of service in all elements of health process is workable (49).

In Botswana, researchers evaluated the adherence of health workers to guidelines of management of acute respiratory infection and diarrhea in children under five years, through observation of consecutive consultation at 30 randomly assigned clinics in three districts. After describing those who obligate with guidelines according to the case of diarrhea or respiratory infection, they concluded that health care providers adhere to the guidelines in taking history in both cases but poor in examining both conditions, and for both cases, it was founds that high level of prescribing inappropriate antibiotic was a great of concern. Overall, there is considerable scope for improving diagnostic and therapeutic management of these major childhood diseases in Botswana PHC (50).

In a study established to produce an overview about the quality of PHC within the Saudi Arabia (SA) context, it was found that there is a lack of knowledge about PHC quality. Researchers used systematic research strategy data with reference to published literature to assess and evaluate

the obstacles that affect the bath of achieving high quality of health care. It was found that there was substantial variation in the quality of Saudi primary health care services. In order to improve quality, it was concluded, there is a need to improve the management and organization of primary care services. Furthermore, professional development strategies were also needed to improve the knowledge and skills of the health working staffs (14).

In the United Arab Emirates (UAE), PHC quality was studied as a target health basement which could strongly affect health behind other factors like population per bed, physician per bed and others. Researchers found out that there was a very good coverage of PHC clinics which has been achieved throughout the country; where all PHC clinics provide curative, preventive and promotive services with a small percentage of rehabilitation services. They recommended that they have a lot to make for improving health services and performance as well as better meeting the specific medical care needs of the people through expansion of PHC services (51).

In United Arab Emirates (UAE) in 2003, a study evaluated the suitability of a patient satisfaction questionnaire to survey health care consumers of traditional Arabic background; a comparison was made in the level of patient satisfaction who attends PHC services. Within the study, a questionnaire was used to compare between the only resource intensive clinic-RIC (exhaustive resources) and one resource thrifty clinic-RTC

(basic resources) in six domains (continuity, comprehensiveness, health education, effectiveness, accessibility and humaneness). The sample was convenient and includes those who attend both clinics for five days. Results showed that RIC was significantly higher than RTC in continuity, comprehensiveness, health education, effectiveness and overall satisfaction (52).

In Gaza Strip, Palestine, a study conducted to examine the extent to which primary care patients are using the PHC services. Researcher concludes that Gazean primary care patients are high users of PHC services. The increased use of these services is associated with the basic predisposing, enabling and needs factors and with the unique bad living conditions, so effective health management, based on promoting a healthy lifestyle, is needed. The findings of the study can be used to improve health service planning and guide decision-makers towards healthcare resource allocation according to healthcare needs (53).

In Palestine, UNRWA reported in 2006 that the pattern of child mortality in Palestine remain unchanged from that which prevailing in the last few years, the two main causes of death were prematurely and congenital malformation plus to other preventable diseases like gastroenteritis and respiratory infection so the main objective of health services is to reduce childhood mortality and morbidity (54).

A study conducted in Nablus city of Palestine to detect patient satisfaction with hospital services, satisfaction was more from the

perception of female, older and high income patients rather than male, younger and low income patients, researcher indicate that patients' satisfaction surveys should be carried out routinely in all aspects of health care to improve quality of services (7).

In a qualitative assessment study in Ramallah, Palestine, researchers tried to detect patients' perceptions of access to care for cardiovascular diseases and diabetes mellitus in Ramallah clinics. The study included; four clinics selected to represent the main health care providers in Ramallah: an outpatient cardiology clinic (urban setting) and three primary healthcare clinics (rural and refugee-camp settings). The most important subject became clear differently between primary and secondary health care centers, patients at the primary health care centers expressed higher satisfaction than for secondary health care, determined by strong social ties and a sense of belonging to the providers and the health care centre (55).

2.5 Integrated Management Program of Childhood Illness-(IMCI) related reviews

Recent studies suggest that despite the availability of effective and applicable guidelines like the IMCI guideline in primary health care centers, which can conduct and manage the childhood diseases, the quality and performance of services is still low (50, 56).

A study in Vietnam, conducted to assess the availability of basic infrastructure. The conclusion was that all community health centers in

rural Vietnam had 100 % supplies of new born scales, stethoscopes, thermometers, adult scales, telephones and disposal plastic syringes (57).

In Totonicap n, Guatemala health facilities; a study conducted to compare validity of three methods for assessment performance of health workers in primary care facilities, these methods are; checklist-based observation of the consultation, interview with the mother following the consultation, and review of patient's clinical record. The study concludes: direct observation demonstrated the best overall balance of sensitivity and specificity. Depart interview of the mother demonstrated good sensitivity and better specificity than record review (58).

Combining with other countries under the umbrella of WHO, Tanzania like others tried in a national study to assess as well as evaluate IMCI effectiveness, cost and impact. The study came to compare between four neighboring districts implementing IMCI; 2 of them started implementing the IMCI in 1997 (Morogoro and Rufiji) and the other 2 districts started in 2002 (Kilombero and Ulanga). Comparing child health survival in the four districts was documented, particularly between clinics according to case management and health systems support in the IMCI. Results showed that those children in IMCI districts that started in 1997, received good quality of health more than those who are within the other districts: more assessed for child health problem, correct diagnosis and treatment for cases, more awareness when it comes to health care takers in relation to their child position and how to deal with the sick child. It was

concluded that it is feasible for the IMCI to be implemented in the poor countries and can lead to rapid gains in the quality of case-management. IMCI is therefore likely to lead to rapid gains in child survival, health and development, and if adequate coverage for all levels takes place, a good quality of health could be achieved and maintained (59).

In the path of evaluating effectiveness, impact, and cost effectiveness of IMCI, Bangladesh like Tanzania and other developing countries evaluated these elements. Researcher described the quality of care delivered to sick children under five years old in governmental facilities; within the results, it was found that few children were fully assessed or treated correctly, almost non of child caregivers were advised on how to continue the care of child at home. Such results pointed that there is necessity to improve a training strategy that should include lower level workers, also findings explored that the IMCI could offer a promising set of interventions to address the child health problem in the country (60).

In Bangladesh, a survey was done in health facilities at baseline of applying IMCI and was repeated about 2 years after implementation. The results showed improvements in the quality of care in health facilities, increases in use of facilities, and gains in the proportion of sick children taken to an appropriate health care provider. These findings are being used to strengthen child health care nationwide. They suggest that low levels of use of health facilities could be improved by investing in quality of care and health systems support (61).

In Cape Town of South Africa, a study showed that under normal operating conditions and in a context of good facility infrastructure and management support, IMCI is associated with improvements in some important aspects of care such as assessing co-morbidity and danger signs in sick children (62).

After 7 years experience for the IMCI protocol, a study established in Morocco to weigh up quality of outpatient health care services delivery of health care for less than 5 years old children on a sample consisted of 397 sick children, at 45 health facilities. It was found that out of 10 main assessment tasks included in this indicator, index was higher in children seen by doctors who had received follow up training compared to those who did not receive follow up training. Most of children requiring antibiotics received them and all were prescribed as recommended by IMCI guidelines, with great compliance with the national essential medicines policy. In addition, prescriptions were in line with guidelines for dose and frequency of administration, though tended to overlook duration of treatment. The findings also suggest the need to improve health providers' communication skills, especially with regarding to messages on care seeking, to check maternal health as per the IMCI guidelines and distribute selected tasks systematically between doctors and nurses for delivering the full scope of IMCI. The findings related to health system support, which affect provision of quality primary child health care services, raise important issues. These include use of (and access to) these services, policy to support child health, availability of essential medicines, lack of

supportive and clinical supervision and functionality and reliability of the health information system (63).

In Egypt, a study in 2002 measured the quality of health situations at IMCI health facilities. 50 health facilities with 296 children were introduced to the study and fully observed by research investigators. Caregivers were also included in the study. It was found that the implemented IMCI strategy seems to act as a powerful channel to improve quality of health services (64).

Contrary to the Egyptian success experience, the Sudanese experience, when a research study measured quality of care at IMCI health facilities, it was found that 74% of the studied children were unnecessarily prescribed antibiotics, caretakers were not educated about how they could use oral rehydration solution and how to give advices in relation to home management for the child. In such poor performance of many tasks, has been attributed to the lack of training in IMCI; a finding that raises many questions about quality of pre-service training and in-service supervision, In addition to the weak health system elements in Sudan.

The study concluded that the current national IMCI guidelines need to be reviewed (65).

2.6 Chapter summary

This chapter aimed at discussing these study concepts in light of previous literature. Showing how the concept of PHC started its

development, and the effect of the PHC on communities. Also this chapter includes studies that assessed the quality of PHC and the effect of IMCI on PHC performance and on health system.

Chapter Three

Research Methodology

Chapter Three
Research Methodology

This chapter describes the research methodology, which includes research design, process of sample selection, training and preparation for fieldwork, and pilot study. Moreover, this chapter includes the practical difficulties, data analysis, instrument validity and reliability of the study.

3.1 Study design

A cross-sectional study (as a class of research methods that include observation of a representative subset, at one specific point of fieldwork in time extent from March to June 2011, and cover selected area consist from three districts: Jenin, Tubas and Nablus). Used structured questionnaire and face-to-face interviews with caregivers, self-report by HW and checklist filled by HW to answer the part related to the facility in order to assess the quality of primary health care services delivered for children under 5 years old in north West Bank.

3.2 Study population and sample

The Palestinian Ministry of Health operates 416 PHC facilities in West Bank and Gaza, with a 4519 population in average for each primary health care facility (28).

In the study area of North West Bank, there are 130 PHC clinics distributed in five regions: Nablus (40 clinics), Tubas and Jenin (48 clinics), Qalqilia (17 clinic), Tulkarm (25 clinic) .

The services provided by these clinics include curative (acute cases) and chronic care (diabetes and hypertension), maternal and child health care (maternity care, immunization, and health promotion).

Integrated Management of Childhood Illness-IMCI implementation in Palestine is in the expansion phase, many PHC facilities is in the beginning of implementing the IMCI guideline.

Study site: include all PHC clinics in a selected sample of three neighboring districts (Jenin, Tubas and Nablus) and operated directly by MOH.

Sample approach: includes all PHC clinics in Jenin, Tubas, and Nablus (n=88), five facilities were excluded for pilot study, convenient sample of PHC professionals (n=216) and a convenient sample of children under 5 years old caregivers (n=133).

