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The American University in Cairo



School of Global Affairs and Public Policy

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**IMPROVING THE QUALITY OF PUBLIC HEALTH SERVICES**

**IN LOWER INCOME AREAS**

**IN CAIRO, EGYPT**

**A comparative study between the accredited and non-accredited**

**Primary Health Care Clinics in Cairo**

A Thesis Submitted to the Public Policy and Administration Department

In partial fulfillment of the requirements of the degree of Master of Public Policy

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**May 2013**

## **ABSTRACT**

The American University in Cairo

School of Global Affairs and Public Policy

Department of Public Health and Administration

### **Improving the Quality of Public Health Services in lower income areas in Cairo, Egypt**

A comparative study between the accredited and non-accredited Primary Health Care Clinics in Cairo

Amira Abdel Latif

This thesis deals with the quality of public health services in the primary health care clinics in lower income areas in Cairo. There are multiple factors affecting such quality, including the motivation of the workforce, the infrastructure and equipment of the facility, and the modes of finance and management. The research examines whether the accreditation of health clinics by the Egyptian Ministry of Health and Population affects these factors and hence improves the quality of the service provided.

To do this, the research is based on a comparative study between accredited and non-accredited health care facilities; where accreditation is granted based on patients' rights, patients' care, environmental and clinical safety, information management, clinical and non clinical services, and management of the facility, quality improvement program, and integration of care. Although the accreditation period has expired for all accredited facilities in Cairo, some improvements to the quality of health care services were introduced as a result of the accreditation. Forty four interviews were conducted with public health workers and health service visitors (patients) in two accredited clinics and two non- accredited. The interviews were transcribed and data was analyzed using qualitative method of analysis. The results have shown that the accredited clinics are more organized, regularly inspected, and hence patients are more satisfied with the quality of service. However, it was noted that there are common impediments to improvement of health services in all public health clinics, like; poor equipments, old outdated devices, lack of utilities, and insufficient medicine supply; which act as de-motivating factors to most of the health workers. The thesis comes to the conclusion that these common factors point out to the need for wider reforms in the health service sector beyond introducing the accreditation system of public health clinics. These reforms should focus on a considerably more investment in the health service sector to modernize the service as well as improving the incentive system for health workers, improving the processes of purchase and maintenance of equipment, revising the essential drug list, and focusing on patients' education.

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## Table of Contents

<b>List of Acronyms</b> .....	<b>7</b>
<b>Introduction</b> .....	<b>8</b>
<b>Chapter (1) Research Question</b> .....	<b>11</b>
Main Question.....	11
Secondary Questions.....	11
<b>Chapter (2) Egypt Socioeconomic and Cultural Background</b> .....	<b>12</b>
A. Population.....	12
B. Poverty and Illiteracy.....	14
C. Gender Issues: Egyptian Women in the Workplace.....	16
D. Cultural issues: Perception of Governmental Jobs.....	18
E. Religious Issues.....	18
<b>Chapter (3) Literature Review</b> .....	<b>20</b>
Health System in Egypt.....	23
Health Sector Reform Program (HSFP) in Egypt.....	25
<b>Chapter (4) Egypt Standards of Quality in Public Health Services</b> .....	<b>34</b>
1. Patient Rights.....	34
2. Patient Care.....	34
3. Safety.....	35
4. Support Services.....	36
5. Management of Information.....	37
6. Quality Improvement Program.....	37
7. Integration of Care: Family Practice Model.....	38
8. Management of the Facility.....	38
Summary.....	39
<b>Chapter (5) Analytical Framework</b> .....	<b>40</b>
Governance of Health Sector.....	41
Health Financing.....	43
Health Physical Infrastructure.....	47
Health Workforce.....	48
<b>Chapter (6) Methodology</b> .....	<b>53</b>

Literature Analysis.....	53
The Research Design and Instruments.....	54
Population and Sampling.....	56
Data Collection.....	59
Limitations.....	59
<b>Chapter (7) Results &amp; Findings .....</b>	<b>61</b>
<b>1 El Nozha General Medical Center- (Accredited): .....</b>	<b>61</b>
General information about the center .....	62
The Facility.....	63
I. Interviews with Health Workers.....	64
II. Interviews with Patients.....	70
<b>2 El Herafeyeen Health Center- (Non-Accredited): .....</b>	<b>72</b>
General Information about the center .....	73
The Facility.....	73
I. Interviews with Health Workers.....	74
II. Interviews with Patients.....	77
<b>3. Ezbet El Haggana Medical Center- (Non-Accredited):.....</b>	<b>80</b>
General Information about the center location .....	80
The Facility.....	81
I. Interviews with Health Workers.....	82
II. Interviews with Patients.....	86
<b>4. El Delta General Medical Center, El Salam- (Accredited):.....</b>	<b>91</b>
General Information about the center .....	91
The facility.....	92
I. Interviews with Health workers.....	93
II. Interviews with Patients.....	98
<b>Summary of Findings .....</b>	<b>100</b>
Evidence of low quality of public health services in low income districts .....	100
Motivating factors for health workers to continue working in public sector .....	100
Main reasons for patients to go to public health clinics.....	100
<b>Chapter (8) Comparative Analysis of Accredited and Non-Accredited Health Centers</b>	<b>102</b>
<b>Patients' Satisfaction .....</b>	<b>102</b>

Patients Degree of Satisfaction.....	102
Measuring Satisfaction.....	106
Common weaknesses.....	106
Vulnerability to corruption.....	107
Conclusion.....	108
<b><i>Health Workers' Motivation .....</i></b>	<b><i>109</i></b>
Human Resource Issues.....	109
Motivating Factors for Public Health Workers.....	111
De-motivating Factors.....	113
Conclusion.....	116
<b><i>Analytical Framework Based on Field Work .....</i></b>	<b><i>117</i></b>
<b><i>Application of the Egyptian National Health Standards.....</i></b>	<b><i>119</i></b>
<b>Chapter (9) Policy Implications &amp; Recommendations .....</b>	<b>122</b>
Policy reforms.....	123
I. Purchasing and maintenance Policy Reform.....	123
II. Essential Drugs Policy Reform.....	124
III. Human Resources Policy Reform.....	124
IV. Community Education Policy.....	126
V. Monitoring and Evaluation.....	127
Future Research.....	128
<b>References .....</b>	<b>129</b>
<b>Annexes .....</b>	<b>132</b>
Annex I.....	132
Interview Questions for Health Workers in Lower Income Areas in Cairo.....	132
Annex (II).....	136
Interview Questions for Patients in Lower Income Areas in Cairo.....	136

## List of Acronyms

BBP	The Basic Benefits Package
DALY	Disability Adjusted Life Year
EU	European Union
FHF	Family Health Fund
FHM	Family Health Model
GAVI	Global Alliance for Vaccine and Immunization
GF	Global Fund
HALES	Health Adjusted Life Expectancy
HIO	Health Insurance Organization
HSRP	Health Sector Reform Program
IC	Infection Control
ISQUA	International Society for Quality in Health Care
MOHP	Ministry of Health and Population
NHIF	National Health Insurance Fund
PHC	Primary Health Care
QI	Quality Improvement
USAID	United States Agency for International Development
WHO	World Health Organization
WB	The World Bank



## Introduction

The wealth of a Nation lies within the health of its people. This thesis tackles a very important issue which is the quality of health services provided in Egypt with a special focus on primary health care clinics in lower-income/poor communities. The main object of the research is to shed light on the challenges within the public health sector, identify gaps and suggest means for bridging the gaps to achieve the highest possible quality of public health services to the Egyptian poor communities. One of the main objectives of the Egyptian Revolution 2011 was to achieve social justice; this thesis will focus on means to achieve social justice in health sector through achieving standard quality service in low income neighborhoods.

Some of the factors affecting the provision of high quality health services are; good governance and collaboration among other health sector partners, sufficient health sector financing which would in turn result inadequate health infrastructure, availability of equipment, basic medicines and vaccines, and finally motivated efficient workforce. The thesis will tackle each factor separately, how it is functioning and how it can be improved.

What gets measured gets managed; the Egyptian Ministry of Health and Population has specified a number of national standards upon which the qualities of health services are assessed. The Egyptian government has also provided accreditation to those facilities that follow these national standards of health care. The accreditation expires every two years, after which another round of inspection have to be conducted and accreditation can then be renewed. Some of these factors are patients' rights to confidentiality and high quality services, patients' care, environmental and clinical safety, clinical and non-clinical support, information

management, quality improvement program, integration of care and management of the facility. This research tackles the outcome of accreditation of public primary health care clinics rather than the process itself. The analysis of the process of accreditation will undoubtedly shed light on the interaction of health workers with the service provision process but this goes beyond the scope of this research and requires further research; the research that would intrigue into the history of the accreditation process.

In order to further analyze the above factors, some document analysis was conducted on the structure of governance of the health sector in Egypt and how to improve its performance. Also imperial research has been conducted to compare accredited public facilities to non-accredited ones by conducting some interviews with both the service providers and service users in some lower income districts in Cairo in an attempt to bridge the gap and find means to achieve satisfaction at both ends; if the health workers are satisfied, their productivity will increase hence achieving higher quality of service.

The thesis is structured as follows; Chapter (1) Statement of the problem in the form of Researchable Question and a number of sub questions that the research is intended to answer; Chapter (2) The Egypt socioeconomic and cultural background; which sheds the light about the Egyptian societies beliefs with focus on gender issues. Chapter (3) Literature Review discusses health as human right, setting global health agenda, Egypt's Health Sector Reform Program (HSRP), Chapter (4) the Egyptian national standards of quality health services, Chapter (5) the Analytical Framework reflecting the different factors affecting quality of health services; governance, health financing, health infrastructure, health service delivery and the health workforce. The following section will be the Chapter (6) Methodology where methods and

limitations of the research are specified, followed by the main body; Chapter (7) Results and Findings. I conclude by Chapter (8) Data Analysis and Conclusion; and Chapter (9) Policy Implications and Recommendations.

## Chapter (1) Research Question

### Main Question

To what extent do accredited public primary health care clinics versus non-accredited clinics serve the poor community in providing quality services and achieving better health for all in lower income areas in Cairo?

The purpose of this study is to assess the performance of primary health care clinics in lower-income areas based on accreditation and national standards, and make recommendations to improve their performance in serving the poor communities. The expected impact of applying the research recommendations would ultimately be achieving social justice in the health sector in Egypt. The study will focus on the following secondary questions.

### Secondary Questions

- What are the health workers perspectives of quality services in lower income areas in Egypt? What incentives would motivate them to better serve the community and decrease turnover?
- Do the residents of low income neighborhoods receive quality healthcare services? Do they have equal access and affordable prices?
- What are the quality assurance and social accountability measures that currently exist? Do they need reform or enforcement?
- How does the quality of accredited health clinics compare to those not accredited ones? And does accreditation affect the quality of the healthcare service provided?

## Chapter (2) Egypt Socioeconomic and Cultural Background

### A. Population

Egypt's population is 83 million (Est. 2012); according to the World Bank statistics the population growth in Egypt from 1990 to 2008 was 23.7 million and 41%. (OECD Report, World Bank). Birth rate is 25.43 births/1,000 populations (2010 est.), death rate is 4.82 deaths/1,000 population (2011 est.). Egypt consists of 27 governorates; 4 of which are urban (Egypt, Alexandria, Suez and Port Said), all the remaining 23 governorates are characterized by urban and rural areas. Nearly 40% of Egyptian population live in urban areas; Cairo and Alexandria are among the world's most densely populated, containing an average of over 3,820 persons per square mile (1,540 per km<sup>2</sup>), as compared to 181 persons per square mile for the country as a whole. Informal areas represent more than half of the urban population and they are occupied by about 16 million inhabitants (WHO, 2010).

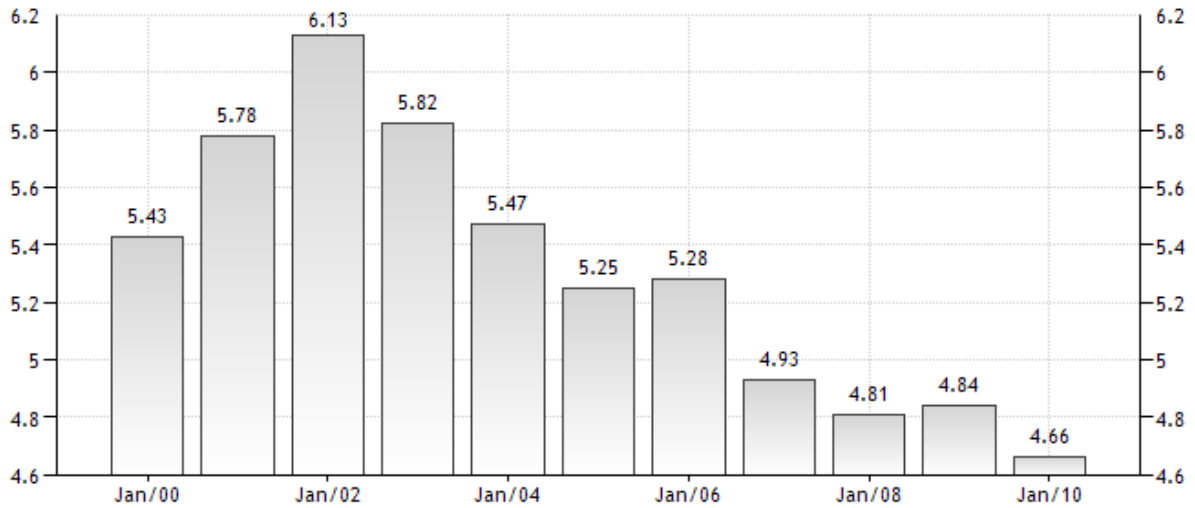


Egypt Gross Domestic Product (GDP) was worth 229.53 billion US dollars in 2011. The GDP value of Egypt represents 0.37 % of the world economy (Trading and economics website, 2013). Due to the political uncertainty, and the rising insecurity the economic growth was negatively affected. Real GDP growth slowed to just 2.2 % from October-December 2012/13 and investments declined to 13 % of GDP by the end of 2012.



SOURCE: WWW.TRADINGECONOMICS.COM | THE WORLD BANK

The total Health expenditure percentage in Egypt for both public and private sectors was last reported at 4.66 in 2010, according to the 2012 World Bank report. It covers the provision of preventive and curative health services, family planning activities, nutrition activities, and emergency aid designated for health; however this does not include provision of water and sanitation. The chart below shows the historical data, for Health expenditure from 2000-2012; total (% of GDP) in Egypt. (Trading Economics, 2013)



## B. Poverty and Illiteracy

The unemployment rate in Egypt was 11.5% in 2011 and increased to reach 13% by the end of 2012 due to the political situation which decreased many investments and slowed down the economy as a whole. This means that 3.5 million people are out of work (IMF, 2012)

Egypt's poverty rate has reached 25% of the population, quarter the Egyptian society is living in poverty according to CAPMAS survey conducted on income and expenditure in Egypt. CAPMAS defined poor as those whose annual spending is less than LE 3,076 (USD 500), or monthly spending less than LE 265 (USD 44), while the extremely poor are those who spend less than LE 172 (USD 29) on monthly basis. CAPMAS has linked poverty with various factors including geographical areas, working conditions, literacy and family size. It was proven that the illiterate rural areas in Upper Egypt, with big families are more likely to be poor. About 51% of rural areas in Upper Egypt are considered poor against about 10% in urban areas. It is also worth mentioning that 26% of illiterate people are poor, and only 6.5% of the university educated people are poor. (Hussein, 2012). Health services in low income areas in Cairo will be

more adversely affected by these trends due to the expected increase of demand for low-cost health services by urban dwellers that are becoming poorer as well as potential rural migrants to low income neighborhoods in cities due to increasing poverty and unemployment in rural areas especially in Upper Egypt.

The Poor and slum areas in Cairo are located adjacent to higher income areas; e.g. Ezbet El Haggana informal area is considered part of Nasr city which is a middle income area; El Salam area which is a poor residential area with limited facilities, is very close to both Heliopolis, El Sherouk and El Obour areas where many of Cairo's elite are living. Even inside the same district, one can find some areas for luxurious houses with gardens and swimming pool, and two blocks later is a compound of very low income citizens, who live in crowded, unclean, unorganized neighborhood; this means that there are pockets of poverty within what is perceived as high-income formal areas.

The point that needs to be highlighted here is that the poor has very easy access to a surrounding rich, good facility area that they cannot afford. They pass by the rich areas every day; they can see the expensive buildings, cars, clubs, and hospitals but they are unable to access them. This gave the poor the feeling that they are left out, and that their government is turning a blind eye to them, the government would serve and support the rich to get the best services in health, education, roads, infrastructure but the poor will remain poor and totally neglected. The poor citizens have lost complete trust in the drive of government towards the public good and being a guardian of equity, which is reflected in their mistrust of public health services, and public health workers. Most of them believe that if the service or medicine is subsidized, then it is ineffective or will be of low quality. But this is also reflected on a higher



degree of satisfaction when they find any element of a good service, simply because they did not expect it in the first place in a government-subsidized service.

### **C. Gender Issues: Egyptian Women in the Workplace**

This section highlights the different perspectives of the female role in the Egyptian society. It is worth mentioning that about 85% of primary health care workers are females, and almost 90% of the primary health care clinics visitors are also females, due to the nature of the service provided; pediatrics, family planning and gynecology. Hence it is crucial to understand the different perceptions towards Egyptian women's role in the workplace which will have direct impact on her performance and capabilities and in turn affect the quality of service she provides at the public health clinics.

The Middle Eastern culture in general believes that the first and foremost female role in the society is to look after her family, take care of kids and manage the household. This believe varies with different degrees depending on several factors; rural or urban residents, the degree of education of both male and female, the personal believe of the female in her role in the society.

In a male-dominant society, Egyptian females struggle to have equal rights like males; they always get the impression that they will never be as good as males in some particular jobs. This message is reinforced over and over to Egyptian females; it even starts from early years of their education, at home, at school and at the university. In most Egyptian families there is discrimination between male brother and his sister; the male is always better, has more freedom, can make his own decisions (El Naggar, 2010)

The above beliefs have put a lot of stress on the Egyptian woman such that she wants to prove that she is as capable as males and in some cases more capable. She refuses to be

judged by her gender. Since the Egyptian males are brought up feeling that household and children are the responsibility of women while men are the breadwinners; they do not provide much assistance at their homes. Due to the economic circumstances, sometimes female partners are working and the male partner cannot find a job, so even though she is the breadwinner, she still have all the household responsibilities, the male would feel humiliated if he participated in any of the household responsibilities. This common situation results in placing a lot of physical and psychological stress on working women.

In addition to the internal stress at home from a demanding unhelpful husband, the Egyptian woman is also faced by external stress in the workplace. Many patients would not trust a female doctor, due to the misconception that males are more capable than females. With the same believe, some managers just do not take female employees seriously, they feel they cannot depend on them and cannot assign them high responsibilities or leading positions. Also due to her family circumstances, the female employee cannot work late, or work in the weekends, or travel long duty travels. Some private sector companies are even reluctant to hire female workers because of their obligations. (Cristea, 2010)

As a consequence, it is totally natural for men to view themselves as superior in the Egyptian society, and hence stressing on the idea that women cannot make good surgeons, judges, or occupy high level jobs such as ministerial or ambassadorial positions. This idea is carried from generation to another, even with all the recent female movements that call for women's rights and for their equality with males; still such ideas are deeply embedded in the minds of the Egyptians.