Table (3.1) shows that (48.1%) of the PHC clinics were from Jenin district, while (43.3%) were from Nablus district, and (8.4%) were from Tubas district (see appendix C).

Table (3.1): Study sample distribution according PHC clinic location, number of PHC workers, and caregivers.

District	PHC center		PHC workers		children under 5 caregiver	
	No.	%	No.	%	No.	%
Jenin	40	48.1%	107	49.5	61	46
Nablus	36	43.3%	90	41.6	59	44.3
Tubas	7	8.4%	19	8.7	13	9.7
Total	83	100%	216	100%	133	100%

3.3 Study instrument

After surveying the literature and previous studies related to the field of assessing quality of PHC clinics, three parts questionnaires (scales) were developed in native language (Arabic). First part related to child caregiver, second part; related to HW, third part related to PHC facility infrastructure. The study scales adopted five-weight likert scale.

1- Quality assessment of PHC services as perceived by children under 5 years old caregivers' scale:

This scale collects demographic data about children under 5 years old caregivers' including (degree of relation to child, level of education, place of living, waiting time to receive PHC service, duration of receiving PHC services). The questions in the questioner was classified into three dimensions: general quality satisfaction, quality of medical examinations and quality of counseling (Appendix A).

2- Quality assessment of PHC clinic services from the perception of PHC clinic workers' scale:

This scale collects data from PHC clinic workers, questions measure PHC clinic workers perception for quality of PHC clinic' services, the questions in the questionnaire was classified into three dimensions: administrative issues, performance issues, and training issues (Appendix B).

3- Quality assessment of PHC clinic:

This scale collects data related to PHC infrastructure to include; infrastructure availability, availability of drugs, medical equipments, and cleanness (Appendix D).

3.4 Pilot study

A pilot study was carried out in five PHC clinics in Tubas, Jenin, and Nablus in order to identify potential problems of study tool and to revise the methods and logistic of data collection before starting the actual filed work. Seventy five (75) PHC workers, caregivers have been selected randomly from PHC clinics, of which; 55 health workers, and 20 child under 5 years old caregivers were also interviewed in the pilot study.

At the pilot test; three questionnaires proposed time have been revised as it was found that more time is needed. In addition, some questions in the questionnaire have been revised to make it easier to understand by the study participants. Some items have been added (7, 8 for HW questions). The sample used in the pilot study was excluded from the study.

3.5 Instrument reliability and validity:

The researcher calculated reliability coefficients for the three previous scales, which were:

A. Reliability for quality assessment of PHC services as perceived by children under 5 years old caregivers' scale:

(Cronbach's Alpha) equation was calculated on another exploratory sample that consists of (13) caregivers from Nablus, (17) from Jenin and (5) from Tubas. The table (3.2) shows the instrument reliability for three dimensions and total score:

Table (3.2): Cronbach's Alpha coefficients for first part of instrument

Dimensions	Cronbach's Alpha coefficients
General satisfaction	0.76
Quality of general Examination	0.80
Quality of counseling	0.84
Total Score	0.89

Table 3.2 shows reliability coefficients for first instrument sections with total score of .89 to be considered.

B. Quality assessment of PHC clinic services as perceived by PHC clinic health workers' scale:

(Cronbach's Alpha) equation was calculated on another exploratory sample which consists of (10) doctors and (23) nurses, the table (3.3) below shows the instrument reliability for the three dimensions and total score:

Table (3.3): Cronbach's Alpha coefficients for second part of instrument

Dimensions	Cronbach's Alpha coefficients
Quality of administration	0.85
Quality of performance	0.75
Quality of training	0.74
Total score	0.71

The table above shows reliability coefficients for second instrument sections and total score of 0.71 was found to be acceptable and suitable.

C. Quality assessment of PHC clinic:

(Cronbach's Alpha) equation was calculated on another exploratory sample which consists of (35) elements in clinics, the table below shows the instrument reliability for five dimensions and total score of 0.96 indicates an acceptable and high score for the instrument to be used.:

Table (3.4): Cronbach's Alpha coefficients for third part of Instrument

Dimensions	Cronbach's Alpha coefficients
PHC services	0.93
Infrastructure	0.91
Medical equipments	0.91
Drug availability	0.93
Cleanness of the PHC facility	0.91
Total score	0.96

Instrument validity:

The researcher makes certain the validity of research instrument by consulting and reviewing a group of expert reviewers consist of professor assistants, doctors work on IMCI programme, and directors in health sector (Appendix E: list of evaluators).

3.6 Fieldwork procedure

Interview with caregiver took 10-20 minutes, health workers have self-administered their questionnaire, and they filled the questionnaire part that is related to the clinic. The total number of clinics visited was 83; 40 in Jenin, 36 in Nablus, and 7 in Tubas. The number of caregivers was 133; 61 in Jenin, 59 in Nablus, 13 in Tubas. Total number of HW was 216; 107 in Jenin, 90 in Nablus, 19 in Tubas. Total days of fieldwork were 29 in Jenin, 25 in Nablus, 10 in Tubas (refer to table 3.1).

Response rate of clinics was 72%; only 60 clinics responded to the researcher from the total number of clinics. Many clinics declined to respond because they want direct order from the ministry directorate, other clinics didn't because they were busy, and in some cases the clinic was closed for meeting in the directorate or due to strike. Tubas area has 100% response rate, Jenin and Nablus have response rate more than 70% (caregiver and HW was convenient sample).

3.7 Statistical analysis

Variables were defined operationally and coded and then entry process using Statistical Package for Social Science (SPSS) version 17. Various statistical descriptive processes were used including (frequencies, percentages, cross-tabulation in order to represent the study samples. Moreover, inferential statistics used in order to answer the study questions and testing the study hypothesis. This process included calculating:

- Means, standard deviations.
- One-sample t-tests: a one-sample t-test helps determine whether the population mean is equal to a hypothesized value (the test mean).

Researcher used one sample t-test to answer the main research question, where the researcher depended on cut-off point (3) to determine the quality assessment of PHC clinics services from the perception of PHC workers and caregivers, making comparison between cut-off point and means of total score for dimensions of child caregiver: general satisfaction,

general examination and counseling dimension (see appendix A). Health worker administration, performance and training dimension (see appendix B). To answer question of clinic quality assessment researcher depend on cut off point (0.5) to determine quality of PHC services, infrastructure, medical equipments, drugs availability and cleanness of the PHC facility (see appendix D), that means making comparison between means of these elements in a chick-lest of items and cut off point which it is (0.5) because we deal with dichotomous scale, so researcher used one sample t-test.

- Chi-square (χ^2) test for independence: the test is applied when there are two categorical variables from a single population. It is used to determine whether there is a significant association between the two variables.

In order to test hypotheses, chi-square (χ^2) test is used to test if there are differences in percentages of quality assessment of PHC clinics from the perception of child caregiver, HW, and clinic infrastructure due to study variables.

- P-value of less than or equal to (0.05) was used to test the level of significance of the study hypotheses.

3.8 Study conceptual framework

This study consist three main parts in PHC services delivery (caregiver, health worker and clinic infrastructure) and how these parts assess the quality of PHC serviced delivered for children.

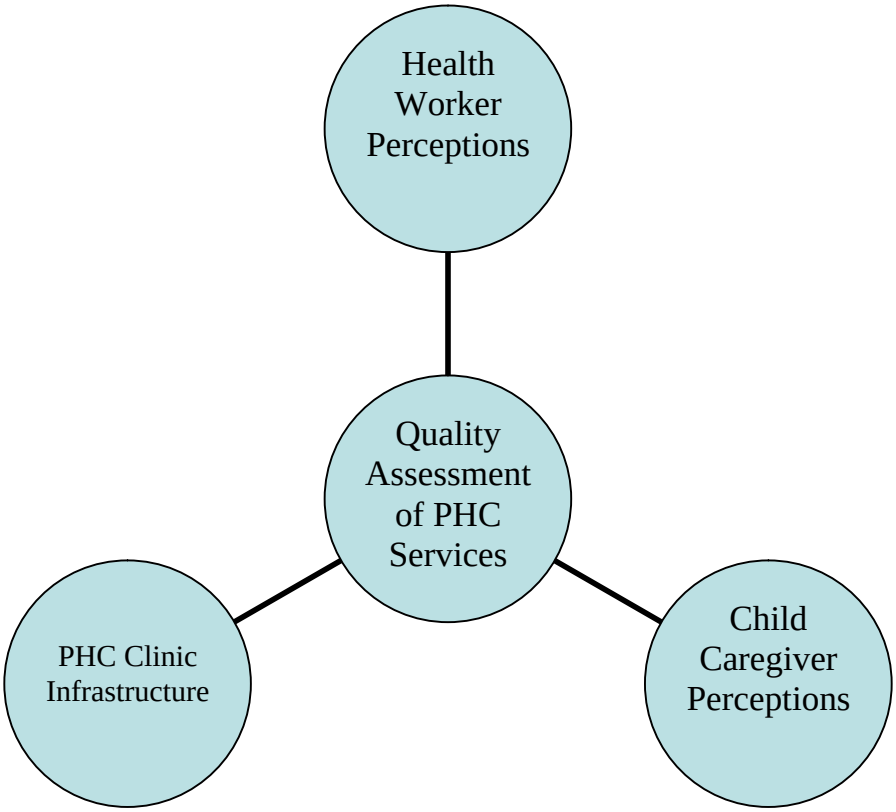

Figure (3.1): Conceptual framework of the study.

3.9 Ethical issues

Permission to conduct this study on human subjects was obtained from MOH. In addition, PHC workers and children caregivers were informed about the purpose of the study before conducting the interview and were told that their participation will be voluntary, anonymous and confidential for the purpose of research only.

3.10 Study variables

Independent variables: place of living, waiting time, education level, duration of receiving health service, child-caregiver relationship, gender, education level, years of experience, specialization, district .

Dependant variables: general satisfaction, general examination, counseling, administrative, performance, and training issues, PHC services provided, infrastructure, medical equipments, drugs availability and cleanness.

3.11 Chapter summary

This chapter aims to specify the design and methodology of this study. Moreover, to clarify the steps taken in carrying out the study. The researcher presents study design, population, sample, instrument, pilot study, data collection procedures, and the statistical analysis.