#### **D. Cultural issues: Perception of Governmental Jobs**

Since this paper deals with public health services, it is important to shed light on the Egyptian society's perception of a governmental job. The Egyptian society still believes that the government occupations are the most rewarding jobs regardless of their low income, due to the stability of the job (no dismissal from the job except for proven corruption or criminal offense) and the pensions they get at the end of their service. There is also common consent in the Egyptian society that certain jobs are ranked as more prestigious than others; particularly doctors and engineers. Egyptian families take pride that their kids are students in Medical or Engineering faculties, even if the job market is saturated and there is a need in other professions, hence they will not find jobs, but still parents are proud of the concept of having a son who is a doctor or engineer. Some lower income families can secure vocational jobs for their kids; however they prefer to enroll them in faculty of medicine, just to tell their neighbors and family member that their son is a doctor. This doctor can end up jobless, with no income but he is labeled a "doctor", which is a source of pride for him and his family. This explains why some public health workers though paid very little are still motivated to work in the public sector and believe that they are securing a life time job. However, if this believe was not engraved in the minds of many Egyptians, they would have looked for a more financially rewarding job in the private sector.

#### **E. Religious Issues**

The medical clinics in both mosques and churches in Egypt fill an import gap between the expensive private healthcare facilities and the public health facilities which are perceived to have lower quality of service than the private sector. In some areas these services compensate

for the nonexistence of public services or their low coverage (one public health clinic for hundreds of thousands of residents). Mosque clinics are not funded from the Egyptian government, and their accessibility varies from one place to another; the majority of them are found in larger urban cities rather than rural areas, due to the larger number of mosques as compared to the rural ones. Such clinics are very popular in Cairo and are highly accessible by the poor. (Sen, 1994)

It is also worth mentioning that health workers that serve in mosques and churches do it out of charity and helping the poor; most of them are already working in either public or private sector health facilities and some even have their own clinics. The revenue collected is very little, as some patients who cannot afford to pay are exempted from paying. Hence the revenue in some cases might not even cover the operating expenses, which can be covered through donations. Patients would shift between primary health care clinics and health clinics in the mosque based on convenience, price and quality of care. Some would feel that quality of service in mosques are better, since doctors do the service on voluntary basis, and hence have a sense of responsibility to provide quality service, in contrast to some primary health care clinics where doctors are not motivated due to the low pay and other factors, and hence do not perform efficiently. However, some would prefer primary health care clinics as they are even cheaper than the mosques' clinics and they provide free medicine, which is not a service provided at the mosques' clinics. On the other hand, patients who cannot afford to pay would target the mosques' clinics as they can get exempted from paying any fees and still get a good quality of health service. (Sen, 1994).

## Chapter (3) Literature Review

Public Health is “the science and art of promoting health. It does so based on the understanding that health is a process engaging social, mental, spiritual and physical well-being. Public health acts on the knowledge that health is a fundamental resource to the individual, to the community and to society as a whole and must be supported by soundly investing in living conditions that create, maintain and protect health. (Kichbush, 2007). Every human being has the right to the highest attainable standard of health, where health not only means “absence of illness”, but rather “a state of complete physical, mental and social well-being and not merely the absence of diseases or infirmity” (World Health Organization constitution). “The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and States.” (WHO Constitution, preamble)

Egypt like every other nation should have two minimum obligations to realize the right for health for all; an obligation of conduct and an obligation of results. An obligation of conduct is to have an appropriate health strategy which engages different parties; health professionals, civil society, and representatives of special groups like people with disabilities, religious groups and indigenous. While the obligation of results is to ensure equal access to health facilities, provide basic shelter, essential food, housing, essential drugs and immunization, and training of health workers. The Egyptian government should also provide educational material through various means on basic information; hygiene, nutrition, breast-feeding, child health, family planning, environmental sanitation and prevention of injuries and accidents. Although Egypt is committed to these obligations to the right to health, however there are still some

areas in Cairo without basic shelter, and without proper clean water supply, the medicine supply in public facilities is not sufficient and sometimes not effective and the education material is not so common in the health sector. The quality of service is also an issue in the public health sector in Egypt that needs to be addressed, and regularly monitored and evaluated. (Tobin, 2012).

In addition to right to health for all, there is also an initiative for the right to quality health services. The United States have initiated a provisional Patients' Rights Law in 2002, which is referred to as "Patient Bill of Rights". This provisional law includes three main categories: the patient's right to autonomy and self-determination which patients have the right and ability to make their own choices and decisions about medical care and treatment they receive, as long as those decisions are within the law, the right to privacy concerning medical information, and the right to receive treatment and not be refused treatment. This law was not finalized or enforced on different hospitals in all states, however there is a generally accepted document prepared by the American Medical Association and used by hospitals. (Patients' rights e-notes 2013)

A similar approach was implemented in Egypt in 2006 by the International Society for Quality in Health Care (ISQUA) which is an international organization that provides independent assessment of medical standards against international principles and practices. Egypt was the first country in the Middle East, and the 11th worldwide to achieve this certificate. The first five pilot hospitals were Nasser Institute, Dar El Shefa, El Helal, El Salam, Al Haram, the aim was to assist these hospitals improve the quality of health care services.

Although such initiatives like ISQUA are effective, however they are not sustainable; health sector in Egypt needs reform. Health reform like any other reform is a complex process, it needs political will, political commitment, clear vision and goals communicated to the public, management and involvement of different stakeholders, specify the scope; whether it be “big bang” reform or “baby bang” , have a clear roadmap with time line, and budget and finally monitor and evaluate implementation. What is also important in a reform besides money and political will is values. Values differ from one person to another; it is about what is most important to the person. Talks about values often includes words like equity, integrity, liberty, security and efficiency, however people only know what each value really means to them when people get in conflict with each other. (McDonough, 2011, p292). Setting the agenda for health sector reform, the following should be considered hand in hand; political commitment, cost considerations, and social values.

In order to introduce any reform in Egypt the main problems have to first be identified then addressed. Equally important to the reform process is proper clear identification of the problem. It is important for governments to see health sector as a means to an end, the health system should be judged by its outcomes. By clearing defining the problem, the government would then decide on its strategic priorities, diagnose the problem and develop the policy. It is also important when conducting health reform to be locally sensitive; using international experience without overseeing the national needs, potentials, and capacities. Roberts and Berman in their book “Getting Health Reform Right” suggested six stages of the health sector reform: problem definition, diagnosis, policy development, political decision, implementation, and evaluation. (Roberts and Berman, 2009)

Before implementing health reform, the health system performance has to be assessed by some indicators like; the overall health status of the population, the degree of people's satisfaction with health services provided, and whether people are threatened by financial risks of illness or covered by health insurance. Health of population can be assessed by collecting proper information and conducting analysis on current data vs. prior years, it would include basic statistics on child mortality rate, number of attained births, and other relevant issues to the community. If the outcomes of health systems are unsatisfactory, this raises the flag to analysis the features of the system to get to the root cause of the problem; among these features would be the quality of service, accessibility and efficiency. (WHO, 2009)

Before moving to the Egyptian experience in the health reform, we need to define "health system", health system does not only include the Ministry of Health and Population, health system as defined by WHO also includes the social security health institutions and individuals, private for profit and non-profit health services providers, the pharmaceutical sector, health infrastructure, physical and mental rehabilitation care, and private health insurances. It also includes institutions outside health sector, whose primary objective is to improve health status; food industry, water and sanitation services, and infrastructure.

### **Health System in Egypt**

There are a number of public bodies responsible for financing, management, providing health care services in Egypt. "The Ministry of Health and Population is the overall health policies which include provision of public health services and in-patient-based curative system. The Ministry of Education is responsible for medical education and the Health Insurance Organization (HIO) acts as both insurer/financer and provider of care to employees,



students, pensioners, widows and the newborns; covering about 45% of the Egyptian population. Care is also provided by ministries of defense, aviation, electricity and interior, the Teaching Hospital Organization, private hospitals and clinics and non-governmental organizations” (WHO, 2010 P.19)

Egypt health system consists of a wide range of public and private health care services which allows good geographic accessibility. Various facilities provide different types of services covering; primary health care, secondary and tertiary care. Primary Health Care (PHC) includes services like; family planning, maternal care, child care, dental care, health educational services, communicable diseases control, emergency care (first aid services) and environmental health services. Primary Health care is provided by Public Primary Health Care centers all over Egypt; Cairo has number 88 public health centers in 31 districts to ensure full coverage. While on the other hand there are 33,063 hospitals beds for secondary and tertiary care in Cairo; out of which the majority of beds are in the public sector. Although the public sector hospitals have big capacity, yet they have low occupancy rate; less than 50% due to the poor quality of services provided in comparison to the private sector hospitals’ quality of services.

The Egyptian Ministry of Health and Population has initiated an accreditation program which assesses the performance of primary health care clinics to make sure that it is up to the national standards for quality of health service provision and grant accreditation accordingly. It is worth mentioning that the accreditation is usually granted for two years period after which the facility needs to be reevaluated and accreditation renewed accordingly.

**Figure 1: Primary Health Care Provision in Egypt**

Provider	MOH (public)		HIO (public)	Private
Reform-status	Reformed	Non-reformed	Non-reformed (with few exceptions)	Non-reformed
Type of facility	<ul style="list-style-type: none"> <li>•Family Health Centers (FHC) – urban, larger</li> <li>•Family Health Units (FHU) – rural, smaller</li> </ul>	Primary Health Care Units (PHCU) (urban or rural)	HIO polyclinics (with specialists)	<ul style="list-style-type: none"> <li>•General Practitioners</li> <li>•Specialists</li> </ul>
User choice & eligibility	Must use facility in catchment. In urban areas, catchments overlap.	Must use facility in catchment. Sometimes, PHCU and FHC/U overlap.	User must be HIO member. Members can use FHU/C. Catchments overlap.	Free choice, if user can pay
	Users often not aware of reform and new nomenclature. Often think in old categories of 'urban' and 'rural' units.			

### Health Sector Reform Program (HSFP) in Egypt

Egypt has experienced a number of initiatives for health reform in the public sector from 1997 to-date; the most significant reform program introduced was the Health Sector Reform Program (HSRP) 1997-2015, which is a joint program between the Egyptian Ministry of Health and Population and the United States Agency for International Development (USAID), the European Union (EU), the World Bank (WB) and the African Development Bank. The HSRP aimed at making a medium and long term comprehensive reform in the way health sector was financed, structured, and delivering. The HSRP included several levels of reform; increase resources for preventive and Primary Health Care (PHC), maternal and child health, increase incentives for health workers especially in PHC and family medicine, restructure of MOHP to decrease number of staff based on needs assessment, improve MOHP capacity in strategic

planning and policy development, creating national health standards for practice and national health accreditation, and finally expanding the health insurance coverage.

In 2002 the Egyptian Ministry of Health has committed itself to a long term strategy to cover the period from 2002-2017 in an attempt to improve the quality of service in the health sector. The main objectives of the initiative were; improve family planning, improve child health and decrease mortality rate, offer better education and decrease literacy rates, environmental health, narrowing the gap between social categories, and strengthening research. The initiative framework was to improve quality of health services, health infrastructure, equipment, medicine, and finally the quality of health workers. (Eldin, 2002).

The Egyptian Ministry of Health in collaboration with the funds providers has started the implementation of the HSRF in some pilot governorates aiming at introducing new funding methods to ensure sustainability of funds to provide high quality services, achieving equality among different sectors of the Egyptian society (rural and urban, poor and rich, males and females) and finally providing low cost service with high quality. Egypt is divided into 27 governorates; 4 of which are urban (Egypt, Alexandria, Suez and Port Said), all the remaining 23 governorates are characterized by urban and rural areas. Lower Egypt which is located in the Nile Delta has 9 governorates, which Upper Egypt which located in the Nile Valley has 8 governorates. This reform was piloted in 4 governorates; Alexandria (84 centers), Monofia (117 centers), Sohag (157), Qena (2 districts) and Suez (1 district).

The Vision of the reform was to improve the quality of providers, increase patients' satisfaction, improve health facilities, and improve information technology. The plan was to improve quality of health workers by enhancing the image of social workers and nurses,

training staff on patient-centered skills, offering incentives based on performance and proving other means of motivating and satisfying health workers. During implementation, there were several evaluations that proved some aspects to be successful and others indeed revisiting and improving the model. The Egyptian Ministry of Health refrained from the quick rolling out the reform to other governorate, without first building the capacities needed for proper implementation.

Regarding Patients' satisfaction the reform aims at empowering patients by having free choice, receiving quality service and getting health education. As for the health care facilities, the main target is to maintain the buildings, offer 24 hour services, and display a patient bill of rights. Finally, regarding information technology, there was a need for more accurate reliable data to allow making informed decisions. According a national list of standards of quality of health services was developed by the Egyptian Ministry of Health and Population, and its application implies receiving government accreditation for the health facility.

The HSRP also aimed at integrated the disjoint Egyptian financing structure of health sector into one National Health Insurance Fund (NHIF), which will be extended to governorates' levels in the form of Family Health Funds (FHF) which provided basic health services to registered families. The FHF is an economically independent entity to implement the separation between the finance and the service provision. It acts as an agency which collects the insurance funds from those insurance and purchase health services to the needy families from public and private health units. The main objectives of this initiative are to ensure sustainability of funds, and separate funding from health service provision.

Another initiative for improving the quality of health services as part of the HSRP was The Family Health Model (FHM) which is a program aiming at enabling the Egyptian health system to deliver good quality family health care (primary curative, preventive, and promotional) through motivating health workers and strengthening first line infrastructure coverage with accreditation based system. This care is provided as a “basic benefit package”. The Basic Benefits Package (BBP) is designed to both prevent and treat the most prevalent health problems in the Egyptian population. This package was designed based on; the most common health needs of the population, Cost-effectiveness of interventions to treat those illnesses and attain the best health value for money and finally availability of financial resources. The Basic Benefits Package includes child health services, women health services, laboratory services, health services for all age groups (adolescent health and health of the elderly) and radio diagnostic service and minor surgeries. (Family Health Model, Principles Guidelines for Health Sector Reform Program 2004) The BBP was implemented in Suez in 2009, and was planned to be implemented in Sohag in 2010 and Alexandria in 2011. The Family Health Model was a successful initiative in the pilot governorates; it has resulted in more organized health clinics with trained health personnel that provided better quality of service.

This reform package focused on preventative care as well as curative care, preventive care is of great importance, in fact studies have shown that every one USD spent on prevention saves three USD spent on cure. Preventative care includes prevention from both communicable and non-communicable disease. Communicable disease such as POLIO, HIV/AIDS, Virus C, tuberculosis and others are prevented through vaccination campaigns. While non-communicable disease like cancer, high blood pressure, cardiovascular disease, are

prevented through awareness campaigns about the causes and effects of such diseases. The accredited facilities in Cairo provided educational material and awareness sessions to patients on regular basis, while on the other hand the non-accredited did not provide such service. Patients appreciated these awareness sessions which results in increasing their satisfaction with the quality of health service provided. (World Bank, 2009)

The Family Health Facilities were accredited based on patients' rights, patients' care, safety, quality improvement (QI) program, family practice model, information management and management of the facility. The components of FHM are staff pattern, essential drug list and the family folder which reflects the general health status of citizens since birth. This initiative aimed at improving the quality of health services in the piloted governorates, however, it could not be widely implemented due to the poor financing of health sector in Egypt, there is a limited supply of medicine, there is no budget to computerize public health clinics and hence improve information management, and there is not much funds for maintenance of some public health facilities, and maintenance of equipment.

Such a reform like the HSRP planned to be implemented on a huge scale, would impact the whole community by having less diseases and disabilities, healthier more productive society actively participating in their communities to achieve comprehensive development, welfare and social justice. The main principles of health services that need to be attained are universality, equity, accessibility, affordability, efficiency and sustainability. The Egyptian vision of health system is one that allows universal coverage for all the population through health services packages based on equity, efficiency, affordability and patients' satisfaction. However, in order to provide good health services packages, a lot of funds need to be utilized to renew

equipment, introduce new medicines, maintain the facilities, and hence improve the quality of service. (MOHP, 2009)

Following the above reform process, the World Bank has conducted for the first time in Egypt in 2005 a Senior Policy Seminar on Health Sector Reform which brought together 45 Ministry of Health Officials to diagnose and evaluate the performance of health sector in Egypt and to seek options on financing health care. The Seminar also offered a comprehensive training package for managers of Health Systems. (MOHP 2009)

HSRP was expected to reach completion by the year 2015, and although it has achieved significant improvements in health sector in the pilot governorates, however, due to the political unrest caused by the Egyptian Revolution 2011, it is not expected the these reforms will continue as planned. According the World Bank has froze its support to Egypt in 2012, and planned to develop a new full Country Partnership Strategy (CPS) in 2013 to cover a period of two to three years. The WB aims at providing universal health insurance for the poor Egyptian citizens working informal sector. Analysis on health sector governance, health sector expenditure, and paying for performance will be conducted by the WB and some grants will be allocated for pilot projects accordingly. (World Bank, 2012)

Poor communities in Egypt still suffer the most from health problems; according to the 2009 survey on the “One Thousand Poorest Villages” in Egypt, it was concluded that 21% of the poor Egyptian families included in the survey have been exposed to economic shock due to health issues, increase in prices and low income. (2009, survey of the one thousand poorest villages). There is a higher possibility for poor families to be exposed to economic shocks (instability) more than rich families. One third of the economic shocks are due to health issues

(34% from poor families' versus 28% from rich families), 25% is due to increase in prices and 20% due to decrease in the income.

Accordingly, the new Egyptian Government is planning to focus more on the poor communities and lower-income families while preparing its budget for 2013. The new Egyptian Government emphasized on “primarily the benefits of all citizens and care for low income citizens by increasing the national income and increase the rate of economic growth, as well as increasing employment and reducing unemployment, to achieve social justice in giving out country finances” (Ministry of Finance Budget Circular of Fiscal Year 2012/ 2013, p.3). The main object is bridging the gap between social levels in Egypt society; through tax reform and new salary schemes based on cost of living and job requirements. Equal opportunities to receive basic public services with high quality, to own their own land and have an active role in the political scene, provide equal voice in the decision making process and to ensure citizenship is another objective, and finally to ensure achieving minimum standards of good life; through providing social security for all, this includes minimum wages and health insurance coverage. (Egyptian Ministry for Planning, 2013).

In order to achieve social justice in the health sector in Egypt, the government has to focus on improving the quality of public health services provided in lower-income areas. There are various factors affecting the quality of public health services; starting from Governance of health sector, the accuracy and timeliness of health information, financing the health sector, health infrastructure and last but not least health workers efficiencies and attitudes. The following section will shed more light about each factor with more details. Equally important to identifying the factors affecting the quality of public health services, is to identify the effect



and impact of poor health services. Having poor health services is critical, as it touches the lives of people; it creates unhealthy community resulting in lower productivity; lower GDP that will result in an overall poor economy and social injustice. The following diagram shows the cause and effect relationship of health services in lower income areas. By analyzing the causes and effects, the research was able to provide solid evidence-based data and recommend some actions to be taken to improve the quality of public health service delivery in poor communities.