Chapter Four

Results

Chapter Four
Results

4.1 Introduction

The purpose of this chapter is to present study results. Results will be arranged into three main parts, each part will present the answers of questions or testing the study hypotheses. The first part presents results related to the quality assessment of PHC clinics' services as perceived by caregivers of children under 5 years old and testing its related hypotheses. The second part presents the quality assessment of PHC clinics' services as perceived by PHC workers and testing its related hypotheses. Finally, the third part presents the results of quality assessment of PHC clinics; infrastructure, PHC services, drug availability, medical equipments, and cleanness of the PHC facility.

4.2 Quality assessment of PHC as perceived by child caregiver in clinics

To answer the first question of the study: what is the quality assessment of PHC clinics services according to children's caregiver? Table 4.1 shows the results of one sample t-test for means of total score and dimensions of child caregiver quality assessment for PHC services.

Table (4.1): child caregiver quality assessment applying one sample t-test..

Dimensions	Means	Std. Deviation	T- value	Sig.
General Satisfaction	3.44	0.54	9.46	0.000*
Quality of General Examination	3.52	0.65	9.43	0.000*
Quality of Counseling	3.59	0.67	10.08	0.000*
Total score	3.51	0.51	11.62	0.000*

*** Significant at level (P<0.05).**

Table 4.1 shows positive assessment of caregivers perceptions for quality assessment of PHC clinics services in three dimensions of study; general satisfaction, general examination, and counseling.

4.2.1 Results of testing first hypothesis:

The first null hypothesis was: There are no statistically significant differences at the level ($P < 0.05$) for quality assessment of PHC clinics as perception of caregivers according to place of living.

Table 4.2 shows the results of chi-square (χ^2) test for independence, for the three dimensions of questionnaire for quality assessment of PHC clinics from the perception of caregivers of children under 5 years old according to place of living.

Table (4.2): Caregiver perception of quality assessment of PHC clinics according to place of living applying chi-square.

Dimensions	Assessment	Percentages		χ^2	Sig.
		City	Village		
General Satisfaction	Negative	55	45	13.66	0.01*
	Positive	23.4	76.6		
Total		26.3	67.7		
Quality of General Examination	Negative	22.3	77.7	1.034	0.59
	Positive	30.7	69.3		
Total		26. 5	71.5		
Quality of Counseling	Negative	45	55	5.566	0.06
	Positive	24.3	75.7		
Total		34.65	65.35		

*** Significant at level (P<0.05).**

Table 4.2 shows statistical significant relationship between quality assessment of general satisfaction dimension and place of living,

perceptions of caregivers in city was (55% negative and 23.4% positive), while caregivers quality assessment in village was higher; (76.7% positive and 45% negative). There is no relationship between place of living and quality assessment of caregiver in two dimensions; general examination and counseling.

Also from the table, it is clear that the null hypothesis was rejected; there is a statistical significant relationship between place of living and quality assessment of caregiver on general satisfaction dimension at ($p < 0.05$).

4.2.2 Results of testing second hypothesis:

The second null hypothesis was: There are no statistical significant differences at the level ($P < 0.05$) for quality assessment of PHC clinics as perceived by caregivers according to caregiver and child relative.

Table 4.3 shows chi-square (χ^2) test results for the three dimensions of questionnaire for quality assessment of PHC clinics as perceived by caregivers of children under 5 years old according to caregiver and child relation.

Table (4.3): Caregiver perception of quality assessment of PHC clinics according to child relation applying chi-square

Dimensions	Assessment	Percentages					χ^2	Sig.
		Father/ Mother	Grandfather/ Grandmother	Uncle/ Unite	Brother/ Sister	Others		
General Satisfaction	Negative	80	3.3	3.3	3.3	10	0.99	0.91
	Positive	75.7	1.9	6.8	5.8	9.7		
Total		76.7	2.3	6	5.3	9.8		
Quality of General Examination	Negative	71.4	2.9	5.7	11.4	8.6	3.76	0.44
	Positive	78.6	2	6.1	3.1	10.2		
Total		76.7	2.3	6	5.3	9.8		
Quality of Counseling	Negative	76.7	3.3	6.7	13.3	0	8.81	0.07
	Positive	76.7	1.9	5.8	2.9	12.6		
Total		76.7	2.3	6	5.3	9.8		

*** Significant at level (P<0.05).**

Table 4.3 clarify that there is no relationship between quality assessment of caregivers in three dimensions (general satisfaction, general examination, counseling) and child-caregiver relation, in briefly the degree of relationship between child and caregiver do not related to quality assessment of caregivers for PHC services.

from the table 4.3, it is clear that the null hypothesis was accepted; there is no statistical significant relationship between child-caregiver relation and quality assessment of caregiver on the three dimensions at ($p < 0.05$).

4.2.3 Results of testing third hypothesis:

The third null hypothesis was: There are no statistically significant differences at the level ($P < 0.05$) for quality assessment of PHC clinics as

perceived of caregivers according to the waiting time to receive PHC services.

Table (4.4): Caregiver perception of quality assessment of PHC clinics according to waiting time applying chi-square.

Dimensions	Assessment	Percentages					χ^2	Sig.
		1-15 minute	16-30 minute	31-45 minute	46-60 minute	> 60 minute		
General Satisfaction	Negative	26.7	40	20	6.7	6.7	1.02	0.91
	Positive	35	36.9	17.5	6.8	3.9		
Total		33.1	37.6	18	6.8	4.5		
Quality of General Examination	Negative	31.4	34.3	22.9	5.7	5.7	1.01	0.91
	Positive	33.7	38.8	16.3	7.1	4.1		
Total		33.1	37.6	18	6.8	4.5		
Quality of Counseling	Negative	23.3	36.7	23.3	10	6.7	2.71	0.61
	Positive	35.9	37.9	16.5	5.8	5.8		
Total		33.1	37.6	18	6.8	4.5		

*** Significant at level (P<0.05).**

Table 4.4 shows that there is no relationship between quality assessment of caregivers in three dimensions (general satisfaction, general examination, counseling) and waiting time to receive PHC services.

From the table 4.4, it is clear that the null hypothesis was accepted; there is no statistical significant relationship between waiting time and quality assessment of caregiver on the three dimensions at ($p < 0.05$).

4.2.4 Results of testing the fourth hypothesis:

The fourth null hypothesis was: There are no statistically significant differences at the level ($P < 0.05$) for quality assessment of PHC clinics as perceived of caregivers according to duration of receiving PHC services.

Table (4.5): Caregiver perception of quality assessment of PHC clinics according to duration of receiving PHC services applying chi-square.

Dimensions	Assessment	Percentages					χ^2	Sig.
		1-5 minute	6-10 minute	11-15 minute	20-25 minute	More than 25 minute		
General Satisfaction	Negative	26.7	33.3	26.7	10	3.3	4.45	0.35
	Positive	28.2	46.6	12.6	6.8	5.8		
Total		27.8	43.6	15.8	7.5	5.3		
Quality of General Examination	Negative	20	57.1	11.4	8.6	2.9	4.20	0.38
	Positive	30.6	38.8	17.3	7.1	6.1		
Total		27.8	43.6	15.8	7.5	5.3		
Quality of Counseling	Negative	30	43.3	10	13.3	3.3	2.9	0.57
	Positive	27.2	43.7	17.5	5.8	5.8		
Total		27.8	43.6	15.8	7.5	5.3		

*** Significant at level (P<0.05).**

Table 4.5 illustrate that there is no relationship between quality assessment of caregivers and duration of receiving PHC services in three dimensions (general satisfaction, general examination, counseling).

From the table 4.5, it is clear that the null hypothesis was accepted; there is no statistical significant relationship between duration of receiving PHC services and quality assessment of caregiver on the three dimensions at ($p < 0.05$).

4.2.5 Results of testing fifth hypothesis:

The fifth null hypothesis was: There are no statistically significant differences at the level ($P < 0.05$) for quality assessment of PHC clinics as perceived of caregivers according to education level of caregivers.

Table (4.6): Caregiver perception of quality assessment of PHC clinics according to education level applying chi-square.

Dimensions	Assessment	Percentages				χ^2	Sig.
		Secondary school	Diploma	University	Master &PhD		
General Satisfaction	Negative	46.7	26.7	26.7	0	7.85	0.04*
	Positive	46.6	8.7	43.7	1		
Total		46.6	12.8	39.8			
Quality of General Examination	Negative	57.1	8.6	31.4	2.9	5.43	0.14
	Positive	42.9	14.3	42.9	0		
Total		46.6	12.8	39.8	0.8		
Quality of Counseling	Negative	33.3	23.3	40	3.3	8.27	0.04*
	Positive	50.5	9.7	39.8	0		
Total		46.6	12.8	39.8	0.8		

*** Significant at level (P<0.05).**

Table 4.6 shows that there is statistical relationship between quality assessment of caregiver and education level at ($p<0.05$) in two dimensions; in general satisfaction dimension quality assessment of university level caregiver was (43.7% positive and 26.7% negative), rather than caregivers with secondary school where negative assessment was 46.7% more than those who have positive assessment. Statistical relationship was also available in counseling dimension; university level caregiver has negative assessment 40% more than positive assessment 39.8%, rather than assessment of secondary school level on the same dimension where positive assessment was 50.5% and negative assessment was 33.3%.

From the table 4.6, it is clear that the null hypothesis was rejected; there is a statistical significant relationship between education level and

quality assessment of caregiver on satisfaction and counseling dimensions at ($p < 0.05$).

4.3 Quality assessment of PHC from the perception of HW in clinic.

Table 4.7 shows the results of one sample t-test for means of total score and dimensions of health worker quality assessment for PHC.

Table (4.7): Health worker quality assessment applying one sample t-test.

Dimensions	Means	Std. Deviation	T- value	Sig.
Quality of Administration	3.04	0.54	1.14	0.254
Quality of Performance	3.06	0.25	2.92	0.004*
Quality of Training	3.55	0.70	10.40	0.000*
Total Score	3.22	0.40	6.80	0.000*

*** Significant at level (P<0.05).**

Table 4.7 shows PHC worker's perceptions of quality assessment of PHC clinics, mean of answers on performance and training dimension was statistically significant and it was positive assessment from the perception of HW. Answers on quality of administration dimension was not statistically significant.

4.3.1 Results of testing first hypothesis:

The first null hypothesis was: There are no statistically significant differences at the level ($P < 0.05$) for quality assessment of PHC clinics from the perception of HW according to gender.

Table (4.8): Health worker perception of quality assessment of PHC clinics according to gender applying chi-square.

Dimensions	Assessment	Percentages		χ^2	Sig.
		Male	Female		
Quality of Administration	Negative	52.4	47.6	7.24	0.007*
	Positive	31.9	68.1		
Total		39	61		
Quality of Performance	Negative	40	60	5.43	0.14
	Positive	40.8	59.2		
Total		40.5	59.5		
Quality of Training	Negative	57.1	42.9	8.32	0.004*
	Positive	32.3	67.7		
Total		38.3	61.7		

*** Significant at level (P<0.05).**

Table 4.8 explains that there is statistical relationship between gender of PHC workers and their perceptions on quality assessment of PHC services. In general satisfaction dimension number of females with positive assessment 68.1 was more than males with positive assessment 31.9 for both gender and at the same dimension. In quality of training dimension, male had negative assessment for the quality of services (57.1 negative and 32.3 positive) rather than females (67.7 positive and 42.9 negative).

From the table 4.8, it is clear that the null hypothesis was rejected; there is a statistical significant relationship between gender and quality assessment of HW on administration and training dimensions at ($p < 0.05$).

4.3.2 Results of testing second hypothesis:

The second null hypothesis was: There are no statistically significant differences at the level ($P < 0.05$) for quality assessment of PHC clinics from the perception of HW according to education level.

Table (4.9): Health worker perception of quality assessment of PHC clinics according to HW education level applying chi-square.

Dimensions	Assessment	Percentages				χ^2	Sig.
		Secondary school	Diploma	Bachelor	Ma &PhD		
Quality of Administration	Negative	34.9	20.6	38.1	6.3	21.5	0.000*
	Positive	9.2	44.5	39.5	6.7		
Total		9.2	44.5	39.5	6.7		
Quality of Performance	Negative	18.2	41.8	38.2	1.8	2.22	0.528
	Positive	16.5	34	43.7	5.8		
Total		17.1	36.7	41.8	4.4		
Quality of Training	Negative	19	23.8	52.4	4.8	5.50	0.138
	Positive	18.8	39.8	33.8	7.5		
Total		18.9	36	38.3	6.9		

*** Significant at level (P<0.05).**

Table 4.9 illustrate that there is strong statistical significant relationship between education level of health worker and their perceptions of quality assessment on quality of administration dimension. HW with secondary school level have more negative assessment 39.3% than these with positive assessment 9.2%, on the same dimension and in bachelor level category positive assessment 39.5%, more than negative 38.1%.

From the table 4.9, it is clear that the null hypothesis was rejected; there is a statistical significant relationship between education level and quality assessment of HW on administration dimension at ($p < 0.05$).

4.3.3 Results of testing third hypothesis:

The third null hypothesis was: There are no statistically significant differences at the level ($P < 0.05$) for quality assessment of PHC clinics from the perception of HW according to experience.

Table (4.10): Health worker perception of quality assessment of PHC clinics according to HW experience applying chi-square.

Dimensions	Assessment	Percentages				χ^2	Sig.
		1-7	8-14	15-21	More than 21		
Quality of Administration	Negative	17.5	39.7	36.5	6.3	22.47	0.000*
	Positive	33.6	53.8	11.8	0.8		
Total		28	48.9	20.3	2.7		
Quality of Performance	Negative	49.1	21.8	23.6	5.5	21.87	0.000*
	Positive	20.4	58.3	19.4	1.9		
Total		30.4	45.6	20.9	3.2		
Quality of Training	Negative	40.3	26.2	26.2	7.1	12.98	0.000*
	Positive	25.6	55.6	17.3	1.5		
Total		29.1	48.6	19.4	2.9		

*** Significant at level (P<0.05).**

Table 4.10 shows strong statistical significant relationship between HW's years of experience and their perceptions of quality assessment of PHC services. Health worker with 15 years of experience or more had negative assessment perceptions in all dimensions. Health workers with experience from 8-14 years had positive assessment in all dimension. Quality of administration dimension from the perceptions of HW in category 1-7 years of experience has positive assessment that is more positive; (33.6% positive and 17.5% negative).

From the table 4.10, it is clear that the null hypothesis was rejected; there is a statistical significant relationship between years of experience and quality assessment of HW on three dimensions at ($p < 0.05$).

4.3.4 Results of testing fourth Hypothesis:

The fourth null hypothesis was: There are no statistically significant differences at the level ($P < 0.05$) for quality assessment of PHC clinics from the perception of HW according to specialization.

Table (4.11): Health worker perception of quality assessment of PHC clinics according to HW specialization applying chi-square.

	Assessment	Percentages				χ^2	Sig.
		Nursing	doctor	Medical lab.	Pharmacy		
Quality of Administration	Negative	58.7	4.8	17.5	19	8.11	0.04*
	Positive	72.3	5.9	16	5.9		
Total			5.5	16.5	10.4		
Quality of Performance	Negative	49.1	10.9	36.4	3.6	30.41	0.000*
	Positive	74.8	2.9	6.8	15.5		
Total			5.7	17.1	11.4		
Quality of Training	Negative	54.8	2.4	33.3	9.5	12.91	0.005*
	Positive	72.2	6.8	10.5	10.5		
Total			5.7	16	10.3		

*** Significant on level (P<0.05).**

Table 4.11 shows significant statistical relationship between HW's specialization and their perceptions of quality assessment of PHC services. Doctors quality assessment for performance dimension was (10.9% negative and 2.9% positive), pharmacist assessment in the same dimension was (3.6% negative and 15.5% positive) that mean pharmacist assessment was more positive than doctors. Nurses had positive assessment in all dimension regarding to specialization.

From the table 4.11, it is clear that the null hypothesis was rejected; there is a statistical significant relationship between specialization and quality assessment of HW on three dimensions at ($p < 0.05$).

4.4 Quality assessment of PHC clinics regarding to services, infrastructure, medical equipments, drug availability and cleanness of the PHC facility.

Table 4.12 explains results of one sample t-test for means of total score and dimensions of PHC clinics infrastructure quality assessment.

Table (4.12): PHC clinic quality assessment regarding to quality of PHC services, infrastructure, medical equipments, drug availability and cleanness of the facility applying one sample t-test.

Dimensions	Means	Std. Deviation	T- value	Sig.
PHC Services	0.58	0.17	4.202	0.000*
Infrastructure	0.65	0.31	4.299	0.000*
Medical Equipments	0.63	0.29	4.225	0.000*
Drug Availability	0.42	0.26	-2.863	0.000*
Cleanness of the PHC Facility	0.80	0.15	18.348	0.000*
Total Score	0.62	0.19	5.525	0.000*

Significant at level (P<0.05).

Table 4.12 demonstrate that quality assessment of PHC clinics regarding to services**,** infrastructure**,** medical equipments**,** drug availability and cleanness of the PHC facility was significantly positive at (P<0.05) in total score, except drug availability; the mean of drugs availability .42 is less than the assumed mean .5, in briefly drugs availability in clinics is less than what is mentioned in the check list.

Results of testing hypothesis:

The only null hypothesis in this part was: There are no statistically differences at level (P < 0.05) for quality assessment of PHC clinics regarding to PHC services**,** infrastructure**,** medical equipments**,** drug

availability and cleanness of the PHC facility according to district (Nablus, Jenin and Tubas).

Table (4.13): Quality assessment of PHC clinics regarding to district.

	Assessment	Percentages			χ^2	Sig.
		Nablus	Tubas	Jenin		
PHC services	Negative	55.6	3.7	40.7	2.231	0.257
	Positive	39.3	8.9	51.8		
Total		44.6	7.2	48.2		
Infrastructure	Negative	56.3	0	43.8	2.120	0.347
	Positive	41.8	9	49.3		
Total		44.6	7.2	48.2		
Medical Equipments	Negative	61.5	0	38.5	2.412	0.299
	Positive	41.4	8.6	50		
Total		44.6	7.2	48.2		
Drug Availability	Negative	52.2	4.3	43.5	2.996	0.224
	Positive	35.1	10.8	54.1		
Total		44.6	7.2	48.2		
Cleanness of the PHC Facility	Negative	25	0	75	1.292	0.524
	Positive	45.6	7.6	46.8		
Total		44.6	7.2	48.2		
Total score	Negative	58.3	0	41.7	1.733	0.420
	Positive	42.3	8.5	49.3		
Total		44.6	7.2	48.2		

*** Significant at level (P<0.05).**

Table 4.13 shows that there is no statistical relationship between distribution of clinics between districts and the quality of PHC clinic regarding to services**,** infrastructure**,** medical equipments**,** drug availability and cleanness of the PHC facility.

From the table 4.11, it is clear that the null hypothesis was accepted; there is no statistical significant relationship between districts and quality assessment of PHC clinic infrastructure at ($p < 0.05$).

4.5 Chapter Summary

- Perceptions of caregivers of children under 5 years old showed positive assessment towards the quality of PHC clinics services in all dimensions (general satisfaction, quality of general examination and quality of counseling**)** at ($P<0.05$).
- Caregiver place of living was found to be statistically significant related to quality assessment of caregiver in general satisfaction dimension.
- Child caregiver relation, waiting time and duration of receiving PHC services was not statistically significant related to any dimensions.
- Education level of caregiver and caregivers quality assessment was found to be statistically significant related in general satisfaction and counseling dimension.
- The perceptions of PHC workers showed positive assessment towards the quality of PHC in quality of performance and training only.
- Gender of PHC worker was found to be statistically significant related to administration and training dimensions.
- Education level of PHC worker was statistically significant related to quality assessment of administration dimension only.

- Experience and specialization of HW related statistically significant to quality assessment of HW administration, performance and training dimensions.

- Quality assessment of PHC clinics regarding to services**,** infrastructure**,** medical equipments**,** drug availability and cleanness of the PHC facility was significantly positive at ($P<0.05$) in total score and all dimensions.

- District do not related significantly with quality assessment of PHC clinics regarding to services**,** infrastructure**,** medical equipments**,** drug availability and cleanness of the PHC facility.

Chapter Five

Discussion

Chapter Five
Discussion

In this chapter, the researcher will discuss the main study results. The Discussion will be grouped into three parts. The first part will discuss the results concerning quality assessment of PHC clinic services as perceived by child caregiver. The second part of discussion will discuss the assessment of primary health care delivered for children as perceived by PHC worker. Finally, the third part will discuss the quality assessment of PHC clinics from the perspective of services**,** infrastructure**,** medical equipments**,** drug availability and cleanness of the PHC facility.