Based on the partnership with WB and USAID in the HSRP, the MOHP Quality Improvement Directorate has developed a set of national standards for accreditation of public health facilities. These standards were categorized into critical standards, core and non-core standards; where critical standards have to be met before accreditation takes place, and a minimum of 75-80% of the core standards need to be achieved for accreditation. Health facilities that reach 75% are accredited for one year period, while facilities achieving 85% or more can be accredited for two years period after which inspections have to take place to ensure application of national standards and accreditation can then be renewed accordingly. These standards serve as catalyst for change in the practice of health care services in Egypt. (USAID report, 2005)

The main purpose of such accreditation process is to improve the health services by making primary care providers more accountable. Accreditation period would not exceed two years as none of the facilities are fully accredited; i.e. achieving 100% of the set standards, accordingly, inspections from MOHP every one or two years would assess the services and management quality to measure the impact of the accreditation process. It is up to the health

clinic to decide if they seek full accreditation or gradual accreditation through making incremental changes in the system and procedures over a period of time. (World Bank, 2010)

In 2007 the Egyptian accreditation standards for primary health care were accredited by the International Society for Quality of Health Care (ISQUA); the “accreditors of the accreditors”, the vision of the Egyptian MOHP back then was to achieve accreditation by 2020. The vision is to apply all standards to all public health clinics in order to achieve high quality of health care. It is worth mentioning that these qualities were revised by different national stakeholders; and tailored to suit the Egyptian society norms, laws and practices. The Egyptian Health Care Accreditation Organization has classified the standards into three categories; the (A) Standards which are structural; that include policies and procedures, plans and required committees, passing 75% will achieve “Level 1” of the pyramid of excellence. While on the other hand (B) and (C) standards are implementation standards; which are discussed further in the following chapter. (MOHP,2007)

In light of the above there are three levels of achievements; Level 1 which includes meeting the (A) standards, level 2 which is achieved by fulfilling the (B) and (C) standards and finally the accreditation which includes complying with all levels (A,B and C). All accredited primary health care clinics in Cairo are partially accredited, reaching from 75-85% of the national standards. However, due to the political instability in Egypt due to the Egyptian Revolution 2011, the inspection and renewal of accreditation was stopped.

## Chapter (4) Egypt Standards of Quality in Public Health Services

As mentioned earlier, Cairo has eighty eight public health centers, out of which forty one are accredited and forty seven are non-accredited. The Egyptian Ministry of Health and Population grants accreditation to primary health care clinics based on the following eight Standards for Quality; patients rights, patients care, safety, support services, management of information, quality improvement Program, integration of care: Family Practice Model and management of the Facility. It is worth mentioning that accreditation expires after two years, after which it needs renewal. (Ministry of Public Health and Population Accreditation Standards document)

### 1. Patient Rights

Patients should be informed about their treatment and are asked for their consent for certain procedures, when applicable. The facility should have a system to deal with complaints, and demonstrated evidence that appropriate and timely action was taken to deal with complaints received, The facility should have a system to assess patient and provider satisfaction, The facility provides training in patient satisfaction and/or interpersonal communication to its staff at least once a year and finally that the facility has a system to ensure that female providers are available, either on site, or through referrals, if requested by client.

### 2. Patient Care

Patients' care includes provision of a number of services; general clinical areas, antenatal care, hypertension, diabetes, IMCI, immunization and family planning. A

comprehensive history and physical examination should be performed for all patients. The physician has to explain to all patients the diagnosis and treatment and any follow-up steps using clear and simple language. The physician has to ensure that patients understood the message through feedback. Vaccination procedures should appropriately be administered to all children according to MOHP guidelines. All providers have to provide right health messages and inform mother about follow-up or next visit. Regarding the Integrated Management of Child Illness (IMCI), a comprehensive history and physical examination should be performed for all sick children according to age of child. The providers should explain to mothers the classification and treatment and any follow-up steps using clear and simple language. Cases requiring diagnostic tests should be appropriately referred according to IMCI guidelines, when needed. An appropriate prevention and treatment to all sick children according to IMCI guidelines should be provided. Children have to be appropriately referred, when needed, according to guidelines.

### **3. Safety**

There are two types of safety; environmental and clinical safety. Environmental safety means that the facility has a physical environment that is safe to patients, employees and clients and that the facility structure/building and its surrounding grounds are suitable for services provided to patients. The facility should have a preventive and corrective maintenance plan for the building and medical equipment, and a system for proper disposal of waste products including contaminated materials. On the other hand, clinical safety includes; Sterilization, infection control and employee health program. The facility should have a coordinated system to reduce the risks of endemic and epidemic nosocomial infections in patients and health care workers by using an Infection Control (IC) process

that is based on sound epidemiological principles and IC research. There should also be a system for sterilization techniques that is well communicated to all staff and enforced.

#### 4. Support Services

Support services include both clinical and non-clinical support services; clinical support services include pharmacy, laboratory, radiology and emergency room, while on the other hand the non-clinical support services include housekeeping, laundry and kitchen.

The health facility should insure that the pharmacy adopts a Basic Drug List (BDL) and that adequate supply of basic drugs (3 months) including IMCI drugs, FP contraceptives, and vaccines are available. There should be an adequate system to store and dispense drugs, expiry dates should be clearly posted on each shelf. The pharmacist should insure that the drugs are appropriately prescribed according to generic names, essential drug list, and are dispensed in appropriate packaging that includes a label with the name of drug and written instructions about it. All patients should receive appropriate verbal instructions on the use of drugs. The health facility should ensure keeping proper administration on the input and outputs of drugs. Finally there should be Fire Extinguishers appropriate for use in case of chemical related fire that is easily accessed.

Another clinical support services are the laboratory and radiology service which should have written policies and procedures, their space, supplies and equipment are adequate for its function according MOHP policies; Quality control is maintained through periodic calibration of equipment and validation of test results, the results of tests and X-rays are given to physicians on time. The laboratory should be clean with adequate supplies and functioning

equipment and machines, Sterilization techniques should be properly enforced in the laboratory. Both laboratory and radiology staff should be certified or licensed technician.

As for emergency room; there should be Emergency Kits adequately stocked with appropriate medication and supplies, and easily accessed; like nebulizers and oxygen source. Staff should be adequately trained on the use of emergency equipment and cardio-respiratory resuscitation training. The health facility should have access to a well equipped ambulance staffed with trained personnel to transport patients after stabilization to the referral facility, and the estimated time for ambulance services is within 20 minutes to final destination.

Regarding non-clinical services; housekeeping, kitchen and laundry; there should be a system for housekeeping to ensure that facility is clean at all times, and a standardized process for changing and cleaning of laundry

## **5. Management of Information**

The health facility should have a system to maintain the accuracy and validity of data and reporting, complete and accurate medical records, with a system for reviewing medical records, and a system to ensure that all records are confidential.

## **6. Quality Improvement Program**

The facility has a system to monitor and improve the quality of care; the facility should have a committee or team assigned for improving the quality of care at the facility, with an assigned QI coordinator whose role is to conduct QI related work. The facility should have an annual QI plan with Priorities for improvement, Implementation plan with timeframe, assigned responsibilities for implementation including process improvement

teams and committees and operating budget included. There should be a system to develop, adopt, and disseminate clinical practice guidelines for priority clinical areas and procedures provided at the facility. There should also be a system to review the use of drugs and/or antibiotics. Staff should also receive regular trainings on QI.

## **7. Integration of Care: Family Practice Model**

The facility should have a prevention program; an effective dissemination program to educate its staff about disease and accident prevention, and screening for illnesses such as diabetes, hypertension, asthma, accidents among children, cancer. The facility should have effective communication to make its patients aware of what they can do to prevent and reduce illnesses. It is essential to maintain Continuity of care; through arrangements with public health, educational and social service organizations and ensuring that patients are seen by the same family doctor over a certain period of time. Another important aspect is the referral system, the facility should have a well-defined system for referrals, with a written referral policy that is communicated to all providers together with a list of referral facilities and/or specialists available and known by physicians. All providers should use the referral forms to hospital and specialists and keep good record of the number of referral cases.

## **8. Management of the Facility**

Any health facility should have a clear mission statement developed and agreed upon by staff, a clear organizational structure with clear lines of authority, A full time director assigned to manage the facility with a clear written job description. The facility director should have appropriate training in health management and participates in continuous education

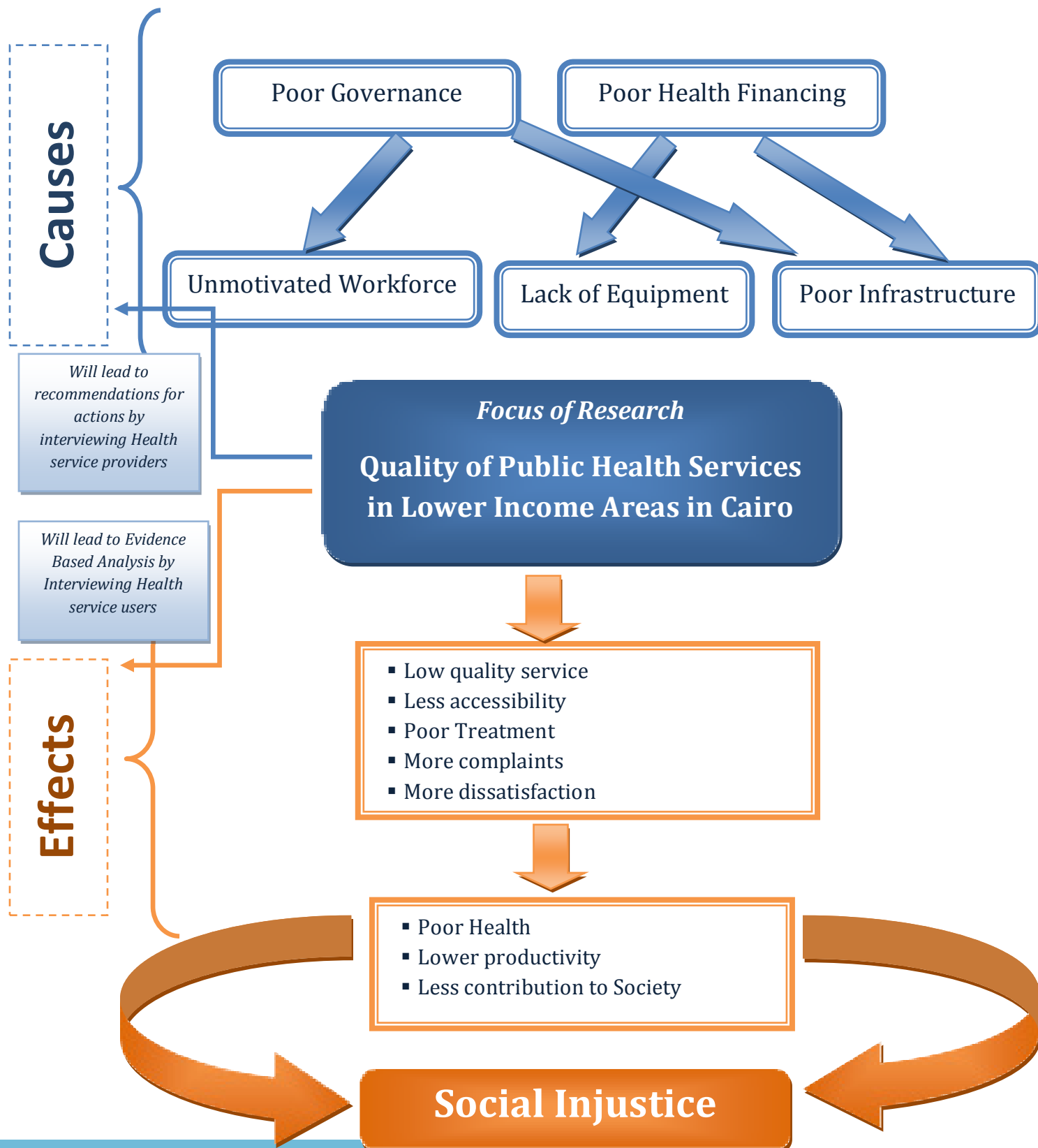
programs. There should be written job descriptions for all positions in the facility which are clearly communicated to all staff. There should be a clear system/process for coordination and communication between the director and the staff. There should also be a fair system of assessment for employees' performance. There has to be an adequate number of staff and distribution by specialty. An orientation program for new comers should be in place, together with a system for continuous education for current staff through trainings in different key areas: At least 80% of providers trained in clinical practice guidelines, At least 60% of providers trained in IMCI, At least 60% of providers trained in Family Planning, At least 80% of staff trained in infection control and At least 80% of staff trained in interpersonal skills and client satisfaction.

### **Summary**

Based on the above national standards of health services, Cairo currently has two sets of public primary health care facilities; accredited and non-accredited. The accredited facilities are the ones partially (75%-85%) applying the national standards mentioned above, while the non-accredited are still not applying the national standards as indicated by the Egyptian Ministry of Health and Population. Since all accredited clinics are only partially complying with the national standards, an accreditation period varies from one and half to two years, after which accreditation is expired and needs to be renewed.



## Chapter (5) Analytical Framework



Based on the above analytical framework, the following section will separately tackle each of the mentioned factors affecting the quality of public health services. It is important to look at the patients' satisfaction from four dimensions; access, quality, financing and customer support. Access includes choosing the service providers, quality includes the efficiency of the health workers, the infrastructure, availability of medicine and equipment, financing focus more on risk sharing in the sense that health problems should not impact the Egyptian family economy dramatically, and finally customer support lies in the overall customer satisfaction.

### **Governance of Health Sector**

Good Governance is the ability to manage all society issues through informed decision making, and proper distribution of roles between the government and other partners; public sector, civil society and the people. Hence the government has to distribute roles, responsibilities and revenues among central and local administration. Decentralization is main requirement for good governance. The performance of good governance is measured through nine dimensions; efficiency, effectiveness, participation, transparency, accountability, responsiveness, application of social justice, law enforcement and combating corruption. (UNDP, 2012)

In order to assess Egyptian Health Governorate, it is important to note the structure of the local administration in Egypt which is structured in five layers; the Governorate which is the main service delivery unit of sub central Egypt, the Markaz which includes a capital city of the markaz and other cities, the City which exists in all governorates as one city governorate, the capital of a governorate, a capital of a markaz, or as a constituent city in a markaz., District

(Hayy) the smallest local unit in urban communities and finally, the Village which is the smallest local unit in rural communities. (World Bank 2010)

Having all these layers, decentralization has to be properly applied in order to achieve good results, the local administrations have to have real responsibility and authority, they need to be involved in the process of strategy setting and allocation of budget for health, there should be coordination among different provinces, Ministry of Health and the Ministry of Local Development, which will ensure that local needs are met. When local governorates are involved in the whole process, they can monitor implementation, identify bottle necks and suggest solutions to improve the services.

In practice Egypt has one of the most centralized public sector systems in the world. The Health System in Egypt is disjointed due to the many layers of government agencies involved. Health Care is provided by the Ministry of Health and Population (MOHP), Health Insurance Organization (HIO) and the university hospitals. There was an attempt in 2005 to empower governorates by giving them more authority and decide on their annual budget, but this was not fully implemented. In order to apply decentralization in Egypt, organizational, institutional and human capital development need to be implemented. The main objectives of decentralization are; to enable more efficient government service delivery, advance democratic reform, and promote economic development. (Allen, 2009)

Since the Ministry of Health and Population is the primary provider of preventive and curative care composed of 5,000 health facilities and 80,000 beds nationwide (Ministry of Health and Population, 2005), the Governance function of Ministry of Health in Egypt has to be improved, the Ministry of Health and Population should be able to perform four main

functions: Policy making and strategic planning, legislation and regulation, building partnership and improving transparency and accountability. (WHO, 2004)

One of the impacts of having inefficient governance is having a poor information system. The information system in Egypt is not well developed. The health statistics reports are prepared annually, however data processing is delayed, there is lack of efficient analysis and failure to use the available information in policy formulation. Transparency and accessibility to information is also an issue especially within the centralized structure of Egyptian government. (USAID, 2002)

### **Health Financing**

The Egyptian Government financing of Health sector has decrease over the past five years, reaching EGP 20.7 Billion in 2010-11, which constituted only 4.7% of total GDP which is considered to be a low percentage compared to similar countries. (MOHP,2012). The national budget for health besides being little, around 50% of it goes to wages and compensations of employees. The percentage of health budget is very low when compared to education budget which constitutes 12% of total budget, social protection 25% and public services which constitute 25% of total budget in 2012/2013. (Financial Statement of State's General Budget 2012-13-Egyptian Ministry of Finance).

There are different sources for health financing in Egypt; among which are tax based financing, fee for service which depends on out-of-pocket financing and health insurance financing. Tax revenues are mostly used to finance the public health services and some health insurance organizations. Egypt is considered to be a low health spender compared to other

countries having the same economic development. The health insurance covers almost 50% of the Egyptian population; including students, newborns, retirees and civil servants. However, 50% of the Egyptian population pays out-of-pocket for provision of health services.

Health financing depends on Health system priorities which keep changing with the changes of political and socioeconomic circumstances. Health priorities in the Middle East region are set according to the health problems of high burden of diseases (WHO, 2004). Hence many Middle East Governments set cardiovascular diseases prevention, HIV/AIDS, and curative programs as their priorities. However, it is more crucial to set health system development as a top priority.

Egypt health priorities are set by the World Health Assembly of the World Health Organization; where the ministries of health of all member states meet on annual basis to discuss the key health issues in their countries and agree on resolutions to address such issues. Health priorities are also affected by other partners in health; NGOs, international foundations, and other advocates for health. Bill and Melinda Foundation have made a huge grant to help establish the Global Alliance for Vaccine and Immunization (GAVI) which was established in 2000. GAVI's main objectives are to improve the ability of Health Systems to carry out immunizations, speed up the development of new essential vaccines, and ensure the safely intake of vaccines. (Technical Paper-Health System Priorities in the Eastern Mediterranean Region, 2004)

Although health partners' contributions are important, however, they should work together to assist developing countries improve their health systems, not only trying to combat certain diseases. Improving Health Systems is a more sustainable approach for countries to

address their key health issues. There should be more focus on improving the quality of public health services, better management. In Egypt 63% of the population seek medical care in private hospital versus 37% go to public hospitals due to low standard quality of service. Although there is a number of European and American trained physicians and dentists in Egypt who follow Western safety protocols, yet, Egyptians choose to do surgeries abroad, unless it is an emergency, because there is not enough hygiene or trained staff in Egyptian hospitals. (Egypt healthcare, medical journal, 2012).

Noting the low quality of public health services, the Egyptian Government has shifted the focus in 2013 budget preparation to the low-income citizen well being, the quality of service provided, and the good performance of the services' providers. Subsidized or low cost services should also be performed with quality and decent manners. (Ministry of Finance, Budget Circular of Fiscal Year 2012/ 2013, p.3). Although the insurance system covers cost of health service to some citizens, yet the quality is still an issue. Studies have also shown that low income countries spend 41-81% out-of-pocket expenditure as a percentage of total health expenditure reached while in higher income countries is only 19-44%. Although Egypt has health insurance programs, yet many suffer from incomplete packages, or high overhead cost due to enrollment in different schemes, or poor quality of service. Out-of Pocket payment is still very high in Egypt in an attempt to ensure better quality of health service. (El Awadi, 2004)

Health Financing schemes globally are usually classified into two categories; public and private, depending on the nature of the insurer and the degree of cross subsidization.