5.1 Quality assessment of PHC as perceived by child caregiver in clinics

Results indicate that there are significant differences in percentages of quality assessment of PHC clinics as perceived by caregivers due to the variable place of living. Place of living related significantly with perceptions of caregivers in general satisfaction dimension only. General satisfaction dimension is affected with Number of reviewers is less in the clinics distributed in rural area so the pressure on health worker is less than clinics distributed in camps and urban area.

Differences exist between services; in South Africa, Orange Free State, researcher did not find significant differences in children who received oral rehydration solution for diarrhea between the village and the city. However, the difference exist in the case of immunization. (66).

Results indicate that there was no significant relationship of quality assessments of PHC from the perception of caregiver due to caregiver-child relation in all dimensions.

In this study, it is obvious that the majority of caregivers are mothers 80%. In eastern cape of South Africa, 88% of caregivers are mothers (67).

Waiting time was not statistically significant regarding to the quality assessment of PHC services; general satisfaction of 40% of caregivers with negative assessment was on the period 16-30 minutes. This problem needs strategic solution in order to be avoided because reducing this problem may enhance caregivers' satisfaction and increase the services effectiveness. Perceptions of long waiting time varies, for example, in Mozambique, the patient waits for 45 minutes as an average before receiving any health services (68). In another study, in Central Karnataka (Davangere District) 9% of the patients had problems with the waiting time in the health care facility (69).

Most countries are trying to decrease the waiting time. For example, in Jordan; PHC clinic used the appointment system to solve the long waiting time problem in PHC facilities. The waiting time declined to 29 minutes and treatment time was doubled. Before using the appointment system, the waiting time was 78 minutes (70).

Furthermore, this study discussed the independent variable; duration of service. The more the time the health worker spends with the child, the more the caregiver becomes satisfied. The duration of receiving PHC

services does not related to perceptions of caregivers of children under 5 years old in all dimensions. On general examination dimension, caregivers gave negative assessment 57.1% on the 6-10 duration of service and 38.8 positive assessments on the same duration, caregivers always want more time for his child.

Like most developing countries, the study finds that the time spent by HW on the child is short; In Mozambique study, researchers mentioned that the duration of service was very short. 50% of the patients spend 4 minutes or less with health worker, and very few spend more than 5 minutes (68).

In Brazil, IMCI-trained providers spent 1 minute and 26 seconds longer per consultation with under-fives years children than untrained providers. The differences was more when patient load was low, and decreased as the number of patients increased during the day (71).

Based on the findings of the current study, long waiting time and short duration of service might indicate poor appointment system. It was noticed that most children were brought by caregiver almost at the same time, that is between 9:30 and 11:30 am. This period is considered to be as the rush hour of the day by HW. Appointment system may be advised in order to give a high quality services.

Education level of child caregiver is related to quality assessment of PHC; in this study, caregivers' level of education significantly related at

($P<0.05$) with perceptions of caregivers in general satisfaction and quality of counseling dimensions. Quality assessment is varies between educated people according to their expectations. Many studies indicate that child's mother has a poor knowledge. Client satisfaction was on average with interpersonal quality rated to be poor (69). In Eastern Cape, 6% of caregivers of the study sample had no formal education (67).

5.2 Quality assessment of PHC from the perception of HW in clinics

This part of the study discusses results related to quality assessment of PHC from the perception of health worker working in PHC clinics. These variables include; gender of HW, level of education, years of experience and specialization of HW.

Gender is related significantly to the perceptions of health workers quality assessment in quality of administration and quality of training dimensions. Males has more significantly negative assessment for the quality of PHC clinics services in administration and training dimensions, while females has more significantly positive assessment in the same dimensions. The gender of workers is not related to their perceptions in quality of performance dimension because they work in the same circumstances.

The percentages of gender of health worker in Mozambique PHC studied clinics was as follows: male 38.3% and female 61.7%, researcher

found that women who are working in rural area are more satisfied in their work than men (68).

The education level is related significantly to perceptions of PHC health workers in quality of administration dimension, HW in secondary school level are more significantly negative assessment 34.9%. This could be the result of complaints of health workers with the lowest education. They feel that this is no fair because of bias compared with the more educated staff in salaries, rewards, and load of work. Also most of them suggest that they had the long experience while the education level of workers does not affect their perceptions in performance and training dimensions.

Strong statistical significant relationship between HW's years of experience and their perceptions of quality assessment of PHC services. Quality of administration dimension from the perceptions of HW in category 1-7 years of experience has positive assessment (33.6% positive and 17.5% negative). While assessment of category 15-21 was negative (36.8 negative and 11.8 positive). The category of 8-14 years of experience has positive assessment. Each category of experience has different assessment perceptions differ from those of other categories.

Most categories in this study have negative assessment on administrative and training dimension. these results agree with a study in Tanzania researcher detects negative assessment of health workers on training, supervision, and other administrative issues; health workers

complained that their supervision was not systematic and not supportive when provided. However, supervisors themselves are often poorly resourced and may not be trained on effective supervision techniques (72).

Specialization related significantly at ($P<0.05$) on perceptions of PHC quality assessment in administration, performance and training dimensions. For example doctors and medical laboratory professional has more significant negative assessment in performance dimension regarding to the high load of work and their need for assistance especially for doctors who complaints that nurses are busy most of the time.

Positive assessment of the training dimension from the perception of doctors and nurses is related to good performance. This agrees with results found by a study conducted in Morocco that out of 10 main assessment tasks included in an indicator, index was higher in children seen by doctors who had received follow up training compared with those who did not receive follow up training (63).

5.3 Quality assessment of PHC clinics regarding to services, infrastructure, medical equipments, drug availability and cleanness of the PHC facility.

Quality assessment of PHC clinics regarding PHC services, infrastructure, medical equipments, drug availability and cleanness of PHC facility was significantly positive at ($p < 0.05$) in total score and all dimensions. District of PHC clinics is not related significantly with clinic capacity**;** Tubas and Jenin scores are higher than Nablus district in many

dimensions. For example in Nablus, drug availability scores lower than Tubas and Jenin. This could be explained on the basis of complaints of staff that the orders of clinics are delayed by Nablus health directorate because of low connection.

Palestine is an occupied country so it faces many financial and political challenges. The Ministry of Health depends mainly on foreign support from the developed countries. All elements which are needed to develop the PHC sector are available so the focus on improving quality should be a priority.

In this study all infrastructure are positively score, and this is agrees with studies in Vietnam and UAE. In Vietnam all community health centers had 100 % supplies of newborn scales, stethoscopes, thermometers, adult scales, telephones and disposal plastic syringes (57).

In Emirates they find out that there was a very good coverage of PHC clinics which was achieved throughout the country. All PHC clinics provide curative, preventive and promotive services with a small percentage of rehabilitation services. Resesrcher recommended that lots of things have to be done for improving health services and performance as well as better meeting the specific medical care needs of the people through expansion of PHC services (51).

The results in this study contradict other results found in other studies such as the study in Mozambique. The study found that facility

infrastructure is often limited while in most facilities there is a private area for patient examination, only 69 percent of facilities have a place for staff to wash their hands and very few clinics have any means of communication. Around 60% of facilities have disposal syringes and needles and availability of certain drugs was varied (68). In kwazulu-natal, 40% of facilities have problems in the toilets of the facility. In addition, Eastern Cape health facilities, 75% have problem with water supplies (67).

Contrary to this study was Nigeria. There was a common problem manifested in an inadequate supply of essential drugs; and mothers complain from long waiting time, lack of drugs, inappropriate behaviors of health worker and weak infrastructure (49).

5.4 Chapter summary

In this chapter, researcher discussed the main study results. Moreover, tried to explore reasons that could affect the relationship between quality assessment of PHC and different variables of the study then comparing it with previous studies.

Limitation

1- Due to limited recourses and time constraints, the sample size was small. A larger study sample cover all PHC workers and the rest of north West-Bank would have been preferable to improve general usability.

2- The study design focused on structure and process rather the outcome measures.

3- Staff morale and attitudes, which are key determinants of the quality of child health services, were not assessed in this study.

4- Observed performance may not be “routine” performance as health workers may have modified their behavior while being observed.

5- Caregivers group did not have a definite appointment visiting schedule and they required aid to understand and respond to scale.

Chapter Six

Conclusions and Recommendations

Chapter Six

Conclusions and Recommendations

6.1 Conclusions

1- Place of living and the education level of child caregiver related significantly with caregiver quality assessment of PHC services; dimension of training and administration for place of living variable, administration dimension for education level variable.

2- Gender, experience, specialization, and the education level was related significantly with health worker quality assessment of PHC services. Gender was related to training and administration dimension, education level of health worker was related to administration dimension, experience and specialization of health worker was related to administration, training and performance dimensions.

3- Quality assessment of PHC clinics regarding to PHC services**,** infrastructure**,** medical equipments**,** drug availability and cleanness of PHC facility was significantly positive.

6.2 Recommendations

1- A new comprehensive study includes all clinics implementing the IMCI.

2- Enhance leadership between the staff and director of health directorate.

3- Enhance teamwork perception between health workers.

4- Improve the reward system that makes health workers feel more comfortable.

5- Improve an appointment system to avoid long waiting times in clinics.

6- IMCI checklists should be more accepted by the staff to make their work easer.

7- After IMCI is implemented, health workers need continuous support even after training.

8- Health workers need to focus on communities by improving caregivers understanding and acceptance of IMCI goals so that there is optimism about public health improvements with the use of IMCI.

9- Public health promoters should focus on health care promotion and education through “health talks” mostly on hygiene and health education which can be done whilst patients wait in queues to be seen.

10- Staff tea and lunch breaks must be spread over a period of time to maintain patient flow.

11- Advice and difficulties in assessment and management should be discussed by telephone with hospitals centers prior to referral.

12- A dedicated health worker who is ideally specifically skilled in pediatrics should give for children.

13- All health workers should be required to undergo the IMCI training.

14- Evaluation should be conducted after training to see if the health workers apply what they have learned during the training.

15- Monitoring and supervision via review of records once in while may help in reinforcing the protocol.

16- Less rotation of staff would enhance their performance and follow up for cases.