Insurance schemes also differ in terms of coverage of basic and supplementary services; they also differ whether it is mandatory or voluntary coverage. (Heidelberg, 2011)

In Egypt, the Health Insurance Organization (HOI) is supervised by the Ministry of Health and Population. Back in 1964 when it was first created, it provided mandatory health insurances for all business' employees. Later in 1992 it was expanded to include pensioners, widows and school students covered by the Student Health Insurance Program (SHIP). The main source of financing the services provided by HOI hospitals and clinics are from the leisure taxes (taxes levied on cigarettes and alcohols) and from payroll. Currently the HOI which is the largest health insurance organization in Egypt is divided into eight regional branches providing health insurance to about 30 million citizens. The Private Health sector in Egypt is growing significantly negatively affecting public health services; as it provides higher quality services compared to public facilities but with much higher prices. Also providers of health care are paid much higher salaries in private sector, which encourages the qualified efficient staff to leave the public sector for better pays, and encourages corruption, by health workers directing patients to their private clinics rather than treating them at the public clinic or hospital. The compulsory health insurance on students does not include private sector facilities; hence students get low quality services as they have to choose. (MOHP,2004)

The American Academy of Pediatrics advocates that all students must have health insurance coverage that ensures them access to affordable and comprehensive quality care. Health insurance plans must be portable from state to state, with administrative procedures to eliminate breaks and gaps in coverage to ensure continuous coverage from year to year. Plans should ensure free choice of clinicians and foster coordination with public and private

community-based programs for infants, children, and adolescents through the age of 26. The scope of services provided by all health plans must include preventive, acute and chronic illness, behavioral, inpatient, emergency, and home health care. These plans must be affordable and have cost-sharing policies that protect patients and families from financial strain and are without risk of loss of benefits because of plan design, current illness, or preexisting condition. (American Academy of Pediatrics Policy Statement, 2010)

In light of the international health insurance schemes and the Egyptian government new approach to achieve social justice in 2013, there is a proposed plan to change the insurance scheme in Egypt to ensure full coverage for all Egyptian citizens; however this will not ensure high quality service. In order to achieve full coverage, Egyptian government need to mobilize internal and external funds, since current expenditure on health is only 4% of GDP which is too low to start such a huge project. Prior to implanting full coverage, the government has to invest in improving the quality of services in different health care facilities; otherwise there will be no use for health insurance if the quality is low.

### **Health Physical Infrastructure**

The physical infrastructure of public health facilities include the state of the buildings, electricity, water, and communications technology available, the quality of access roads, and the availability of equipment (both medical and non-medical) in working condition. Delivering health care above a certain level of complexity is difficult in the absence of good infrastructure. Shelter for patients and staff, drinkable water and a source of electricity for, among other things, refrigeration for vaccinations, are fundamental for the safe provision of health care. A working communications mechanism is necessary for the functioning of a referral system, as



well as to enable the provision of support services such as laboratory, pharmaceutical and radiology services to the facility. A traversable access road is necessary to enable patients to attend the facility in the first place. (Lutge, 2007)

As a result of poor health financing, the Egyptian physical resources; hospitals, medicines, technology assessment and various health facilities are also poor. There a big number of health facilities in both urban and rural areas in Egypt, but the percentage of non-functional health facilities is considerable and significant disparities exists in the geographic distribution of health facilities. Infrastructure is a core component of development. Well-constructed hospitals and health clinics enable communities to achieve sustainable improvements in health. Many health facilities need maintenance in order to be functioning; there should be regular update on the buildings deterioration over time. This should be the responsibility of the local administration to update such information and find means for solving it.

Studies conducted in the Middle East and lower income countries have shown that poor infrastructure has a direct effect on health service delivery. A number of projected supported by UN and NGOs failed to achieve their targets because of the poor infrastructure in which services are delivered. Moreover, poor infrastructure has proven to have significant affect both on patient's perception of quality of care and on health professionals' satisfaction with their working conditions.

### **Health Workforce**

The last, but not least important factor affecting the quality of health services is the quality of health personnel; nurses, physicians, dentists, birth attendants and pharmacists. Most of

Middle East Region suffers from untrained and unqualified health workers, Gulf countries rely on expatriate workforce, instead of investing in training and educating their national workforces. Nursing schools in Gulf countries suffer from shortage of nationally qualified nurses and teachers. The quality of health workers in Egypt is related to the quality of Education. The education system in Egypt needs to be reformed, in terms of the educational material, the teachers, the number of students in schools and universities. The idea of having an exam with certain grades that would direct the whole future of students is a wrong notion in the first place. (Farag, 2009)

Although the main objective of medical students is to “Save Lives”, such objective may not be reflected in their attitudes towards their patients. The main material for medical schools in Egypt is designed so that students will acquire knowledge with very little or no focus on skills especially interpersonal and attitudinal skills. Accordingly, some interventions are needed not only to improve the quality of health services as a whole, but also to eliminate health care disparities through promotion of attitudinal learning. (Smith, 2007). Although Egyptian Health workers did not study the patient-doctor relationship in the medical schools, the MOHP has provided training packages on the topic due to its important impacts on improving health. Studies have shown that symptoms resolve faster if there is a good patient doctor relationship; diabetics have lower cholesterol, lower hemoglobin. The biomedical aspect is not the backbone but rather the impact of disease on the life of patient, his ability, his work that he/she might lose and their inability to support their families. Physicians should have patient centered skills to be able to listen carefully to their patients, and have a dialogue with them emphasizing on the notion of hope and empowering their patients. (Drs. Fortin & Schlair, 2012).

Acquiring the above skills is critical, most patients go to public health care centers in Egypt complaining from physical illness; however the psychology of the patient is crucial to their cure. Having a calm smiling doctor who would take the time to explain the case and comfort the patient and his family make all the difference, especially if the patient is a child or elderly and their families are really worried about them. It is also recommend by the Egyptian MOHP as part of the patients' rights, that each patient has the right of 10-15 minutes from his visit dedicated for answering his queries and explains more about his/her illness. Being human is an essential character of being a doctor or nurse; they need to touch the human side of the patient so that patients would not feel that they are dealing with machines, hence increase the patient's satisfaction with the quality of service provided.

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Effective patient-physician communication is associated with safer patient care, higher patient satisfaction and adherence to treatment, lower malpractice rates, and higher physician satisfaction. Yet physicians in Egypt have historically received little training in evidence-based

methods of communication. Studies have shown that physicians with patient centered skills not only have more satisfied patients and better diagnosis of the problem, but also are more satisfied motivated physicians themselves, because they feel that they are doing an important job that touches the lives of people.

Having motivated personnel is the key principle to the success of any organization. If there is vision, and good strategies in place, but de-motivated staff, nothing will get implemented. According to Maslow's Need Theory; humans in general are motivated according to their needs starting from Physiological needs; which are basic biological drive for food, air, shelter and water, then Safety needs; which is to be free from danger, then Love needs; which is feeling of belonging and the socially accepted, then Esteem needs; which includes recognition and attention from others and finally the Self-actualization need; which is seeking self fulfillment. (Denhardt & Aristigueta, 2009)

In light of the above theory, the Egyptian health workers need to have a minimum pay that can cover the basic needs for them and their families; food, water and shelter. They should be able to support their families; they should afford sending their kids to schools and have enough money or insurance schemes to keep them healthy. This is basic principle for achieving social justice. After ensuring the basic needs are met, health workers can be motivated by various ways; monetary and non-monetary. Health workers who work in hazard areas should have some financial incentives, the infrastructure of the workplace is equally important.

Health workers can also be motivated by non-monetary incentives like their desire to serve the public, which gives them a sense of loyalty, fulfillment of duty and citizenship. Others would be motivated by their "status", being a doctor that saves lives of the neighboring

community. There is no “one size fits all” strategy when it comes to people’s motivation. The United States have also introduced the notion of Quality Improvement (QI) in health sector in 1970s. Quality is improved when the providers are motivated, people need to be motivated on the basis of “Workplan Citizenship”, and this is the idea behind the new management science of quality improvement. This notion was also introduced in Egypt within the national standards for quality of public health care. Many Egyptian medical care personnel are motivated by a sense of responsibility towards their community, and a sense of pride in doing their job well hence saving lives of many (Jennings, 2003)

## Chapter (6) Methodology

### Literature Analysis

Most of the literature depended on technical reports from UN Organizations, since the development organization have conducted a lot of studies about health sector reforms in various countries all over the globe with specific emphasis on under developed countries. The World Bank have conducted in depth analysis on health sectors in many countries from different regions since 2000 like; China, India, Turkey, Mozambique, Uganda, Ethiopia Vietnam and Egypt. Accordingly a big part of the literature depends on WB reports.

The World Health Organization also has a number of reports, however not much literature was found on the quality of health service, most of the reports focused on medical issues like maternal and child health, HIV/AIDS, Malaria and POLIO control. Most of the literature found in WHO technical reports on the Health System Reform in Egypt was in collaboration with the World Bank as a fundamental donor.

The literature also depended on some books on Global Health, social research, human behavior in public organizations, and the right to health. Some health journals were also used in the literature like The Lancet and others.

The Websites of Egyptian Ministry of Health and Population and the Egyptian Ministry of Finance were also useful in the literature. Some reports and presentation prepared by a number of former Egyptian Ministries of Health were also used.

However, it was of note that most of the literature about health sector in Egypt was about health insurances schemes, but there were limited literature about the quality of health

services especially in lower income areas in Cairo. This paper intended to use field data in order to reflect the real life/environment, listening to lower income citizens' view and concerns that might not be heard by the policy makers and/or Egyptian government authorities. The paper also aims at highlighting the health workers frustrations which impede them from providing quality service.

### **The Research Design and Instruments**

Different methodologies and analytic tools were used to assess quality of public health service; qualitative method is used in the form of two sets of semi-structured interviews with different stakeholders and focus groups designed to highlight the main areas of dissatisfaction of both service providers (health workers) and their clients (lower income citizens/patients). In a qualitative interview, the information is contracted through an exchange of opinions and view between two persons having a common interest. The main purpose is to capture the diversity in the respondents' answers (Kvale, 1997). The reason behind choosing semi-structured interviews is that the interview is neither an open discussion not restricted to a certain number of questions, which allows more insights and opinions of interviewees to be incorporated in the study.

In Cairo there are two sets of public health facilities; accredited and unaccredited, as mentioned earlier. The accredited facilities are the one applying the national standards of quality of health services, while the unaccredited are still in the process of preparation for these standards as indicated by the Egyptian Ministry of Health and Population. The plan was to visit two accreted facilities and two unaccredited and interview five health workers in each and four patients in each, however the research was completed conducting forty four

interviews with both health workers and patients, then a comparative analysis was conducted based on the findings.

In addition to the interviews, and comparative analysis, some document analysis was also conducted on the structure of health sector, flow of resources, transparency, accountability, and how these factors affect the quality of public service.

The main indicators used in the interviews are accessibility, equity, degree of satisfaction of clients, degree of motivation of health workers, patients' rights, national standards for quality of health care, and responsiveness to complaints. The interviews were semi-structured and flexible which allowed collecting information from interviewees on their points of views and perceptions in an attempt to get some knowledge from real life, which will guide the research in making proper recommendations.

The reason behind using qualitative analysis is that it has proven to be the most beneficiary to the study as the research is trying to get more insight on the reasons behind poor quality of public health services in Cairo. Qualitative analysis usually seeks in depth analysis about a smaller group of people, with overall objective of learning about how and why they think and behave and assign meaning to action, hence the data collected is what people say, believe and life stories. (Babbie, 2007). Based on the injustice of acquiring quality health service in the Egyptian public health clinics that has been discussed in the literature review, and the role of State to provide quality health service for all citizens as part of their human rights, this research aims at highlighting the reasons for provision of low quality service and suggests means to fix these drawbacks. It was important to hear more about the issues causing dissatisfaction for both service providers and users in their own circumstances to pin point the



main reasons behind having poor quality of health services in lower income areas, in order to have evidence based information and set sound recommendations. The findings of this study will enable policy makers to direct their attention and spending on health to such variables that need to be changed in order to achieve higher quality of health services which will in turn result in attainment of social justice in the Egyptian society

## **Population and Sampling**

### ***Target Population***

The targeted population of this research is the health workers (service providers) and patients (clients) in lower income areas in Cairo. In Cairo there are about eighty eight public primary health care facilities in twenty five districts, divided as follows fifty eight medical centers, eighteen child care centers and twelve general clinics. Forty one medical clinics have been accredited from the Government of Egypt for following national health standards of quality of health care provision. The accreditation started from 2005 till 2010, it is worth mentioning that the accreditation period is two years after which accreditation expires and needs renewal. Some of the forty one facilities have renewed their accreditation and others have not. On the other hand there are about forty seven public health facilities that were never accredited in the first place hence not following national standards for provision of health care.

The plan was to take random sample of health workers and patients were taken from five accredited facilities and another sample from five unaccredited facilities. However, after interviewing participants from two accredited and two unaccredited facilities, the researcher felt that all information needed is provided and any additional interviews will only be repetition to what has already been said.

The choice of Elsalam, Ezebet El Hagana and El Nozha district is to make the sample representative of the lower income areas in Cairo. It is worth mentioning that the three districts are located few kilometers away from higher income areas, that is why the study choose these districts, as some patients might have had some access to a better quality service at private hospitals or clinics in the neighborhood. This was needed to complete the analysis and get an insight of the lower income citizens' views and choices.

### *Parameters*

The participants included in the sample were based on; their willingness to participate, their existence in the public health clinic (as workers or patients), a mixture of males and females in different age groups to obtain different perspectives. Though the female representation is more in the sample due to the difficulty of finding male doctors and male patients, since most of the services are for children and women with only dental services for both males and females.

Forty four interviews were conducted in four health centers related to three districts; twenty seven with health workers and seventeen with patients. The semi-structured interviews were conducted with them during April 2013. The results and analysis presented in this research represent the situation at this moment.

### *Sampling Frame*

A list of all public health clinics in Cairo was provided from the Egyptian Ministry of Health and Population. A separate list was provided showing the accredited facilities in Cairo by name and date of accreditation. After getting these two lists, a meeting was conducted with

the Head of Egyptian Health Governorate who assisted in identifying the sampling frame based on the previously identified parameters.

### *Sampling Method*

A non-probability sampling method was used to conduct the study, which is “a technique in which samples are selected in some way not suggested by probability theory. Examples include reliance on available subjects as well as purposive, quota and snowball sampling”. (Babbie, Social Research, 2007, p. 183). The sampling method selected was not bias and was restricted to the parameters of interest indicated above. There are four different types of non-probability sampling; reliance on available subjects, purposive or judgmental sampling, snowball sampling and quota sampling, the study is based on purposive or judgmental sampling; as it compared the views of health workers and patients in two different setups; the accredited facilities and the unaccredited ones. Although such sample might not provide the full list of characteristics of both facilities as a whole, but it was sufficient to conduct the comparative analysis.

### *Sample Size*

The interviews were conducted in four public health facilities in lower income areas in Cairo. Five to eight health workers and four to five patients were interviewed in each facility making a total of forty four interviews. Twenty five interviews are related to the accredited facilities and the other nineteen are from the unaccredited. The number of facilities where interviews were conducted represents 28-33% of the facilities in the each district; El Slam two out of seven facilities in the same district were interviewed (28%), El Nozha one out of three

centers was interviewed (33%) and same for Ezbet El Hagan one out of three centers (33%). The three selected districts represent 10% of the total number of districts in Cairo.

### **Data Collection**

The data was collected from four public health clinics in three districts. Approvals have been granted from the Chair of the Institutional Research Board (IRB) prior to data collection to ensure that ethical issues are taken into consideration while conducting interviews; no harm is done to participants either injuring self-esteem, endangering their lives or jobs and ensuring anonymity and confidentiality of data (Babbie, 2007). Another approval was granted from the Egyptian Ministry of Health and Population after reviewing the interview questions and discussing the main objectives of the research. The Egyptian Health Governorate also reviewed the interview questions prior to conducting the interviews, the head of the Health Governorate suggested some areas where he believed needed more investigation, and based on his recommendations the above areas were selected.

### **Limitations**

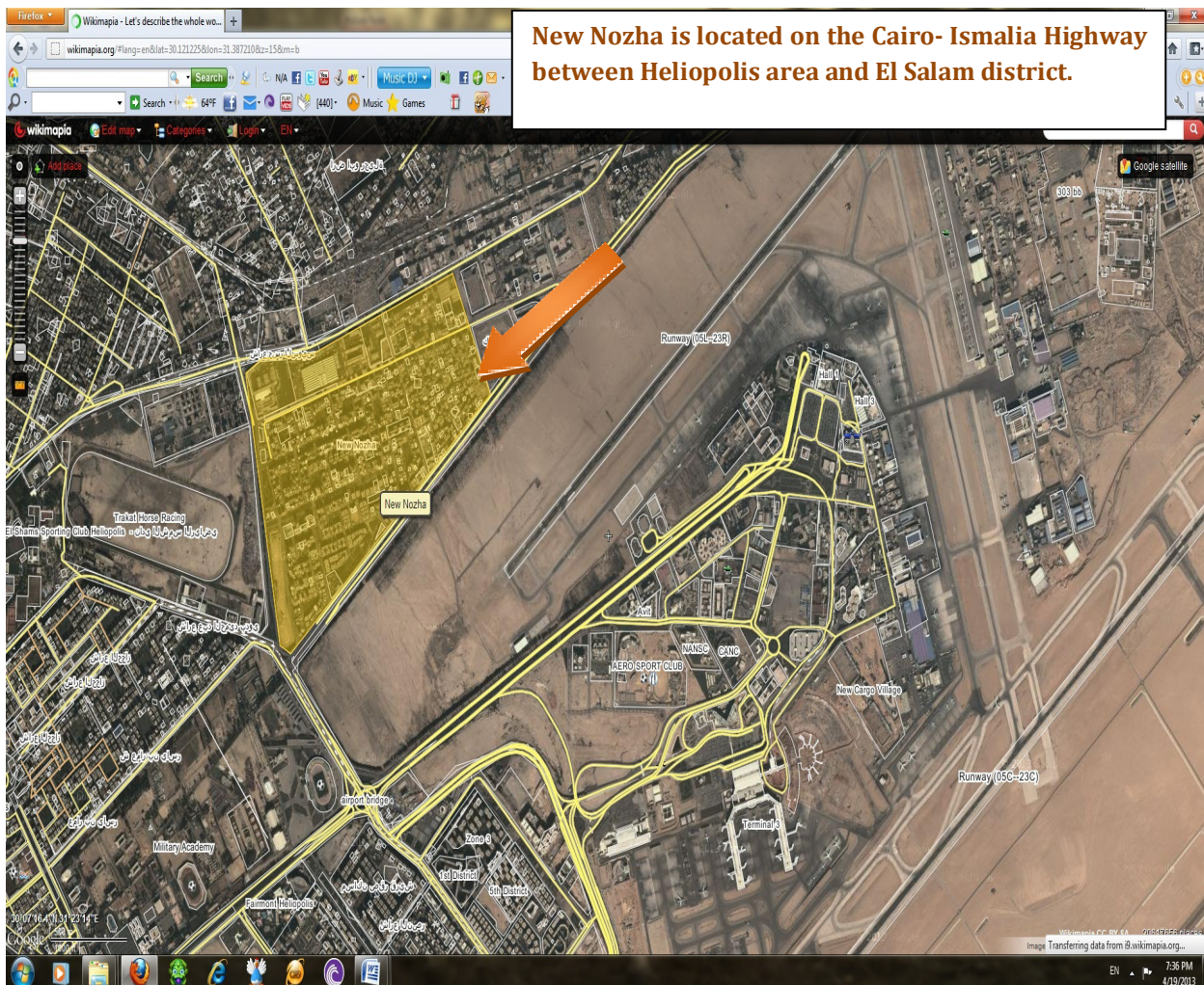
- ✚ Most of the interviews conducted at el Nozha Medical center were attended by the Health Directorate representative, which might have affected the responses of both patients and health workers, as they would not feel free to pin point the negative issues. Workers would not want to have bad relation with the Health Directorate representative who is in charge of their evaluations and trainings, and on the other hand patients would not feel secure highlighting negative aspects because this service is the most convenient for them due to low cost.