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Appendices

Appendix A

Dimensions of child caregiver quality assessment of PHC

Item No.	General satisfaction dimension
1.	During my visits to the PHC clinics, I felt the courtesy and concern of PHC staff toward my child.
2.	I felt of the Availability of drugs in the PHC clinic.
3.	Cleanness of the PHC clinic was acceptable.
4.	I am satisfied about the level of health care my child received at this PHC that I mentioned it whenever appropriate.
5.	The PHC staff was professional and well-trained that they gained my trust
6.	I was satisfied with how procedures were handled at the PHC clinic
7.	If my child needed health care again, I will choose this PHC clinic for treatment.
8.	I did find some difficulties reaching this PHC clinic.
9.	Every time I visit the PHC for my child, I wait for a long period of time to receive the required services.
10.	I felt the time given to examine my child was enough.
11.	The health worker explains the methods in avoiding the current condition that my child suffers form.
12.	Workers in the PHC clinic ask me about the dangerous signs of my child.
	General Examination dimension
13.	When I visit the PHC clinics in my area the weight and temperature is being measured.
14.	When I visit the PHC the health workers ask about my child's eating.
15.	The health workers investigate my Childs conditions if he lost his consciousness.
16.	I've been asked if my child condition is around losing his movement
17.	Health worker asks if my child is suffering from diarrhea

18.	The health workers investigate if my child suffers from cough or difficulty in breathing.
19.	Health worker makes diagnosis of my child through observation only.
20.	The health worker asks me take the measurements of my child like temperature.
21.	Health worker ask me if my child suffer from any digestion problems.
	Quality of counseling dimension
22.	The health worker explains the methods in avoiding the current condition that my child suffers form.
23.	The health worker explains the procedures and steps that I should do at home to take care of my child.
24.	The health worker encourages me to make visits and currying my child's condition.
25.	The health worker discusses my child nutrition condition.
26.	The health worker advice me of the suitable food to my child's age.
27.	The health worker advice me to use complementary food for my Childs condition.
28.	I regularly visit PHC for receiving the PHC services.
29.	The health worker greets and welcome me when I visit the clinic.
30.	Health worker ask me if my child suffer from any digestion problems.

Appendix B

Dimensions of health worker quality assessment of PHC

No.	**Administration dimension**
1.	I think that the Regularity of administrative meetings (reviewing/ evaluating work) at PMH clinic are acceptable.
2.	I belief that The PHC clinic maintains an effective staff assessment
3.	I belief, that in the PMH clinic there is degree of Staff accountability.
4.	I belief that this PHC clinic implements a plan for Quality Management.
5.	I belief that Wages scale, annual raises are reasonable.
6.	In PHC clinic The Division of load of work among the staff is just.
7.	Administratively, you feel that your direct supervisor/head is qualified well enough.
8.	Most of the PHC employees perform their duties efficiently.
9.	The PHC clinic policy inspects good relations between the staff and their supervisors/heads & among the staff themselves.
10.	The PHC adopts quality directed Strategic Planning for Enhancement.
11.	Communication with the MOH is available and easy.
12.	I belief that in the PHC, there are good relations between colleagues.
	Performance dimension
13.	PHC Working environment is quite pleasant & comfortable for me.
14.	I believe that The PHC clinic satisfies patient's needs & desires.
15.	The PHC clinic carries out surveys checking Patients Satisfaction.
16.	In PHC, The number of staff is proportional to the no. of visiting patients.
17.	I find difficulties in IMCI implementation
18.	In find difficulties in the language used in IMCI
19.	There are many steps in IMCI protocol
20.	Child caregiver cooperation helps in implementation of IMCI
21.	availability of health worker helps in IMCI implementation
22.	Child caregiver accepts the description of prescribed alternative medicine.
23.	I respond to child caregiver demand of prescribing other drugs without prescription.
24.	My performance is influenced by the load of patients coming at the same time.

	Training dimension
25.	This PHC maintains continuous planning for training, by preparing outlined programs & courses.
26.	The training plan (if exists) ensures orienting new staff, and offering advanced training for senior ones.
27.	I receive specialized training in application of IMCI
28.	I feel that there is a need to receive further training in PHC and IMCI.
29.	PHC clinic regulations encourage training programs for the staff.

Appendix C

Location of clinics

NO.	PHC clinics in Jenin
1.	Aja
2.	Al Arqa
3.	Al Atara
4.	Al Fandqumeyeh
5.	Al Gharbiyeh
6.	Al Hashimeyeh
7.	Al Jadeedah
8.	Al Jalameh
9.	Al Mughayyer
10.	Al Rama
11.	Al Sharqiyyeh
12.	Al Yamoon
13.	Al Zababda
14.	Aneen
15.	Anza
16.	Attaybeh
17.	Barqeen
18.	Barta'
19.	Beit Qad
20.	Deir Abu Da'if
21.	Fahma
22.	Fahma Al Jadeeda
23.	Faqoo'ah
24.	Jaba
25.	Jalbon
26.	Jalqamoos
27.	Kaferet
28.	Kafr Dan
29.	Kafr Qud
30.	Kafr Ra'ee

31.	Marqa
32.	Qabatya
33.	Raba
34.	Sanoor
35.	Silet Al Dhahr
36.	Silet Al Harithiyeh
37.	Siris
38.	Tourah Al Gharbiyeh
39.	Yabad
40.	Zaboba
40.	Total

NO.	**PHC clinics in Nablus**
1.	Al Balda Al Qadeema
2.	Al Gharbiya
3.	Al Majdal
4.	Al Naqoora
5.	Al Sawiyeh
6.	Aqraba
7.	Aseera Al Shamaliyeh
8.	Awarta
9.	Aynaboos
10.	Balata
11.	Barqa
12.	Beit Dajan
13.	Beit Furik
14.	Beit Iba
15.	Beit Imreen
16.	Beita
17.	Bureen
18.	Bzaryah
19.	Deir Al Hatab
20.	Deir Sharaf
21.	Howara
22.	Jamma'een

23.	Oreef
24.	Qablan
25.	Qaryoot
26.	Qasra
27.	Quseen
28.	Ras Al Een
29.	Rojeeb Clinic
30.	Sabastya
31.	Sara
32.	Tal
33.	Talfeet
34.	Talooza
35.	Yaseed
36.	Yatma
36.	Total

NO.	**PHC clinics in Tubas**
1.	Al Aqaba
2.	Al Fari'ah
3.	Aqaba
4.	Bardalah
5.	Ein Al Beidah
6.	Tayaseer
7.	Tamoon
7.	Total

Appendix D

Questionnaire

الاستبانة

الاستبانة أ
خاصة بمركز الرعاية الأولية التابع لوزارة الصحة الفلسطينية

جامعة النجاح الوطنية
كلية الدراسات العامة
برنامج الصحة العامة

تقوم الباحثة بإجراء دراسة بعنوان "تقييم جودة الخدمات في مراكز الرعاية الصحية الأولية المقدمة للأطفال دون سن 5 سنوات في محافظات شمال فلسطين"، نرجو من حضرتكم التعاون في تعبئة بيانات الاستبيان وأنها سوف تستخدم لأغراض البحث العلمي فقط.

شاكرين حسن تعاونكم

الباحثة: بهية الشولي

رقم الاستبانة:.....
تاريخ التعبئة:.....
اسم العيادة:.....

رقم العيادة:..... .....
موقع العيادة:.....
عدد العاملين في العيادة:.....
مستوى العيادة:.....

عدد العاملين الذين يقدمون خدمة للبالغين والأطفال
جنس العامل:
ذكر **أنثى**
المؤهل العلمي :
سنوات الخبرة :
التخصص :
التدريب: غير مدرب **الرعاية الصحية**
الرعاية الصحية الأولية (IMCI)

الخدمات المقدمة:

العناية الشافية	☐	العناية المزمنة	☐	التطعيم	☐
إعادة التأهيل	☐	الرعاية ما قبل الولادة	☐	الرعاية العقلية	☐
الرعاية بعد الولادة	☐	تنظيم الأسرة	☐	غير ذلك	☐

البنية التحتية:

كمبيوتر		زاوية علاج		غرفة استشارت	
حمام خاص بالموظفين	☐	هاتف	☐	حمام عام للمراجعين	☐
كهرباء	☐	خزانة ملفات	☐	غرفة انتظار(استقبال)	☐
صنبور ماء وحوض لغسل اليدين	☐		☐		☐

المعدات/الأدوات المتوفرة لتقديم الرعاية الصحية الأولية:

ميزان للصغار	☐	مقياس الارتفاع	☐	ميزان للكبار	☐
أكسجين	☐	طاولة لقياس الطول	☐	جهاز فحص الأذن	☐
سماعة طبيب	☐	ساعة غرفة الاستشارة	☐	ميزان حرارة	☐
سخان ماء	☐	إنعاش الأطفال	☐	جهاز تبخير	☐
كمامة	☐	حقيبة إسعاف أولي	☐	متر قياس الطول	☐
التصوير الإشعاعي	☐				

بعض الأدوات التي يجب أن تتوفر في عيادات الرعاية الأولية:

24G IV catheter	☐	2cc syringe	☐	23G needle	☐
1 liter container	☐	5cc syringe	☐	BCG/25G needle	☐
easpoon/tablespoo n	☐	10cc syringe	☐	20G IV catheter	☐
al rehydration solution	☐	20cc syringe	☐	22G IV catheter	☐
8F Nasogastric tube		Cups		10F Nasogastric tube	
		6F Nasogastric tube		12F Nasogastric tube	

وفرة الأدوية الأساسية في العيادة:

Amoxicillin	☐	Tine test	☐	Oral rehydration solution	☐
Penicillin VK	☐	Ceftriaxone	☐	Measles vaccine	☐
Erythromycin	☐	Benzyl benzoate	☐	Vitamin A 50 000IU	☐
Cloxacillin (flucloxacillin)	☐	Monosulfiram	☐	Vitamin A 100 000IU	☐
Cotrimoxazole (Bactrim)	☐	Sterile water	☐	Vitamin A 200 000IU	☐
Paracetamol	☐	Intravenous fluids	☐	Chloramphenicol	☐
Nalidixic acid	☐	Adrenaline	☐	Prednisone	☐
Phenobarbitone	☐	Diazepam	☐	Iron Supplements	☐
Beta2-agonist	☐	Nystatin	☐	Deworming medication	☐
				Purified protein derivative	☐

نظافة مرافق العيادة :					
المرفق	كبيـــرة جدا	كبيرة	متوسطة	منخفضة	منخفضة جدا
الملفات مرتبة ومنظمة					
الغرف والممرات نظيفة					
الأرضيات نظيفة وفيها سلات مهملات					
المقاعد نظيفة وجيدة					
الحمامات الخاصة بالموظفين نظيفة					
الحمامات العامة نظيفة					
حفظ الأدوية في العيادة:					
فعالية ثلاجة الادوية					
تخزين الأدوية بشكل منظم ومرتب بدرجة:					
فعالية ميزان حرارة					
انتظام اخذ درجة الحرارة					

الاستبانة (ب)

خاصة بالعاملين في مركز الرعاية الأولية

جامعة النجاح الوطنية
كلية الدراسات العليا
برنامج الصحة العامة

تقوم الباحثة بإجراء دراسة بعنوان "تقييم جودة الخدمات في مراكز الرعاية الصحية الأولية المقدمة للأطفال دون سن 5 سنوات في محافظات شمال فلسطين"، نرجو من حضرتكم التعاون في تعبئة بيانات الاستبيان وأنها سوف تستخدم لأغراض البحث العلمي فقط.