- # Some patients were visiting the center for the first time or for couple of times only which was not sufficient enough for them to make proper judgment
- # Some patients were accompanied by many kids which make it hard to interview them without distraction
- # All patients leave before 12pm, so by 11 am it is hard to find any patients to interview, and from 09:00-11:00 all patients are busy getting in turn or trying to book a ticket
- # It is hard to get negative views on the service because usually people express their disappointments when something goes wrong with the services, so in the couple of times I visited each facility, there were few incidents of patients that are upset, shouting or complaining.
- # Official complains are not part of the Egyptian culture, in very rare cases do people write an official complaint and escalates the issue. Usually people would look for the head of the center, shout, then in most cases would calm down and be easily satisfied.
- # Due to time constraints there was no possibility for conducting more interviews to better measure the satisfaction from the quality of service provided
- # Due to time constraints it was hard to measure all factors affecting the quality of service and conduct in depth assessments of the quality controls.
- # Due to time limitation, I was unable to discuss in details the accreditation process itself; who initiated the process, who was involved and what was the value added to medical staff that assisted in planning and implementation of the process. These were important questions but were out of the scope of the study which mainly focuses on the quality of health services and factors affecting it.

## Chapter (7) Results & Findings

This section will present the observations and interviews resulting from the four visited health care facilities, followed by a summary of the findings. The centers visited by sequence are El Noha General Medical Center, El Herafeyeen Health Center (El Salam District), Ezbet El Hagana Health Center (Nasr City district) and El Delta Medical Center (El Salam district. Two of the visited facilities are accredited for following national standards of health care provision and two are not accredited.

### 1 El Nozha General Medical Center- (*Accredited*):



## General information about the center

The overall number of workforce is eighty five staff; fourteen general practitioners, fourteen pharmacists, twenty three nurses, five specialists, five administrative staff and one logistics. It is worth mentioning that all staff are fixed term, none of them are on contract and they are all recruited from the Cairo directorate of health

The center was accredited by the Egyptian Ministry of Health and Population in 2005 and the accreditation was renewed in 2009 which is expired by now; however they have ten internal quality assurance/efficiency committees to monitor performances on monthly basis. The ten committees are divided as follows:

- Infection control committee,
- Training committee,
- Referral committee,
- Health education committee,
- Medicine committee,
- Complaints and suggestions committee,
- Maintenance committee,
- Health of workers committee, and
- Records committee

The Nozha Medical center is one of four other centers in the Nozha district, three out of which are accredited and one new recently open in the process of getting accreditation. The plan was to visit another center in the same area, but I was told by the representative of the

Nozha Health Department, who accompanied me in the visits that all centers in this district are the same in terms of quality assurance, So it was more useful to visit other centers in other districts to be able to provide diversity of data and conduct analysis. When the district representative, who is also responsible for monthly monitoring of the performance of the three Nozha centers, was asked about the main issues that needed to be addressed in the facility, she said “accessibility”, since the center is located at the end of a highway, people and workers find difficulties in transportation.

The Nozha center works two shifts, one from 8:30 am till 12:00 pm where patients pay one pound for the visit and medicine, and the afternoon shift from 12:00-7:00 pm where patients pay three pounds for the visit and they have to pay for the medicine separately. Although there is an afternoon shift, but most of the cases prefer morning time as it is obviously cheaper.

### **The Facility**

The General Medical Center at Nozha is a three-floor building with a large number of rooms; it provides all primary health care services including; maternal and child health, health office, health education, dental services and it also has a laboratory and radiology scanning. There is a spacious reception with enough waiting seats. The examination rooms’ size is convenient, but overcrowded in cases of dental clinics and the pharmacy due to the large number of staff



## **I. Interviews with Health Workers**

Eight interviews were conducted with health workers working at the General Medical Center of El Nozha. Five of the interviewed were married females, in the age group of 30-50 years old, including two pharmacists, one clinical pathologist, one general practitioner and one family health specialist who is also the coordinator of the efficiency committees. The other three were males, two dentists and a receptionist. The average salary for all health workers was EGP 700 - 1,000.

### **Human Resources issues**

#### **i. Number of Staff and their roles**

All the eight interviewee agreed that there is no shortage of staff, the number of staff is sufficient compared to the numbers of daily patients and covers all specialties needed, and in some cases overstaffed. However, the two pharmacists complained that they are assigned tasks that are not related to their specialization and were not part of their job descriptions. They believe that their role is to advise patients on how to use the prescribed medicine by the medical doctors and to monitor the in and out of the medicines, but in reality they do all other processes that should be conducted by clerks and nurses; like recording the number of patients' tickets, the quality of medicine provided to each patient, and preparing sheets of all the medicines sold on daily and monthly bases. Although there have been recently a decision from the Minister of Health that pharmacists should not be recording medicines, however, it is never implemented

ii. **Staff Motivation and impediments to higher quality performance**

One out of the eight interviewed health workers mentioned that she is motivated and the other seven are less motivated. The motivated staff is mainly because she felt it was her religious duty to help the needy. One out of the four less motivated showed no interest in work, she stated that work was not her priority but rather her family, and that this work suited her family life due to the good flexible working hours. Two of the less motivated staff were unsatisfied by the lack of career development and unjust salary scale (the incremental differences of the salary scale based on the years of experience), e.g. the salary of someone with fifteen years of experience will differ slightly from someone with only five years experience. Finally the last unmotivated staff felt that the lack of equipment is preventing her from doing her job. She needs a device (blood cell counter) that is used to do CBC test and that would save time and effort and increase the accuracy of diagnosis, instead of using the old manual way. According to her, the manual count takes about 30-45 minutes per person, while on the other hand the counter does the whole process automatic resulting in serving about one hundred patients in the same 30-45 minutes. Although she has requested purchase of this device, the management refused to buy it as it cannot be covered by the available budget. Consequently, she refers patients to other clinics/hospitals to do the CBC test as she does not have this facility, hence providing incomplete service.

The two dentists complained that some devices were broke for a couple of months, and a request for maintenance was submitted. Different companies submitted their offers, and the management did not decide on the maintenance company yet. Another complaint was about the size of the room, the dental room included two patients' chairs and two desks with four

chairs for doctors, this room contains about twenty doctors, so they end up sitting on the desks and crowding the room which is unhealthy for them and the patients, besides it gets too noisy which distracts the operating dentist and makes patients uncomfortable.

Another impediment is the unavailability of medicine. In many cases the medicines on the Essential Drug List are unavailable, which weakens the quality of service provided. Due to the increasing cost of medicines, the patients are now entitled to only two medicines instead of three or four like in the past years, which also annoy patients and add more economic burden on them. Some antibiotics are prescribed only for three days, after which the patient has to come back to the clinic if he/she did not improve to prescribe another medicine with another ticket (one pound)

A common source of disappointment of staff is their salaries although with relative degrees. Some felt that they have exerted a lot of efforts throughout their career that was met with very little reward. They felt sorry for themselves being stuck in governmental job all their lives, while their counterparts who shifted to private sector are well off. The main reasons for some employees to continue in the public sector are the accommodating working hours, less load of work and the pension fund received after retirement which is a percentage of the monthly earnings over the number of years of service.

An interesting discussion took place during the interview between one of the health workers and the Nozha Health department representative regarding buying a new device that is expensive but will save a lot of time and effort and produce better results. The health department representative believed that it is not a cost-effective approach to buy such an expensive device, when she knew that patients will not afford to pay for using it even if the fees

will be half the price of using it in any other hospital, besides the capacity of staff needed to operate the device. She believes that it is more appropriate to do tests manually. However, on the other hand the health worker confirmed that the device will be well utilized as she refers many patients on daily basis to other clinics do these tests (CBC), and confirms that within one year they will get return-on-investment. Such an interesting debate showed clearly the perspectives of both parties, and emphasized that the upper management is not open to suggestions from health implementers, that is why health workers might feel alienated because their voices are not heard, although they are in the best position to advice on issues for quality improvement.

The budget of the Ministry of Health is stagnant; it is the same every year, for the past five years health expenditure constituted 4.7-5% of the total Egyptian government expenditure (Ministry of Finance, budget breakdown report 2011), while on the other hand the cost of equipment, utilities, maintenance and the cost of living are increasing. The primary health care clinics' revenue is very little, and their budget allocated from MOHP is also little, while the expenses of their operation are increasing every year. The MOHP should increase its budget to accommodate such expenses.

### iii. Trainings

When the medical district representative was asked about the trainings provided to health workers she confirmed that there are regular trainings for all staff every two-to-three months. However when health workers were interviewed one staff who has been there for 5 years did not receive any training, another one who was recruited for twelve years attended only one training a year ago, another worker attended a training two years ago and another

one five years ago, and finally an eighteen years recruited staff attended one training in the past three years.

All participants confirmed that the trainings were very useful as they refresh their information and keep them updated with the latest technologies. This is beside the fact that going to the training may be one of the job's incentives scheme. However, some thought that trainings were good for self fulfillment only since they will not be able to apply these high-tech in their poorly equipped clinics. For example, many basic tests are not conducted in the facility but rather referred to other clinics due to lack of the testing device; the clinic conducts only hemoglobin tests as they do not need high-tech devices, but not the CBC test commonly requested but cannot be conducted in the facility.

Although health workers do not get many chances to attend external trainings, the representative of the Health department confirmed that there are monthly on-job trainings contacted by heads of units and supervisors to ensure efficiency and effectiveness of service provision. Based on a meeting conducted with the head of the training committee at the center, she indicated that not all the trainings on the training list are conducted, only two or three technical topics which are attended by three to four specialist for fifteen minutes. The training room was unequipped, no computer, or overhead projector; it consisted of a medium size table with six chairs around it and a white board, that is not even hanged on the wall. Obviously, a training room existed to fulfill the accreditation requirements rather than to be actually be used for training.

To sum up this section, it was noted that the main impediments to improving the quality of health service provided at the clinic were lack of equipment, dysfunctional devices

and the poor distribution of staff in various specializations. The main motivating factor for health workers is their social responsibility to serve the needy or to keep a secured job with a pension, and main de-motivating factors are the low pay and lack of incentives. Much of these factors were related to central government roles such as budget allocation, which creates a disabling environment for the health workers to provide quality health service.

### Patients Rights

All interviewees strongly believe that “the psychology of the patient is as important as the medical treatment and sometimes more important”. They also all confirmed that the most important factor affecting the satisfaction of patients is the doctors’ attitudes. They all confirmed that they give sufficient time to listen to the patients’ problems, and sometimes allow them to talk about their private lives and try to comfort them. They said that patients come and ask by name about certain doctors whom they feel comfortable with. Some medical doctors even give their private mobile numbers to some patients who have chronic cases so they can contact them in emergencies.

Regarding patients’ folders and history, all interviewed health workers confirmed that all patients have history folders that are updated by the treating doctor every time they visit the clinic. They have also developed “family folders” for patients who live in the catchment area, which gives them privileges like annual full check-up for free and free sonar for pregnant women. There is also a social worker who studies the financial situation of patients and based on their status recommends free of charge visits and treatment.

The infection control committee at the Nozha center is responsible to monitor patients’ safety including clinic safety and environmental safety and report on them on monthly basis.

Dentists confirmed using masks and gloves all the time, a new bag of equipment is opened for each patient, at the end of the day all the utilities and satirized and re-packed.

Regarding the complaints system, there is a box for complaints placed in the reception which is collected by the complaints committee, studied and submitted to the efficiency committee and accordingly actions are taken. There is also a survey conducted every three month on the satisfaction of patients with the service provided (*Annex 3*). There are also efficiency inspectors that visit the clinic from the Directorate of Health and the Ministry of Health every 2-3 months. When asked about the nature of complaints and the amount, the head of the center indicated that complaints are very rare and usually are due to patients wanting to break some rules and get disappointed when confronted by the health workers; e.g. some patients are in hurry and do not want to wait for their turn, or have an expired ID but still insists to issue marriage clearance certificate, which requires a valid ID.

The above shows that the accredited facilities care about patients' satisfaction of the service provided, they have monitoring and evaluation committees in different quality areas to ensure attainment of best quality of services.

## **II. Interviews with Patients**

Four interviews were conducted with available patients in the Nozha General Medical Center; three females and one male. One forty two years' old female, one fifty years' old male, one twenty six years' old female and finally one sixteen years' old female, who was surprisingly coming for vaccinating her newly born baby. None of them were highly educated; they all had not gone to colleges, only secondary school education. Two females knew about the center two months ago only through neighbors recommendations. The sixteen years' old was following

her pregnancy with the center so dealt with them for about a year, and the male dealt with the center for four years.

#### Accessibility and cleanliness of the facility

The four interviewees were satisfied with the service, they believed the center was clean, cheap and health workers were efficient and pleasant. They confirmed that the waiting time is not more than 10-15 minutes and waiting area is convenient with fans and enough seats, except the area of vaccination, which does not have enough waiting seats and gets very crowded during certain times. When asked if they knew how and where to make a complaint, they all answered “we go to the head of the center”. When I asked them if they have seen the “complaints box” in the reception area, they were indifferent because they did not feel the need to use it.

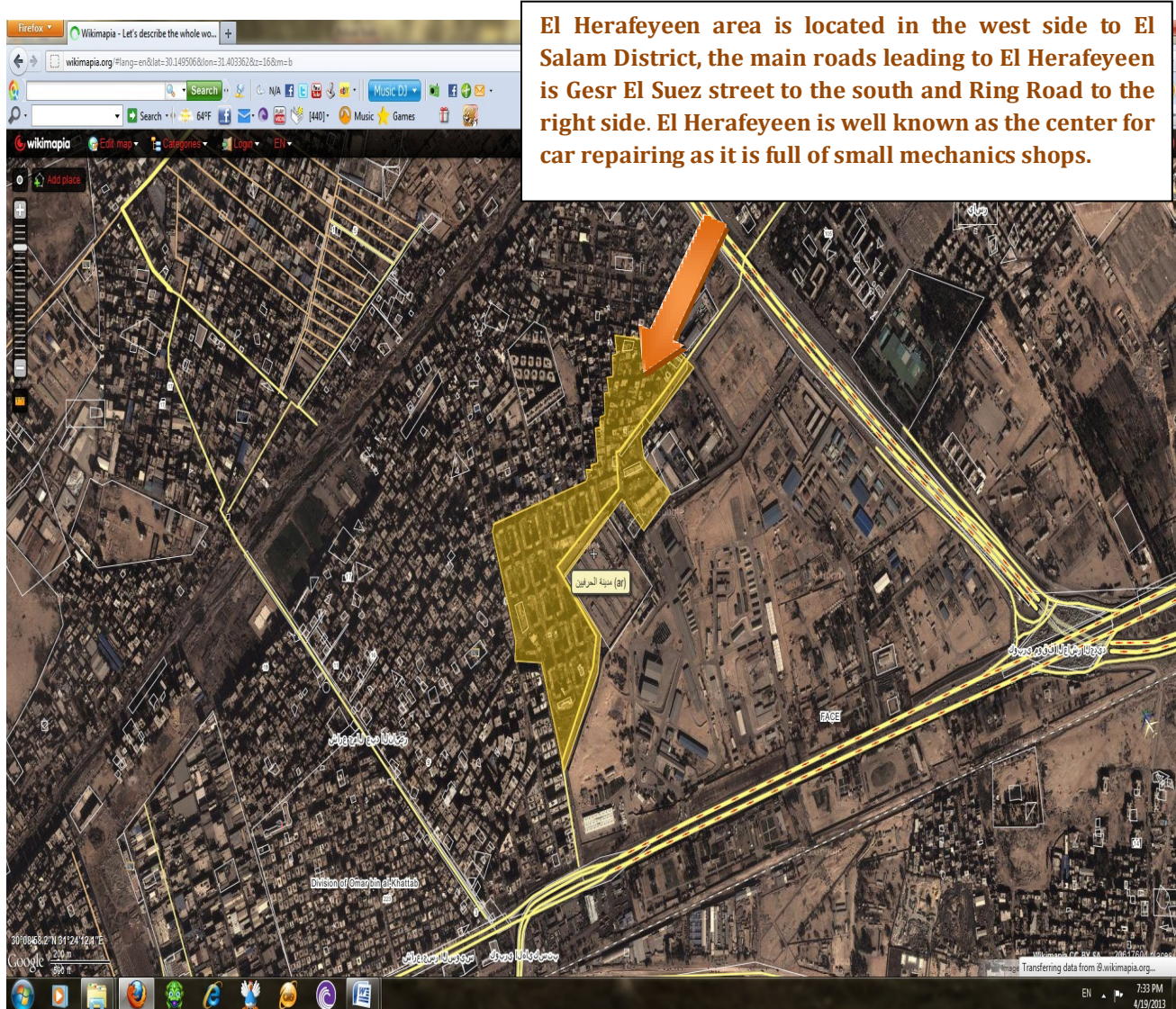
#### Reason for choosing this facility

All interviewees have visited other facilities that are close to their houses, but it is more convenient to come to the center because of the kind and sensitive treatment of the health workers. The male interviewee said that he has access to a free service hospital where he has his health insurance and which has the authority of giving him sick leave if needed, but he would rather come to the center and pay the one pound ticket and sacrifice the sick leave for the better treatment of doctors. He said that at the hospital they treat them in an inhumane way which is humiliating and insensitive. All four participants agreed that the most important aspect in any health facility is the doctor’s attitude.



It was concluded from the patients' interviews that they were all satisfied with the quality of service provided; the most important factors that encourage them to visit this specific facility is the good professional treatment of the health workers, and the convenience of the facility in terms of waiting areas, availability of doctors and other administrative workers, and the easy access due to low ticket cost and proximity to their homes.

## 2 El Herafeyeen Health Center- (Non-Accredited):



## General Information about the center

The center is located in the area of El Salam, which is an informal area in Cairo, where there is no planning for buildings or the roads. There are seven primary health care centers in El Salam area, four out of which are accredited and three unaccredited which include this center. The center consists of thirty one staff; fifteen nurses, ten doctors, and six administrative staff. All ten doctors are not “specialists” they rather general practitioners.

## The Facility

The center is in the ground floor, very small rooms, with two poorly constructed rooms (made of metal sheets); for pediatrics and abdominal diseases, due to the shortage of space. The portable rooms are still very small and not well equipped, no water and no sinks of any of the rooms, as there are no sewage pipes reaching this area of the building. There are two very unclean bathrooms one for the patients and one for the staff, with no toilet paper and most of the time no water. The waiting area is in open air with very little number of chairs, patients are sitting on the floor and on the fences. Waiting area is unpleasant in cases of very hot or very cold days or sandy weather. It is worth mentioning that there is an empty land just next to the center same size that is not utilized, a request has been sent to get approval for building on the land long time ago, but no reply was received. Accordingly the area is used for parking or left useless.

The used utilities are placed in a plastic sink with water and soap until they are sterilized in the sterilizer and repacked for usage. The x-ray room is very dusty a ceiling fan is placed in the middle of the room and an electric wire is moving throughout the room, which is

very dangerous, they said that this is how the maintenance guys placed it after there was an electric mass. The room looked underutilized, although they claimed that they use it mostly for x-rays on teeth, the x-ray device is not for dental use, it is for chest x-rays.

In the dental room there are two chairs with the dental devices, one is working and the other is broke. So all seven dentists work by turn on one chair, which slows down the process, they end up referring cases that need casts to some other place and they only conduct “cleaning”, “filling” and “removing” teeth processes which are faster.

#### **I. Interviews with Health Workers**

Interviews were conducted with five female health workers; a pharmacist, a nurse, two dentists and one administrative staff who is also responsible for providing patients with health awareness raising sessions. The average salary is EGP 500-1,000

#### **Human Resources issues**

##### **i. Number of Staff and their roles**

The center is overstaffed with doctors and pharmacists but have shortage in cleaners and nurses. The head of the center complained that she requested recruitment of cleaners several times but no action was taken.

##### **ii. Staff Motivation and impediments to higher quality performance**

The five interviewed staff are motivated by the sense of serving the needy and that they are making use of the long years of education. Some staff were supported by their husband's income others were the main bread winner in the family, who try selling some simple items

like cosmetics as another source of income to support their families. Another source of motivation for them was the friendly working environment, most of the workers are on good terms and the head is a pleasant understanding manager.

The main impediments are lack of equipment and devices. The small space also is another factor affecting the performance of work. Also the pharmacists added that the Ministry's List of Essential drugs include the least effective medicines and antibiotics due to their low cost. Accordingly some high blood pressure patients or diabetics find the medicine's ineffective, which results in coming back over and over to follow up on their case which does not improve. Or in other cases the doctors prescribe other medicines from other pharmacists which are more effective but more expensive too. There are also sometimes conflicts between doctors and pharmacists; some fresh graduate doctors who lack the experience which prescribe insufficient dose or concentration, so the pharmacists would intervene to revise the dose which is sometimes unaccepted by the doctors.

Another problem that is faced in the center is that there is no standard means for medicine transportation from the store to the center. The pharmacists take public transportation on their own expenses to transfer medicine 3-4 times monthly. If they are transferring vaccines, they use some iceboxes that they carry themselves going back and forth to the center. When they requested official means of transportation for this purpose the answer they got was there is no budget line for this expenditure.

### iii. Trainings

There are no regular training sessions for health workers in El Salam center. Most of the staff never attended any trainings, some nurses have attending trainings on family planning,

and family health three years ago. Those who attended trainings said they were very useful but still cannot apply it in their work place due to lack of equipment and sometimes unrelated topics like “health of the elderly” which does not exist in the center. One of the pharmacists attended training on how to organize the records, although this is officially not in their terms of reference.

### Patients Rights

All interviewed health workers highly supported that the psychology of patient is more important than the physical treatment. They could see that there are more patients coming to the shift of a welcoming doctor who takes the time to explain to the patients and treats them with kindness and sensibility. Some doctors explained that it is in their own privilege to take the time to explain to the patient so that they do not come later with infection or complication due to misunderstanding.

Health workers are faced with some difficulties with patients; i.e. some patients with inflated gums insist on removing the tooth, while they have to get some treatment for couple of days then remove the tooth. Others refuse to make a stitch while their case requires stitching. These patients would usually complain that the doctors are not cooperative or do not want to operate on them, the health workers get out of their ways to try to explain that what they are doing is for the patient’s own good. This goes back to two main reasons; the ignorance of some patients and their belief that they will not receive good treatment with low cost.

Some awareness raising sessions are also conducted in the center about the different means of family planning, the instructor would speak individually to each patient, but she said that she is only able to affect 7% and to make them change their minds on the means they

insist to use. It was also noted that she is not fully aware of all relevant health information, when I asked her about Female Genital Mutilation (FGM) she did not say that it was illegal or that there was a religious misconception about it.

To sum up the interviews with health workers, it was noted that the main impediments to provision of better quality of service is also lack of equipment, lack of means of transportation of medicine from the store to the clinic, added to it the difficult patients with little education who would insist on getting certain treatment that does not serve their case and the consequent fights and complaints.

## **II. Interviews with Patients**

Four interviews were conducted with four females visiting the center, three of which were visiting for the second or third time and one was a permanent visitor. They were all married with two or three kids. Two were working in an informal business; i.e selling kids and women's clothes at houses. While the other two were not working; their husbands were a porter and a mechanic.

### **Reasons for choosing this facility**

One of the interviewees indicated that she visits the center when there are simple issues with the kids' health, but if she felt there was a major issue she would rather go to more advanced hospitals which would be more expensive by default. She also added that she would not trust the results of the test in this center due to the low cost; she would rather go to a specialized laboratory. Another said that she came to this center because they provide her with free powder milk for her newly born that cannot be provided in other primary health

care centers close to her house. Others would double check with external pharmacists if the medicine provided was appropriate for the case.

### Accessibility and cleanliness

The cleanliness of the facilities was a relative issue some saw it clean and others thought it was not very clean especially the bathroom. According, to some workers' opinion cleanliness is not a priority for most of the people who visit the center; they care more about the low prices and free medicine. These opinions are indicative of the cleanness standard of the residents of this informal area compared to those in the other formal area.

### Doctors' attitudes and efficiency

As for the doctors attitudes; participants agreed that there are very nice and friendly doctors and some unpleasant doctors, who would not listen to them and would be in a hurry to diagnose and write down the subscription without saying a word to the patient. Patients knew the shifts of each doctor and would visit only during the shift of the pleasant doctor. It is also worth mentioning that the pediatrician whom they liked was a female while the unpleasant one was a male. This is also part of the Egyptian culture that women would feel more comfortable talking with another woman rather than a man.

### Complaints

Most patients would complain that the medicines are only available in the first half of the month. They have a sense of mistrust in the doctors, so the doctor might ask them to buy medicine from outside because it is finished in the center, but the patient might see the medicine with another patient. Another incident that adds to the mistrust of the patient is that

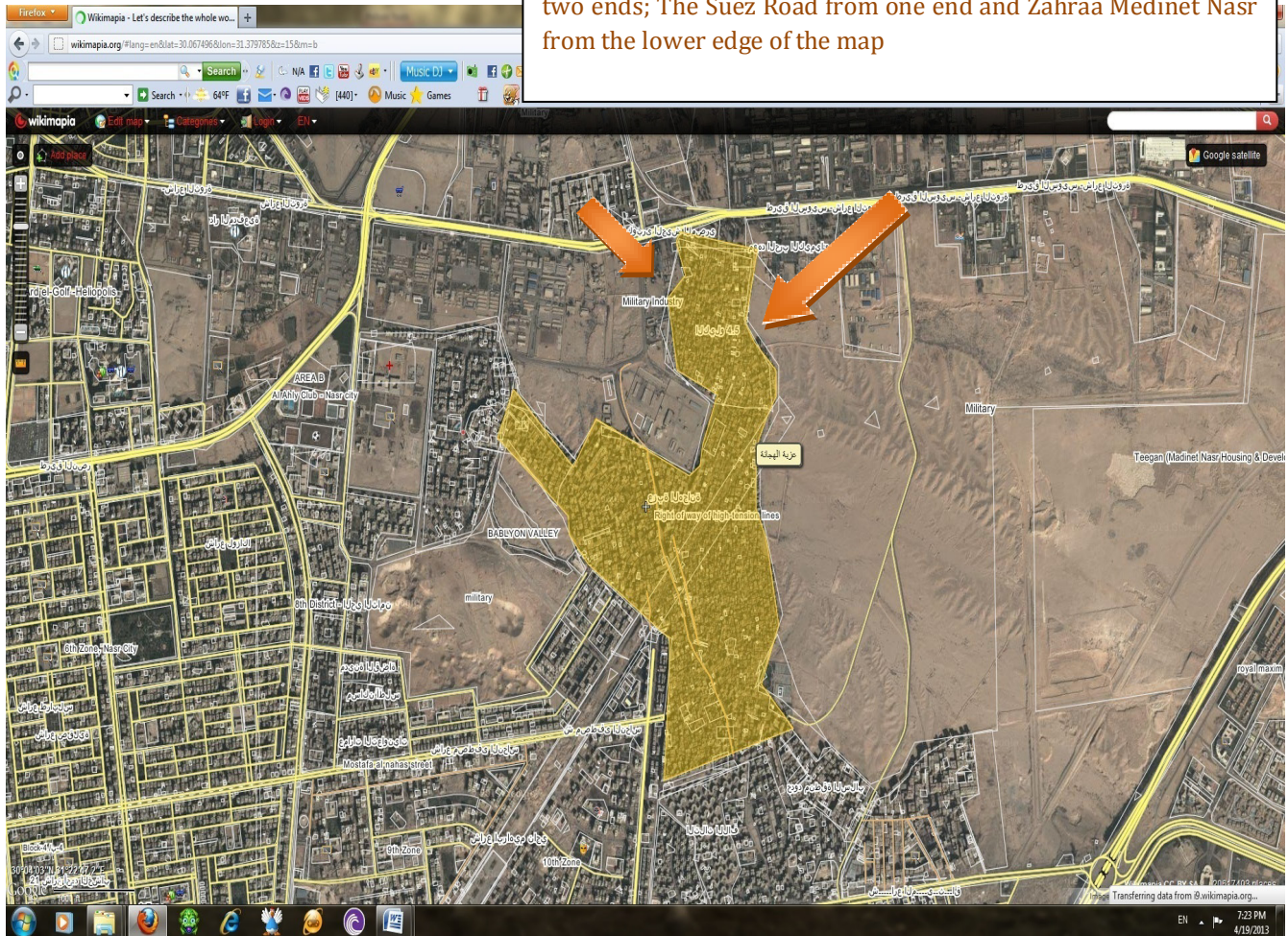
once she told the dentist that she has pain in her tooth and without even looking at her, he asked her for an X-ray, so she felt the carelessness in his attitude and decided to seek other centers.

There is a noted decrease in the degree of patients' satisfaction in non-accredited facilities to the accredited ones. Patients in El Herafeyeen clinic were doubtful about the quality of service, they would question the diagnosis and the treatment, and they would double check with external pharmacists on the effects and side effects of the prescribed medicine. The health workers attitudes give them the impression that they do not care about their well being, and that they will do only the minimum effort to diagnose and treat them. Also the unclean poorly equipped x-ray room and laboratory have results in a sense of mistrust of the results.



### 3. Ezbet El Haggana Medical Center- (*Non-Accredited*):

Ezbet El Haggana is a semi formal area that can be accessed from two ends; The Suez Road from one end and Zahraa Medinet Nasr from the lower edge of the map



#### General Information about the center location

Ezebet El Hagana Medical center is a non-accredited center. It is located in semi formal area; Ezbet Elhagana which is inhabited by a mixture of rural migrants from Upper Egypt and from the Delta region. Although water and electricity services recently exist in El Hagana, but the water and sanitation services remain lacking in terms of quality and coverage, also the roads are unpaved.

## Ezbet El Haggana



### The Facility

The Haggana center is two floors building that have underutilized space. The center is so unclean and unorganized; it gives the impression of a market place, many crowds, people shouting, lots of fights, no turn, and no waiting area with enough seats. There are two rooms for dental care, two for pediatrics, two gynecologists and family planning, and a delivery room that is never utilized. On the other hand there are six bathrooms, an educational kitchen, two stores, a meeting room, extra room with a bed for doctors' sleep over; all these rooms can be better utilized to serve the huge number of patients that come daily to the clinic. There is no record of the number of health workers, administrative staff and nurses.

The pediatric room consists of three desks and a bed. The three doctors diagnose the kids on the desks due to lack of space, the bed is only used very limitedly. The delivery room is unclean, under equipped; all utilities are sterilized in a central room made for that purpose. The head of the center office is over equipped with a plasma screen television, a computer and printer that are not used as they are put aside not on the desk. The folders' closet is filled with tea, coffee, sugar and empty cups. The assistant of the manager is so indifferent; she is on her private phone and not answering any queries. She mistreats patients and sometimes would even shout at them if they ask a couple of questions. There was a room with five broken fridges that needed maintenance for six months.

## I. Interviews with Health Workers

### Human Resources issues

#### i. Number of Staff and their roles

All health workers working in the clinic are general practitioners; three work in the pediatrics clinic, two in family planning and about seventeen pharmacists. All doctors interviewed complained that they are short of human capital compared to the flow of patients they receive daily. The doctor does everything starting from organizing the waiting lines, recording the data for patients, and diagnosing; there are no nurses to assist in organizing patients or recording data. The three pediatricians receive an average number of 120-150 patients daily; in addition to the shortage of nurses and support staff, which results on overloaded stressed health workers. Two of the three pediatricians are fresh graduates who cannot find a chance to learn from the more experienced pediatric working in the desk next to

them, due to the high flow of patients; since the three of them work in the same time in one room with high flow of patients, one doctor cannot afford to working to learn from another, as there is along queue waiting for their turn. Same applies to other specialization

## ii. Training

None of the doctors interviewed have attended any trainings some have been there from 6-10 years; however the newly appointed pediatricians for newly born babies were planning to attend training for the first time next week on “child psychology” which though will add to their personal knowledge, will not be relevant to their work in this clinic at this stage, more relevant trainings can be attended. Due to the load of work young doctors do not get a chance to learn from the more experienced ones. One of the doctors stated that she goes to an evening private clinic with her husband to get more training and exposure which is missing in the Haggana clinic.

## iii. Staff Motivation and impediments to higher quality performance

Two out of the six health workers interviewed stated that they are moderately motivated, while the rest faced many problems that prevent them from doing their jobs and hence stated that they are not motivated. It is worth mentioning that the two more motivated staff had their private business in the evening; when asked about the reason they still come to the clinic in the morning, the answers were; their obligation to help the needy, the secured job with pension, the closeness of the facility to their residence.

The main impediments for provision of service are the lack of equipment, utilities, small crowded under ventilated rooms, aggressive attitude of some patients and shortage of

support staff. The doctors complain from lack of basic utilities; like tissue paper, needles, basic emergency medicines; cortisone and francolins. According to them they claimed that many equipments, devices and even chairs are bought then are stolen by the management, which reflects corruption at various levels of the organization. The OBG confirmed that she does not have the basic equipment or medicine to save the life of a pregnant woman if she got an complications, she does not even have an ambulance to take her to the nearest hospital to save her life. There is no thermometer at the pediatrics clinic, no device to measure the blood pressure at abdominal clinic; accordingly the clinic is unable to provide the basic services.

Health workers also complain from the aggressive attitude of the manger, who is so unprofessional and does not respect the doctors; she shouts at them in front of the patients and treats them with condescending attitude. She does not support them or provide them with basic needs to be able to conduct their work; i.e. no water cooler, no fans although she has an air conditioner and a fan in her office; they have to buy their own tissue papers. She delays most of their paper work for weeks for no obvious reason. When they were asked if they have complained officially, they said that she is supported from the staff in the district and if they complain officially she will treat them even more badly and nothing will change.

Some health workers stated that the head of the clinic gives wrong information to patients; i.e. she would refuse to provide their kids with vaccination if they were not registered in the same district, which is against the rules; vaccination should be provided to all regardless of district they are registered in. Many patients do not know their rights, and even the doctors sometimes get confused.

Another important issue is the security of health workers, due to the nature of the neighborhood, many inhabitants are drug dealers or X-prisoners, so they might threaten the lives of doctors if they do not issue certain official documents, or prescribe certain medicines to them, and nobody protects the doctors. Even the head of the clinic does not do anything about it. Some patients visit the clinic while they are on drugs, which threaten the doctors and endanger their lives, as there are no rules to prevent them from entering the clinic.

Finally, the staff do not trust management with their entitlements; i.e. a percentage of the clinic income should be used for some maintenance and the rest should go to doctors as incentives. The health workers monitor the daily flow and know that they should get about EGP 200-300 monthly, while the amount they get is only EGP 2 monthly, which causes more frustration among workers.

### Patients Rights

Due to the un-organization of any process in the clinic, the doctors are facing a lot of difficulties with the patients' attitudes; many patients would rush into the rooms while the doctors are busy with other patients, they would shout and fight for their turns. Some doctors claim that they take the time to explain to patients what is wrong with them but many patients would lose interest, as they are only interested in getting the free medicine. Other doctors lost hope from explaining; e.g. one of doctors told a lady that her kid had chest allergy and should not be exposed to any smoke, but the response she got from the patient was shocking and depressing; the patient told her that she is living with her in laws in one room, and they do not stop smoking drugs all night.

Some health workers have bad attitude with patients due to the stressful environment they work in, and because they feel that they exert a lot of effort with no reward, so they have a feeling of indifference and might treat patients badly; this is due to the unfair unorganized health system in general “repulsive health sector” as stated by one of the doctors. There is also an issue of “mistrust” between both patients and doctors; patients feel that doctors don’t prescribe good medicine or give wrong diagnosis because of the low cost of the service; while on the other hand the doctors believe that some patients just come for the free medicine, pretending that they are ill just to get the medicine.

To sum up this section, the main impediments for improvement of quality of health service are same as all previous clinics dysfunctional devices and lack of equipment, added to it is the mismanagement and bad treatment of the head of the clinic to health workers. Since this facility is unaccredited, there is no monitoring on the performance and attendance of doctors or on the safety measures or the degree of patients’ satisfaction; hence one gets the feeling of chaos which creates a fertile environment for all types of corruption; theft, discrimination, low productivity without accountability, no reward and punishment systems, which will all result in very low quality of health services.

## **II. Interviews with Patients**

Four patients were interviewed; three planned and one unplanned; as the patient was screaming and complaining while I was there. Three patients were unsatisfied with the service and one was partially satisfied. All interviewees were females middle age 30-40 years' old.

### Accessibility and cleanliness of the facility

All patients buy one pound ticket then head for the specialized clinic; where there are not enough seats or any worker responsible to organize the entrance process. There are no numbers or queues, just a crowd where everyone has to fight for their turn. Sometimes patients are calm and organize among themselves but sometimes they lose control due to the long waiting hours, standing, in the hot weather, with no fans or windows and a whole crowd of people and kids, so they start rushing into the rooms and disturbing the doctor and the current patient in turn.

The facility is so unclean, there is dust everywhere, the toilets are extremely dirty, and kids are diagnosed on a desk, not on the bed with the bed sheets, however all patients agreed that the clinic was clean; this highlights that cleanliness of the facility is not a priority to the recurrent visitors and it also sheds light on their background and perception of cleanliness and quality of service as a whole. It is important to highlight that Ezebet el Haggana is a semi-formal area; many of the inhabitants live in poorly constructed buildings, sometimes with no access to clean water, so their judgment on the cleanliness of the facility is very relevant to their living conditions.