شاكرين حسن تعاونكم

الباحثة: بهية الشولي

رقم الاستبانة:.....
رقم العيادة:..... .....
تاريخ التعبئة:.....
موقع العيادة:.....
اسم العيادة:.....
عدد العاملين في العيادة:.....
مستوى العيادة:.....

عدد العاملين الذين يقدمون خدمة للبالغين والأطفال

جنس العامل : ذكر **أنثى**

المؤهل العلمي :

سنوات الخبرة :

التخصص :

التدريب:1 - غير مدرب **2 -الرعاية الصحية**

3 -الرعاية الصحية الأولية 4 - (IMCI)

يرجى وضع اشارة (X) في المكان الذي تراه مناسبا:

	الفقرة	موفق بدرجة كبيرة جدا	موافق بدرجة كبيرة	متوسط	معارض بدرجة كبيرة	معارض بدرجة كبيرة جدا
1.	اعتقد بان الاجتماعات الادارية والمراجعة والتقييم في مركز الرعاية الأولية مقبولة.					
2.	اعتقد بان عيادة الصحة الاولية تحتوي على نظام فعال لتقييم العاملين.					
3.	اعتقد بان عيادة الصحة الاولية تتمتع بدرجة بمسائلة كافية للعاملين					
4.	اعتقد بان عيادة الرعاية الصحية الاولية تطبق خطط ادارة الجودة بشكل مناسب.					
5.	تحافظ عيادة الرعاية الصحية الاولية على استمرارية في التدرسي والنحضير للعاملين فيها					
6.	البرامج التدريبية اذا ما كانت متوفرة تضمن توجيه العاملين الجدد وتقدم تدريب متقدم للقديمين منهم					
7.	يساعد مركز الرعاية الصحية الاولية على تدريب العاملين وتخصص الوقت للكذ					
8.	اعتبد بان الرواتب والحوافز السنوية كافية .					
9.	اعتقد بان هناك جو من العلاقات الجيدة بين الزملاء في عيادة الرعاية الصحية الاولية					
10	البيئة التي اعمل فيها في مركز الرعاية الصحية الاولية تعتبر مريحة بالنسبة لي.					
11	أن توزيع المهام والمسؤوليات بين العاملين في مركز الرعاية الصحية الاولية يعتبر جيدا وعادلا					
12	يسمح ضغط العمل بان يقوم جميع العاليمن في عيادة الصحة الاولية بواجباتهم بجودة عالية					
13	يتم مراجعة وتقييم للسياسات التي تدرس سير العمل في مركز الرعاية الاولية والعلاقات بين الطاقم الاداري والعاملين					
14	تسمح ظروف العيادة من ممارسة التخطيط الاستراتيجي وتحسين جودة العمل					
15	اعتقد بان مركز الرعاية الصحية الاولية يستطيع تحقيق رغبات المرضى المراجعين بشكل ملائم					

16	تقوم العيادة الصحية الاولية بعمل مسوحات لقياس مدى رضا المرضى عن الخدمات المقدممه لهم.					
17	عدد العاملين كافي ومناسب اذا ما تم مقارنه بعدد المرضى المراجعين..					
18	أتلقى تدريب مختص في تطبيق برنامج الرعاية الصحية الشاملة لأطفال (IMCI)					
19	أجد صعوبة في تطبيق برنامج الرعاية الصحية الشاملة لأطفال (IMCI)					
20	أجد صعوبة في لغة برنامج الرعاية الصحية الشاملة لأطفال (IMCI)					
21	الخطوات كثيرة في برنامج الرعاية الصحية الشاملة لأطفال (IMCI)					
22	تعاون مرافق الطفل يساهم في تطبيق برنامج الرعاية الصحية الشاملة لأطفال (IMCI)					
23	عدم وجود عامل صحي يساعد في تطبيق برنامج الرعاية الصحية الشاملة لأطفال (IMCI)					
24	يتقبل مرافق الطفل المريض وصف العلاج البديل					
25	استجيب لطلب مرافق المريض إذا كان يريد دواء من غير وصفة طبيةاو يرغب في صرف مضاد حيوي مثلا					
26	يؤثر على أدائي قدوم معظم الأطفال في توقيت متقارب					
27	يساعد الكادر الصحي في العيادة على أداء المهمات بشكل أفضل					
28	وسائل الاتصال مع المديرية متاحة ومتوفرة					
29	اشعر بالحاجة الى تلقي تدريب وتأهيل إضافي للقيام بالرعاية الصحية الأولية وخصوصا في الرعاية الصحية الشاملة.					

الاستبانة ج

خاصة بأولياء الأطفال تحت سن 5 سنوات المراجعين لدى مركز الرعاية الأولية

جامعة النجاح الوطنية
كلية الدراسات العليا
برنامج الصحة العامة

تقوم الباحثة بإجراء دراسة بعنوان "تقييم جودة الخدمات في مراكز الرعايـــة الصـــحية الأوليـــة المقدمة للأطفال دون سن 5 سنوات في محافظات شمال فلسطين"، نرجو من حضرتكم التعـــاون في تعبئة بيانات الاستبيان وأنها سوف تستخدم لأغراض البحث العلمي فقط.

شاكرين حسن تعاونكم

الباحثة: بهية الشولي

رقم الاستبانة:..... رقم العيادة:.....موقع العيادة:.....

تاريخ التعبئة:.....

اسم العيادة:..... عدد العاملين في العيادة:.....مستوى العيادة:

بيانات عامة:

اسم الطفل:.....

عمر الطفل.: .....

جنس الطفل	ذكر			أنثى		
مكان السكن	مدينة			قرية		مخيم
صلة القرابة	أب \ أم	جداجدة		عم \ عمة	أخ \أخت	غير ذلك
مدة الانتظار	1 - 15	16 -30		31 - 45	46 -60	أكثر 60
مدة تقديم الخدمة (المعالجة) الطبية:	1 - 5	6 - 10		11 - 15	20 - 25	أكثر 25

الحالة المرضية للطفل.....

المؤهل العلمي لولي امر الطفل المراجع:.....

الرجاء وضع اشارة (X) في مكان الاجابة الملائم لي:

	الفقرة	موافق بدرجة كبيرة جدا	موافق بدرجة كبيرة	محايد	معارض بدرجة كبيرة	معارض بدرجة كبيرة جدا
.30	خلال زيارتي الى عيادة الرعاية الصحية الأولية شعرت باهتمام العاملين تجاه طفلي.					
.31	اشعر بان الأدوية متوفرة في العيادة					
.32	نظافة المكان مناسبة وجيدة					
.33	انا راض عن مستوى الرعاية الصحية التي يتلقاها طفلي في هذه العيادة وأوصيت بها لمعارفي					
.34	اشعر بان العاملين مهنيين ويتمتعون بخبرة جيدة ومدربين وقد حازوا على ثقتي					
.35	أنا راض عن الإجراءات المتبعة في عيادة الرعاية الصحية					
.36	إذا ما مرض طفلي في المستقبل فاني سوف أراجع الرعاية الأولية					
.37	لم اجد صعوبة في الوصول الى مركز الرعاية الصحية الأولية .					
.38	كل مرة ازور فيها الرعاية الصحية الاولية انتظر فترات طويلة من الزمن لتلقي الرعاية.					
.39	اشعر بان الوقت التي تم تخصيصه لفحص طفلي كان كافيا					
.40	عادة عندما أقوم بزيارة مركز الرعاية الأولية في منطقتي يسألني العامل الصحي عن سبب زيارتي					
.41	عندما أقوم بزيارة مركز الرعاية الأولية في منطقتي يقوم بتعبئة بيانتي الشخصية					
.42	يتم سؤالي عن الأعراض الخطرة للطفل					
.43	عندما أقوم بزيارة مركز الرعاية الأولية في منطقتي يتم اخذ قياسات الحرارة والوزن لطفلي.					
.44	عندما أقوم بزيارة مركز الرعاية الأولية يستفسر العامل الصحي عن قدرة طفلي على الأكل او الرضاعة.					

.45	يستفسر العامل الصحي عن حالة طفلي ما سبق وان فقد وعيه سابقا(إغماء).					
.46	تم سؤالي عن حالة الطفل إذا كان خامل أو فاقد للوعي					
.47	يستفسر العامل الصحي عن حالة طفلي إذا ما كان يعاني من إسهال.					
.48	يستفسر العامل الصحي عن حالة طفلي إذا ما كان يعاني من قحة او صعوبة في التنفس.					
.49	يقوم العامل الصحي بعمل تقديرات لحالة طفلي من خلال الملاحظة فقط.					
.50	يقوم العامل الصحي بطلب مني بإجراء قياسات لطفلي مثل قراءة الحرارة					
.51	يقوم العامل الصحي بشرح طرق تفادي المشكلة الحالية التي يعاني منها طفلي.					
.52	يقوم العامل الصحي بتوضيح الإجراءات والخطوات التي يجب أن أقوم بها في البيت لرعاية الطفل.					
.53	يقوم العامل الصحي بحثي على المراجعة في الموحد المحدد ومتابعة حالة طفلي.					
.54	يقوم العامل الصحي بمناقشة حالة التغذية الحالية لطفلي					
.55	يقوم العامل الصحي بنصحي عن الأغذية المناسبة لسن طفلي.					
.56	يقوم العامل الصحي بنصحي بالأغذية المكلمة لحالة طفلي او ينصحني بأخذ مكملات أخرى.					
.57	أتردد على العيادة الصحية من اجل تلقي خدمة الرعاية الصحية.					
.58	رحب بي موظف الخدمة الصحية					
.59	تم سؤالي عن الطفل إذا كان يتقيأ كل ما يأكل					