### Reasons for choosing this facility

The three interviewed mothers do not trust this facility, but still would go due to the low cost and free medicine. They visited other private clinics for OBG and pediatrics who would provide better service by listening carefully to them, giving them brochures on nutrition, and how to take care of newly born, have a pleasant waiting area. Patients get the



impression that the doctors are not efficient in this facility because they do not give them enough time, they are always in a hurry, they diagnose and prescribe in a very short time due to the load of patients, which gives the patients impression that they do not care about them and that they provide poor service due to the low cost. When comparing the private pediatric clinic to the one in the facility; the patient stated that doctors only listen to the kids chest and subscribe right away, while in the private clinic, they weigh the kid, check his/her temperature, check the ears, treat them with more care.

There is a misconception in the lower social classes that antibiotics cure everything, so if the patient visits the doctor and did not prescribe antibiotic, she/he would feel that the doctor is not efficient. They complain that the medicines are weak, and kids take time to recover but in private clinics they prescribe strong medicines that cure kids immediately, which is medically wrong approach as this would affect on the kids' immunity systems. This goes back to the point mentioned earlier that the drug list in all primary health care facilities include low cost drugs that are not very effective, and does not introduce new medicines or antibiotics. Patients mistrust doctors to the extent of accusing them that they do not prescribe any medicine for them in order for the doctor to use the patient's ticket and get a free medicine for himself.

### Doctors' attitudes and efficiency

Patients also complain from the aggressive attitude of the doctors, doctors do not treat them as clients but rather as if they are doing them a favor. So they would refuse to check the patient after 12:30 as they have to leave at 01:00pm, they would scream in their faces and ask them to come the next day early. If any of the patients ask for their rights to be treated in a

better way and properly served, the doctors would get offended and refuse the case all together. Doctors would discriminate against those who dared to complaint for their rights. In some cases patients would come as early as 11:00 am and would not find any doctors in the clinic, so they would go and ask the head where all the doctors are, then after short time the doctor shows up in a very bad and aggressive mood cause he/she feels that the patient complained about them. Another issue also is with the pharmacists, one of the patients claims that they come with their kids to baby sit them and even get some vegetables to prepare for their lunch at home, and would ignore the long queue of patients waiting at the window; patients would call them but they would not respond although they could hear them from outside talking and laughing.

### Complaints

Patients are totally unaware of the rights in this clinic, they are treated badly and they waste a lot of time just to know the procedure or find anyone to guide them. Typical bureaucracy, a very old lady about 80 years old wanted to get some paper stamped, she stayed over two hours between two rooms each worker directs her to someone else, then she stood lost in the corridor, tired, confused unable to finish a very simple business “stamping”. Also people scream and fight a lot and no one interferes to stop the fights.

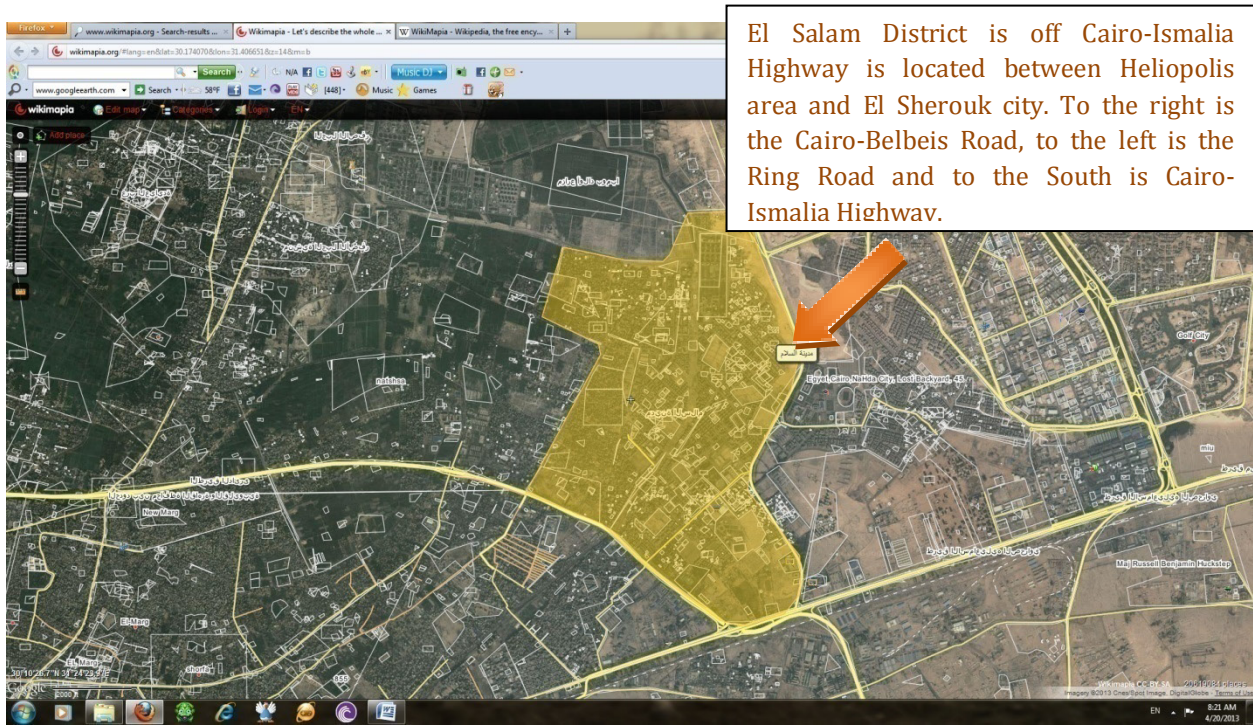
Some patients’ suggestion for improving the quality of health service in the facility was to expand the range of operation they are doing, due to lack of basic equipment the center only operates on very limited case, so patients do not feel that their needs are met.

Although Ezebet El Haggana center was the third to visit, it offered another dimension to the whole public health sector; in all other centers there was shortage of equipment and

some frustrations due to low income, but there was no obvious corruption and indifferent attitude like this center. It is not in the Egyptian culture to complain, especially in lower income societies, most people do not know their rights and feel thankful with the little service they are getting, but it was shocking the amount of patients' anger and workers' aggressiveness in this center. Doctor's role is always comforting the patient both physically and psychologically, this cannot be maintained if the facility is poorly managed; if it is corrupt. Hardship conditions were in many other facilities as discussed earlier, but because they were properly managed, both patients and health workers were more satisfied. But the oppression exercised in this facility led to disastrous results. People saw the corruption but cannot do anything about it. In addition to the openness of corrupt people, they totally did not care what others would say, as if this was their own private business and they have the right to do what they please without interference from anyone.

There is a high degree of dissatisfaction from the service provided in the clinic, patients complain that in many cases doctors are not present, and when they are present, they are socializing with the manager and not doing their jobs, and when they are doing their jobs, they are very aggressive and humiliating for the patients. Many patients feel they are poorly served and want to complain but there is no one to complain to as the head of the clinic is corrupt and will not do anything about the complaint. There is a crucial need for inspection from the health governorate to this clinic, to put things in place, and make the manager and health workers more responsible and accountable for their work, and make the patients feel that they can express their disappointments and that there is hope for improvement. This also calls for the need for accrediting the non-accredited clinics to improve the health service.

## 4. El Delta General Medical Center, El Salam- (Accredited):



### General Information about the center

El Delta General Medical center is located in El Salam district, it is a one floor building with a good number of rooms, it is spacious and has a big backyard garden. The workforce of the center consists of twenty five dentists, eleven pharmacists, twelve general practitioners, twenty nine nursed, nine admin staff, three cleaners and one driver. The center was accredited by the Egyptian Ministry of Health and Population in 2009. As mentioned earlier in the literature section that accreditation is only valid for two years period after which it needs to be renewed. But due to the political instability in Egypt due to the 2011 Revolution, no renewal of accreditation was conducted in any of the health facilities after 2010.

## The facility

Though the facility is huge, 50% of the building is underutilized due to the absence of electricity. A year ago the main electricity cable feeding this part of the building was cut, and since then it was never fixed. The management tried temporary solutions like make simple connection from the working part of the building to the other part just to light small lamps, use fans when it is too hot, but they had to move the sonar room the other side of the building which has electricity. The electricity cut also affected the central sterilization room which is no longer used; most of equipments are sterilized in the dentists' sterilizer.

The dental room is spacious with two working chairs, one desk and few chairs for twenty five doctors, there is a good waiting area with a fan and good ventilation (big window), they have one lab with some old and some broke equipments, one spacious pediatric room, two family health planning rooms, a delivery room, newly born room, a pharmacy, an emergency room, vaccination room, official certification room, a room for weighing babies before vaccination, and two sleep over rooms for doctors and nurses.

It was noted that there are signs hanging in different parts of the building indicating the different services provide, with their prices, a list of patients' responsibilities and a list of patients' rights; including privacy, confidentiality, respect, quality service, complaints and suggestions. There are guiding signs on the wall to different clinics.

The overall impression of the building is that it is relatively clean and properly ventilated. However, the coat of the head of the clinic was so unclean. She took me on a tour to explain the different rooms and services provided but did not say a word, the accompanying

nurse did all the talking, even when any questions were asked, the answers were received from the nurse, rather than the head of the clinic.

## **I. Interviews with Health workers**

Eight interviews were conducted with eight health workers; three dentists, two pharmacists, one pediatrician, one health planning specialist, and the head of the center; two males and six females.

### **Human Resources issues**

#### **i. Number of Staff and their roles**

There is shortage of human capital in certain areas like pediatricians, gynecologists, and cleaners, while on the other hand there is overstaffing in dental care and pharmacy. There is only one dental clinic with two chairs and twenty five doctors, which results in excess workforce, a big number of patients, but limited number of working units, and hence limited number of patients per day. According, dentists have divided work as follows; a maximum number of patients of twenty from 09:00-12:00, most of the morning work would be diagnostic, while all operations would be conducting in the afternoon with specific appointments. This approach though organized can cause some problems with patients, as the twenty tickets might be all booked and finished at 09:30 which causes patients to be angry that they came early yet are unable to get a ticket.

The pharmacists are also overstaffed like the dentists which sometimes annoys them since some days they would not have any work to do because the loads of work is less than the

human capacity. Besides the efficiency incentives get to be divided on bigger number of staff, resulting in less individual amount.

However, there is clear shortage of pediatricians and gynecologists, only one in each specialization, who receives around 30-70 patients in three hours (morning shift). This results in an overloaded stressed doctor, who though believes in the psychology of the patients, but unable to treat them properly and give them ample time for diagnosis and queries.

## ii. Training

Although the center is accredited, which entails that there should be regular external and internal training for all staff, yet most of the doctors did not receive any trainings. Staff who have been there for two years or less haven't had any trainings, while some staff who have been in the center for over four years have received one training for couple of days at the Ministry of Health and Population. However, when I was there they received an announcement from the MOHP that there is a training opportunity for dentists but they were reluctant to go since they have to pay for the training with 25% discount from MOH. This training was organized by the dental department in the district in collaboration with the Cairo University, so the dentists working in the center felt that the university is only trying to raise funds and was disappointed that they would have to pay for it.

## iii. Staff Motivation and impediments to higher quality performance

There are two types of frustration in the facility; frustration from overload of work with no reward and frustration from lack of work hence waste of time and missed learning opportunities. Dentists suffer from the excess workforce, which results in some dentists

spending a whole day unable to practice, because there are only two units and twenty five dentists waiting for their turn to work. Also pharmacists feel that they are developing their skills since they are not doing much work, they do not get the needed exposure for their growth and development, even the list of drugs has been the same for ages, no addition to new medicines, or antibiotics, which makes them feel isolated from the pharmaceutical market.

Staff also complain from the lack of supplies and basic utilities; they sometimes do not have enough gloves, or bad quality masks. For dentists, in several occasions they would not find adrenaline, according they are prevented from conducting any dental operations. Pharmacists have requested the management to buy them a computer for more than two years, with no response. Computers would facilitate their work on recording in and out of all drugs, the amounts, the expiry dates. So the alternative is recording on hard copies, which is even problematic too, when they run out of recording copybooks, they have to replace them from their own money. Due to the limited number of utilities, sometimes the clinic has to stop working until the used utilities get sterilized in order to be reused, which takes about an hour.

Besides the limited number of utilities, most of the devices are very old, and in some cases the center gets used devices from public hospitals that need regular maintenance or replacement. If any device broke it takes them from 6 months to a year or more to fix it.. This is a result of the bureaucratic procedures that limit the decision making of the center to approval a small amount of money, which if exceeded has to get approvals from district, and sometimes from the Ministry of Health. This lengthy process results in having many broke unfixed devices which decrease from the capacity of the center to deliver the expected services. In many occasions the center would receive bids from different maintenance



companies, and when they decide on a provider, he would offer them new prices that differ from the ones he provided a year ago. So they have to start the whole process all over again.

Another problem facing the health working is the security issue. Any patient can start shouting and using bad words, sometimes even physical fights, and no one can stop them. They complained that some of their patients would come under drugs and want to be served on the spot without waiting for turn and it would be very hard to deal with them since they are under the effect of drugs. Also during the afternoon and evening shifts there is limited number of patients and doctors, some females doctors are sometimes scared that anyone can come and steal anything from the center and it would be her responsibility due to the absence of security guards.

Although there are several impediments to providing proper health services, the physicians are striving to serve patients with the little utility they have. Most of the centers income is based on charity; many people would either give the center money or buy the missing devices and utilities. Most male doctors have their own private business, young doctors would go to the center to learn more from more experienced doctors and to have the hands on experience, older generation would continue to go for the pension. As for the female doctors they feel that the working hours and working conditions suit their circumstances, as they need to spend more time with their families, besides, they want to feel that they are taking part in the community by using their education to serve the society.

### Patients Rights

Most of the doctors complain from the quality of patients that visit the center. Most of them are lower income citizens with little education that would not respect the doctors or the

system of the clinic. They would fight to cut the waiting lines, they do not want to wait for their turn, and they shout and insult the doctors.

Most of the patients visit the clinic with a predetermined diagnosis of their case, if the doctors advise otherwise; they do not trust the doctor's judgment. Especially in family planning clinic, some women would want to use the specific mean for family planning and would insist although it does not suit her, but because one of her friends or family is using it and is happy with it, she wants to use it as well.

In the dental clinic, sometimes patients would ask specifically for a male doctor as they do not trust female one, this is due to the perception of females in the Egyptian society as mentioned in the gender section, that females are less capable than males and cannot be trusted in some types of jobs. However, the head of the dental care would refuse to do so. He puts a system for the clinic by turn if some patients want to pick a certain doctor they should take an appointment. Otherwise the head of the clinic would decide whose turn to work, because he feels that it is humiliating for doctors to feel rejected or distrusted by patients only because of their gender.

To sum up health workers' interviews, the main impediments to improving the quality of health services are lack of equipment and supplies, poor distribution of staff; overstaff in some clinics and shortage in others, and the aggressive attitudes of some patients due to their poor education and poor social backgrounds.

## II. Interviews with Patients

Five interviews were conducted with five female patients; two in the dental clinic, one at the pediatricians and the two interviewees in the family planning clinic. All interviewees were females as no males existed in the clinic at the time of the visit.

### Accessibility and cleanliness

The facility is easily accessed; it has two big gardens; front and backyards. The center is clean and organized, except for bathroom which are not very clean; no toilet paper, or hand washing soap. Like other primary health care clinics, the ticket cost is one Egyptian pound from 09:00-12:00, then the ticket becomes for three Egyptian pounds from midday till 08:00 pm where the flow of patients dramatically decreases.

### Reasons for choosing this facility

Some patients have been to other facilities, yet they chose to come to this one; one of the participants indicated that she followed up during her pregnancy in the center, the monthly visits, the sonar, and all pregnancy tests, however she delivered in a health insurance hospital, although there is a delivery room in the center. She felt more secure in a hospital with blood bank, and all needed emergency tools during delivery. Another participant have been to a dental clinic related to a mosque, she paid EGP 150 for treatment she was getting for EGP 80 in the center, and she said that the mosque clinic though expensive was inefficient and resulted in complications.

### Doctors' attitudes and efficiency

All patients interviewed confirmed that the doctors treat them in a good respectful way. However, some patients have preference to a certain gender; females in most cases. Some patients feel that the female doctors are more kind, and take time to explain the problem and the treatment. They also feel more open taking to female doctors especially gynecologists and pediatricians. On the other hand, some patients prefer male dentists over female ones, as they feel they are more efficient.

### Complaints

All participants interviewed are satisfied with the quality of service, however they need a wider range of services; i.e. the dental services lack the service of putting braces or tooth crowns. Also some patients complain from the lack of medicines, by mid month most of medicines are unavailable. Besides the types of medicines were weak and ineffective, so in most cases they get to buy medicines from external pharmacies.

To sum up the patients' interviews there is a degree of satisfaction of the services provided in the clinic, patients appreciate the low cost, the comfortable waiting areas, and the respectful attitude of doctors. However, they are seeking a wider range of services in dental clinics and gynecology.

# Summary of Findings

## Evidence of low quality of public health services in low income districts

- Lack of equipment; most equipment are old, and are not working, some advanced devices are lacking due to their high price compared to the available budgets
- Poor distribution of staff, overstaffing in some areas of specialization working in small over crowded rooms, and lack of staff in some other specializations.
- Aggressive attitude of some patients with poor education and poor social background, and can be extended to physical fights in some cases. On the other hand some doctors are not dealing with patients in a welcoming or humane way.
- Same set of drugs on the Essential Drug List in all primary health care clinics for ages without revisiting or updating it with new more effective medicines and antibiotics.

## Motivating factors for health workers to continue working in public sector

- Short working hours from 09:00 am -02:00 pm
- Less load of work ; due to overstaff in some specializations
- Social responsibility; to use their long years of education to serve the society
- Religious motive; a sense of obligation to serve the poor/needy.
- Pension; getting a percentage of the monthly salary after retirement which is viewed as a reward for all the years of service in the public sector

## Main reasons for patients to go to public health clinics

- Low price; ticket cost is 1 LE from 09:00 am -12:00 pm which includes diagnosis and free medicine, after which the ticket cost is 3 L.E. for diagnosis only

- Free medicine, though not very effective and is sometimes not available
- Good treatment by health workers in some clinics
- Location; the closest to patients houses, to save transportation fees
- Easy access
- Convenience; comfortable waiting areas in some clinics
- Familiarity, many patients prefer to visit the same doctor they feel comfortable with, even if the overall service is not the best
- Poor Patients' education and social standards; which in turn lowers the expectations for the quality of services provided.
- Recommendations from neighbors or family
- Habit

Some of these factors are evidence of good quality service in public health centers, while some other factors are related to the background of patients and the options they can have in a low-income district.

## Chapter (8) Comparative Analysis of Accredited and Non-Accredited Health Centers

This section gets closer to the overall purpose of this research which has focused on assessing the quality of primary health care services in accredited and non-accredited facilities in Cairo. The study assumed different factors that can directly or indirectly affect the quality of services and their impact on the satisfaction of the recipients of the health service as shown in the analytical framework (chapter 4). These factors were used in the field work to find out the opinion of service providers and users concerning the quality of primary health services. The field work presented in the previous chapter collected evidence that confirm the hypothesis of the factors suggested in the framework. The correlation of these factors with the quality of health services are further analyzed in this section, focusing on comparing accredited facilities and non-accredited. Light is also shed on the impact of low quality of services on both service providers and recipients based on evidence collected from the field work.