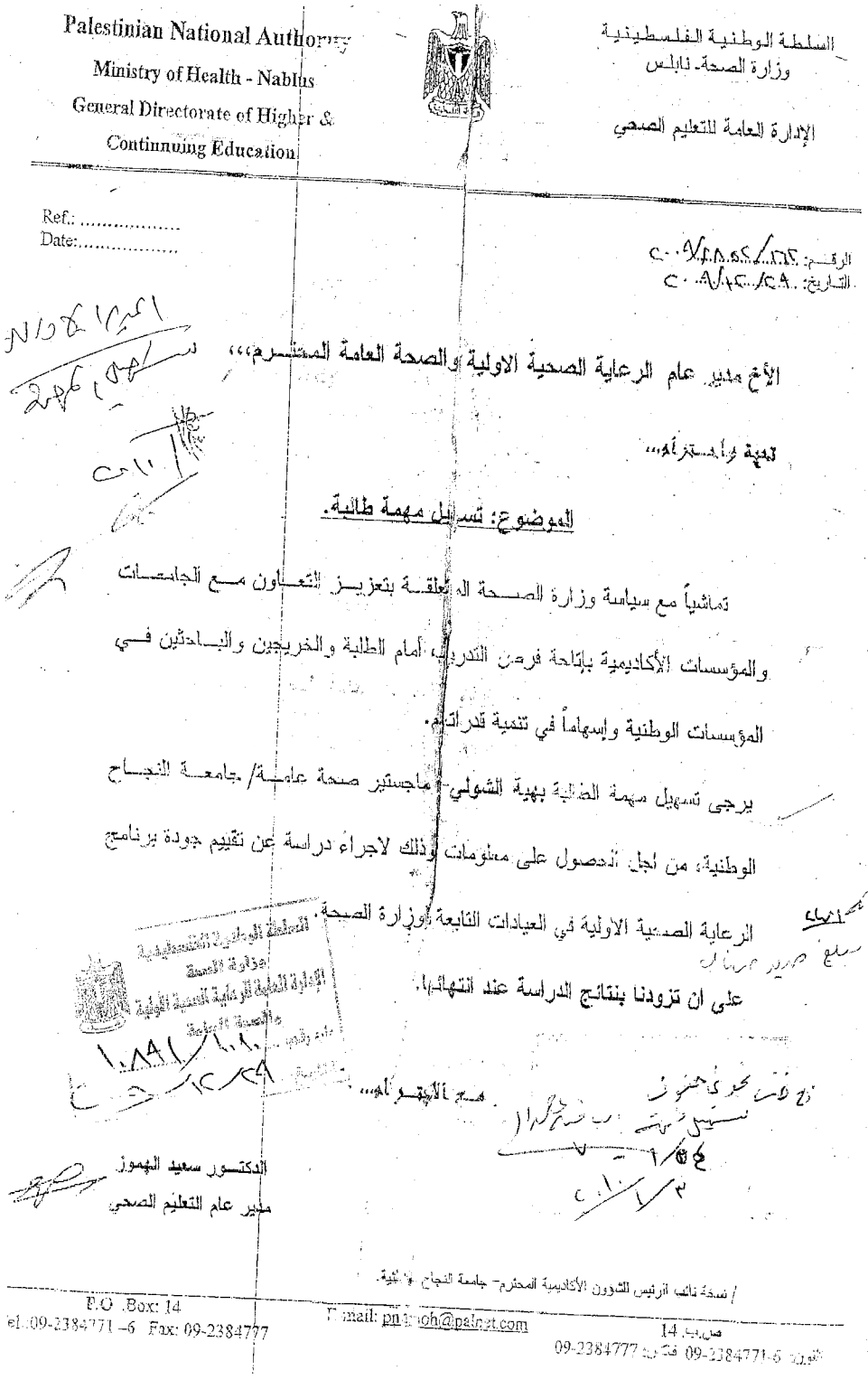
Appendix E

قائمة المحكمين list of evaluators

د.وائل أبو الحسن	محاضر في الجامعة الأمريكية
د.يوسف صادق	محاضر في الجامعة الأمريكية
د.معز شلبك	محاضر في الجامعة الأمريكية
د.مأمون زيود	ماجستير صحة عامة مدير مديرية صحة طوباس
محمد بشارات	رئيس قسم الرعاية الأولية في مديرية طوباس
د.أسامة فقها	طبيب مسئول عن برنامج IMCI
د.قدري ضراغمه	طبيب يعمل على برنامج IMCI

Appendix D

كتاب تسهيل مهمة



Palestinian National Authority
Ministry of Health - Nablus
General Directorate of Higher & Continuing Education

السلطة الوطنية الفلسطينية
وزارة الصحة- نابلس
الإدارة العامة للتعليم الصحي

Ref.: .....
Date:.....

الرقم: ٢٠٠٩/٢٨٥٤/٠٢
التاريخ: ٢٠٠٨/١٢/٢٩

الأخ مدير عام الرعاية الصحية الاولية والصحة العامة المحترم،،،

تحية واحترام،،،

الموضوع: تسهيل مهمة طلبة.

تماشياً مع سياسة وزارة الصحة المتعلقة بتعزيز التعاون مع الجامعات والمؤسسات الأكاديمية بإتاحة فرص التدريب أمام الطلبة والخريجين والباحثين في المؤسسات الوطنية وإسهاماً في تنمية قدراتهم.

يرجى تسهيل مهمة الطالبة بهية الشولي- ماجستير صحة عامة/ جامعة النجاح الوطنية، من اجل الحصول على معلومات وذلك لاجراء دراسة عن تقييم جودة برنامج الرعاية الصحية الاولية في العيادات التابعة لوزارة الصحة.

على ان تزودنا بنتائج الدراسة عند انتهائها.

مع الاحترام،،،

الدكتور سعيد الهموز
مدير عام التعليم الصحي

/ نسخة نائب الرئيس للشؤون الأكاديمية المحترم- جامعة النجاح الوطنية.

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جامعة النجاح الوطنية
كلية الدراسات العليا

تقييم جودة خدمات الرعاية الصحية الأولية المقدمة للأطفال دون سن الخامسة في شمال الضفة الغربية / فلسطين

إعداد
بهية عبد الجليل مصطفى شولي

إشراف
د. حليمة الصباح
د. وائل أبو الحسن

قدمت هذه الأطروحة استكمالاً لمتطلبات الحصول على درجة الماجستير في الصحة العامة من كلية الدراسات العليا في جامعة النجاح الوطنية في نابلس، فلسطين.

2011م

تقييم جودة خدمات الرعاية الصحية الأولية المقدمة للأطفال دون سن الخامسة في شمال الضفة الغربية/ فلسطين

إعداد

بهية عبد الجليل مصطفى شولي

إشراف

د. حليمة الصباح

د. وائل أبو الحسن

الملخص

مقدمة: تعد خدمات الرعاية الصحية الأولية في الدول النامية نقطة الالتقاء الأولى بين المجتمع والنظام الصحي, ولكن معظم هذه الدول تركز على الناحية الكمية في النظام الصحي وتغفل عن أهمية جودة الخدمة المقدمة, مع العلم أن الأداء الجيد للنظام الصحي يؤدي إلى تحسين المؤشرات الصحية للمجتمع.

هدف الدراسة: تهدف الدراسة إلى تقييم جودة خدمات الرعاية الصحية الأولية المقدمة للأطفال دون سن الخامسة في شمال الضفة الغربية / فلسطين.

طريقة البحث: أجريت دراسة مسحية لمراكز الرعاية الأولية التابعة لوزارة الصحة الفلسطينية في ثلاث محافظات مختارة من شمال الضفة الغربية (جنين, نابلس, طوباس), وذلك باستخدام الاستبيان والمقابلات مع العاملين والمراجعين لمراكز الرعاية الأولية. تشكلت عينة الدراسة من 83 عيادة, 133 مرافق, 216 موظف صحي.

نتائج الدراسة: توصلت الدراسة إلى أن مكان السكن يرتبط بعلاقة ذات دلالة إحصائية عند مستوى الدلالة ($P<0.05$) من وجهة نظر المرافقين عند بعد الرضا العام فقط، أما بالنسبة لمستوى التعليم لدى المرافقين فقد كان مرتبطا بتقييم المرافقين لجودة خدمة الرعاية الصحية الأولية عند مستوى الدلالة ($P<0.05$) وقد كان ارتباطه في بعد الرضا العام وبعد جودة الإشارة. علاقة الطفل بالمرافق, مدة الانتظار ومدة تقديم الخدمة الصحية لم يكن لها علاقة ذات دلالة إحصائية بتقييم مرافق الطفل لجودة الخدمة الصحية وذلك في جميع الأبعاد.

كما بينت الدراسة في جانب تقييم جودة الخدمة الصحية بالنسبة للموظفين الصحيين العاملين في العيادات أنة كان ايجابيا بشكل عام في أبعاد (الإدارة ،الأداء والتدريب) وكان جنس الموظف الصحي له علاقة ذات دلالة إحصائية عند المستوى($P<0.05$) بالنسبة لتقييم الموظف لجودة الخدمة الصحية وذلك على بعد الإدارة والتدريب.

توصلت الدراسة إلى أن المستوى التعليمي للموظف ارتبط بتقييم الموظف الصحي لجودة الخدمة الصحية عند مستوى الدلالة ($P<0.05$) وذلك على بعد الإدارة فقط.

خبرة وتخصص العامل الصحي لها علاقة ذات دلالة إحصائية ترتبط بتقييم الموظف لجودة خدمة الرعاية الصحية الأولية وذلك على جميع الإبعاد (الإدارة، الأداء، والتدريب).

أما فيما يتعلق بتقييم جودة عيادة الرعاية الصحية الأولية من حيث الخدمات المقدمة، البنية التحتية, المعدات الصحية, الأدوية ونظافة العيادة فقد كان ايجابيا.

لم يكن هناك أي علاقة ذات دلالة إحصائية بين المناطق التي توزعت فيها العيادات الصحية (نابلس،طوباس ، جنين) وبين تقييم جودة خدمات الرعاية الصحية الأولية من حيث الخدمات المقدمة، البنية التحتية, المعدات الصحية, الأدوية ونظافة العيادة.

ملخص الدراسة: اظهر مرافق الطفل والعامل الصحي تقييما ايجابيا تجاه الخدمة التي تقدمها عيادة الرعاية الصحية الأولية.كما أن تقييم عيادة الرعاية الصحية الأولية كان ايجابيا من حيث الخدمات المقدمة، البنية التحتية, المعدات الصحية, الأدوية ونظافة العيادة.