### Patients' Satisfaction

#### Patients Degree of Satisfaction

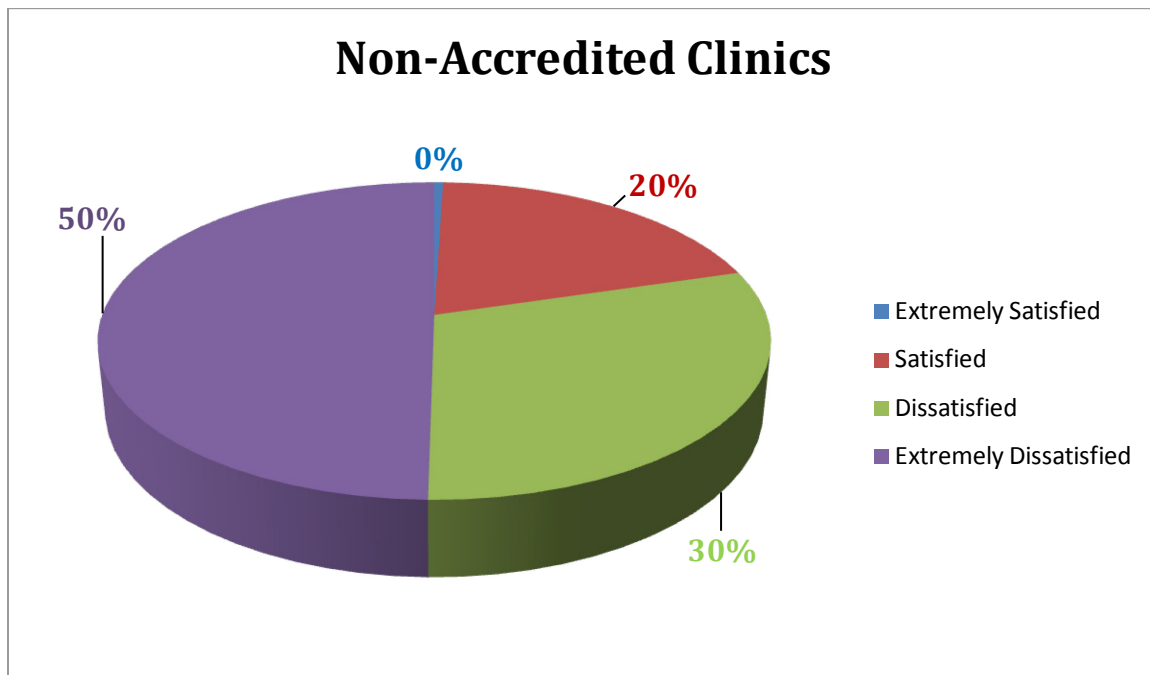
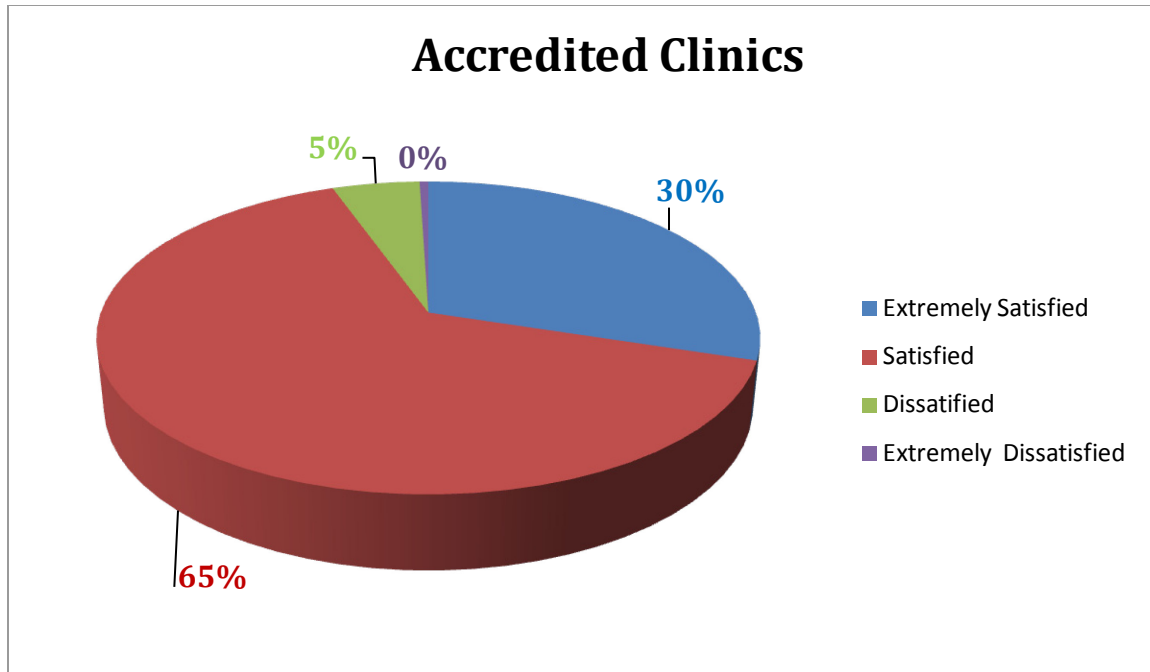
There is a clear variance in the degree of satisfaction from the health service in the accredited facilities and non-accredited ones. Although all visited primary health care clinics suffer almost from the same issues; lack of equipment, dysfunctional devices, some qualitative problems of medicine, infective drug list, and lack of incentives for health workers, however, patients going to accredited facilities are more satisfied than those who go to non-accredited ones.

The analysis has shown that 95 % of the patients interviewed in accredited clinics versus 20% of patients in the non-accredited clinics indicated a “positive” opinion (extremely satisfied or satisfied) from factors like cost, waiting area, friendliness and availability of staff, qualifications of staff, cleanliness and comfort level and location of facilities. However, 5% of patients in accredited clinics versus 80% of patients in non-accredited clinics expressed their dissatisfaction with the quality of service and inability to complaint due to absence of complaint system. There were no major differences in opinion between males and females or people of different age groups. The following table and two charts highlight the degree of patients’ satisfaction in accredited and non-accredited facilities.

**Table (1) Degree of Patients’ Satisfaction with the quality of health care in visited facilities**

<b>Degree of Patients Satisfaction from the Quality of Health service</b>	<b>Accredited Facilities</b>	<b>Non-Accredited Facilities</b>
Extremely satisfied	65%	-
Satisfied	30%	20%
Dissatisfied	5%	30 %
Extremely dissatisfied	-	50%





The research has shown that the main factors of patients' satisfaction in the accredited facilities are the availability of health workers, their respectful and professional attitude, the organized process of entry to different clinics, and the possibility of complaining to the head of

the clinic. While on the other hand the main factors of dissatisfaction are doctors' absenteeism, their aggressive and humiliating attitudes, lack of management and lack of organization within the facility in terms of numbering the patients, recording their data and arranging their entry by turn.

### *Types of patients*

The degree of satisfaction also varied from “extremely satisfied” which represented 30% of participants to just “satisfied” which represented 85% of participants opinions. In my point of view the degree of satisfaction does not only depend on the quality of service, but rather on the different perceptions to the quality of service. The analysis shown that there are two types of patients who visit the primary health care clinics; some patients cannot afford other health services so they are happy with any quality of service so long as they pay very little and get checked up and have free medicine. On the other hand some patients can afford better quality services, but would go to primary health care clinics if they feel that the health problem is not a major one; regular kids cold, regular pregnancy check up, etc, but if they feel that there is a more complex problem they would go to private hospital or clinic in the hope to get better service in return for the higher price. Both categories of patients have different standards or expectations of standards for the quality of the service. The two levels of satisfaction of the two groups of patients are also affected by their level of trust in the provided service; the accredited clinics seem to have won the trust of their visitors, while patients of the non-accredited ones remain suspicious of the treatment they receive and hence less satisfied with the service as a whole.

## Measuring Satisfaction

In light of the different perceptions of patients to the quality of service, it is crucial to know what they expect to receive from the health facility, in order to be responsive to their needs. The accredited facilities have a survey that is filled by patients every three months about their opinion on the services provided; based on the feedback received a quality assurance committee meets on a monthly basis to discuss the steps forward to improve the service provision. Although this procedure is currently stopped in all facilities due to the expiry of the accreditation period, it seems that the system remained responsive by inertia (the common complaints of the patients became known and responded to previously). When considering improving the quality of service, it will be easier in the accredited clinics because the system is there and only needs to be functional, but in non-accredited facilities there is no such system in the first place which adds to the dissatisfaction of patients who feel that their voices are not heard.

## Common weaknesses

All PHC centers suffer from the same impediments of work; the unavailability of medicines, the poor quality of medicines offered in the Essential Drugs List in all PHC, the old equipment and the dysfunctional devices. It was also noted that most of the doctors are “general practitioners”, yet no patients have complained from the lack of qualifications or specialization in the worker force. Most of the clinics are relatively unclean with low hygiene measures, yet all patients confirmed their satisfaction with the cleanliness. However, patients and doctors are more satisfied in accredited facilities as compared to the non-accredited.

Consequently, the research concludes that the key factor that influences patients' satisfaction is "Proper Management" of the facility and regular monitoring and supervision from the higher levels; i.e. the Health Directorate and the Ministry of Health and Population. There is a direct correlation between well managed facilities and patients' satisfaction. Hence, what the patients are seeking in the primary health care facility is minimum organization of work, so that they feel that they are treated as good as they would have been treated in a private clinic. The presence of doctors who are welcoming and who show interest in carefully listening to their health problem and take the time to diagnose and explain the case is another important aspect. These factors would increase patients' satisfaction and trust in the service provided in the clinic. The accredited centers are better managed than the non-accredited ones, there is more monitoring and quality checks from the Health Directorate on the accredited centers, hence creating a higher sense of health workers' responsibility to deliver better services. It is worth mentioning that private sector clinics do not necessary have more qualified efficient health workers, but patients feel more comfortable going to private clinic because of their psychological feelings that they will get better service because they paid more money.

### **Vulnerability to corruption**

Poor management can add another dimension to the poor quality of services; which is corruption. While healthcare workers in accredited and non-accredited clinics share the same frustrations due to lack of equipment and incentives, no signs of corruption were detected in the accredited facilities, while in some of the non-accredited facilities health workers were complaining from corruption due to lack of monitoring and accountability measures.

Corruption can start from top management; managers can treat health workers disrespectfully, can discriminate among different workers in terms of working hours, attending trainings, and other administrative issues, they can allow absenteeism, and they themselves can be absent, they can misuse the budget of the center that is allocated for maintenance or buying equipment or should be used as incentives to doctors. This kind of corruption also reflects on health workers and in turn on patients' satisfaction. Health workers would feel oppressed that they are discriminated against hence will reflect their unrest in their attitude with patients, by shouting at them or treating them disrespectfully. They would also seek every opportunity to be absent or not to do their jobs. This attitude will then reflect on the nurses and administrative staff who would be reluctant to carry on their jobs and would prefer being on the phone or not being in the clinic at all if possible. This attitude was very obvious in El Haggana clinic, the feeling of indifference was felt in all different parts of the center, which was transmitted into anger of patients and useless complaints that are unheard by any responsible official who would take action to change this situation. It can be said that the accreditation system introduces measures and mechanisms for internal and external accountability, through which health workers feel that their performance is well observed.

## **Conclusion**

To sum up the above there are various factors that affect the degree of patients' satisfaction based on the field work, some factors are more influential than others; the cost, doctors' presence, doctors' attitudes and organized accessibility are the most influential factors, while on the other hand, cleanliness of the facility, lack of health workers specializations, unavailability of medicine and dysfunctional devices are less influential factors.

Some factors are common in both accredited and non-accredited facilities like the cost, the cleanliness, lack of medicine, lack of equipment and lack of specialized doctors. However, the more influential factors differ drastically in the accredited from the non-accredited; like the presence of doctors, their attitude, the organization and convenience of the waiting area and time.

## **Health Workers' Motivation**

### **Human Resource Issues**

Staff recruitment decisions are made at the intermediate level of administration; by the Health Directorate at the governorate level without consultation with the health facility level. This is reflected in the mismatch between the ratios of staff in a certain specialties to the number of patients. As mentioned earlier in many cases there is overstaff in the dental clinic and pharmacy, while there is shortage in staff in areas like pediatricians, gynecologists, and family planning physicians. The Governorate decides on the number of staff in each district, and then the district officials allocate the staff to different health facilities in their respective districts. The heads of the health facilities do not have a say about the hiring and firing of staff they are supervising, they can only highlight the areas of shortage of staff and request from the Directorate or the Ministry of Health to hire more workers, which is usually a request that is never answered or not answered according to the requested profile. This centralized process of staffing which needs approvals of three levels of the organization, negatively affects the productivity of the health centers as discussed earlier in the findings section.

Some of the factors affecting the recruitment process are staff requests to be appointed to clinics close to their residence in order not to commute much. Accommodating such

requested in order not to upset the workforce, the clinics ends up with the unbalanced distribution of staff specialization, another factor is that recruitment is done centrally and then distributed to governorates, so the governorates redistribute depending on what they have rather than what is needed, and finally, rare specializations may be sent to accredited clinics or clinics in middle and high income districts. The lack becomes acute and felt in the low-income districts.

### *Performance Evaluation*

Performance evaluation is a standard process undertaken in all governmental jobs. The annual performance evaluation process is just a routine process that does not have in reality a direct effect on the promotions or career enhancement for employees (although it should). It is not conducted in a dialogue form, wherein the supervisor evaluates the staff, then the staff comments and discusses with the supervisor, on the contrary the supervisor fills in the evaluation form, sends it to the second level supervisor, then to the health directorate and then the staff gets a copy after it is finalized. According to health workers, the only use for performance evaluation form is if someone wants to apply for a certain study or apply for a managerial position, but other than that it does not affect the monthly appraisal or increase the possibility of promotion of staff member. Promotions are prepared by schedules from the Ministry of Health and in groups not individual. Usually the performance evaluation is filled for all employees indicating “excellent” performance with very rare exceptions.

## Motivating Factors for Public Health Workers

### I. Serving the needy

The main motivating factor for most of the health workers interviewed was to serve the community and help the needy. Most of the female workers interviewed were genuinely self-motivating women who were not dependent on their salaries for living, as they were supported by their husbands. One of the comments said by one of the health workers was “the income we take is inhumane, even the porter gets paid higher than us”, however it was said with a light spirit and did not affect the woman’s performance. Health workers are trying with the little facilities and equipment available to provide the best possible service. Working in public health clinic is almost more like doing volunteer work, as it does not involve good money and has little career development.

### II. Short Working Hours

It was also noted that the working conditions suited many of the health worker, they enjoyed the short working hours and less load of work compared to hospitals and private clinics. This is affected by the Eastern culture that women’s first and foremost role is looking after her family and supporting the kids. Even if the female is the bread winner in the house, the kids are still her responsibility; the male will not interfere in raising them up and would always blame the female if anything went wrong with the kids. Accordingly, public workers in general would sacrifice the higher income in return for spending more time with their families and having less stressful job. While this suits female workers, male public workers proceed after the short working hours to their second job. One of the female workers interviewed



stated “what’s the use of money if I lose my kids!” On the other hand, female workers want to have a role in the society, they want to prove that they are capable like males, some young pharmacists stated that they are working because they exerted a lot of effort in education and in some cases spent a bulk of money on their education so they did not want to feel that all these years of education were useless, they want to make use of what they studied and take an active part in the society.

### **III. Job Stability**

Another privilege of working in public sector was the job stability, some did not want to risk working in private sector for couple of months then they get released and find themselves jobless. Others thought that if they move to private sector even with over fifteen years of experience, they would be treated as new comers or beginners.

### **IV. Civic Participation**

By visiting the last Primary Health Care center El Delta center, I was able to draw a full picture on the motivation of different health workers to work in the public clinics. About 85% of health workers in primary health care clinics are females; most of them are working to take an active part in the society, not to waste the long years of education in medical and nursing schools. So the public sector jobs is accommodating to female circumstances in Cairo, with shorter less stressful working hours which gives them more time and energy with their families and hence fulfill their utmost roles. As for the 15% of male health workers, they are either young males who recently graduated, and need to get the practical experience which will help them get a better job in a private clinic or hospital, or they are older male workers

who have their private business continue in the public sector just to get the pension upon retirement.

## **De-motivating Factors**

### **I. Lack of Equipment**

Although health workers' salaries are very low and there are no financial incentives, yet the main cause of their de-motivation is lack of supplies and the poor dysfunctional devices, which prevents them from conducting their work. Many health workers are de-motivated due to the poorly equipped clinics, which acts as a major impediment to the service provision. For example in one of dental clinics, there are two units; one working and one dysfunctional, there are twenty doctors and a long queue of patients that cannot be served on time due to the dysfunctional unit, which places stress on both the patients and health workers. In other clinics there is shortage in the utilities of gynecology, so patients have to wait for long hours for the limited number of utilities to be sterilized and re-used. This key de-motivating factor exists in both accredited and non-accredited centers; however since the work is more organized and better management in the accredited facilities, health workers are not as frustrated as in the non-accredited ones.

Maintenance of equipment is also a critical issue which negatively affects productivity of any health facility. The average waiting time for fixing or maintaining the heavy equipment is from 6 months to one year. Due to lack of funds for such purpose, the clinic has to get approval from the health department and directorate officials to be able to maintain any dysfunctional equipment. Sometimes after waiting for months, they receive negative response from the directorate that there is no budget line for repairing such devices at this point in time.

So the health clinic has one of two choices, either wait for donations from the community or keep the equipment broke, a situation that slows down the work pace.

## **II. Working Environment**

The research has also proved that there is a direct correlation between the working environment and workers' motivation; health workers are more motivated in clinics where there is harmony among the health workers and the head of the clinic. On the other hand staff members are highly de-motivated when they are working in a stressful working environment, no cooperation among different team members, and discrimination by the head of the clinic. Although none of the health workers are financially rewarded on their efforts, workers in accredited facilities feel more appreciated by the head of the clinic and sometimes the appreciation is shown from the department or directorate representatives when they visit the clinic, on the other hand, worker in non-accredited facilities do not feel any appreciation, they feel that they are left out and their input is not important, which results in de-motivation and hence poor quality of health service.

## **III. Patients' Attitudes and lack of security**

Another de-motivating factor is the patients' attitudes toward health workers; all the visited clinics are in low-income areas; where most of the inhabitants are poor uneducated people, so they mistreat the doctors, mistrust them and sometimes even attack them. Such attitudes are more controllable in accredited facilities, while in non-accredited the patients can feel the chaos and would shout at the doctors to get their service done. There are no security guards in both accredited and non-accredited facilities which cause a feeling of insecurity to health workers which prevent them from doing their work. One of the health workers was

complaining that they work in very difficult circumstances where some of the patients are on drugs and need to be served right away, without waiting for their turn and doctors sometimes have no choice but to break the rules and obey the patients because they feel insecure. In addition, after the revolution, patients as users of public facilities may be reflecting their negative feelings towards the government or the political transformation on the public health clinic as a governmental service; sometimes lay people deal with any government employee as the 'government' itself.

#### **IV. Lack of incentives and lack of Trainings**

A common complaint is lack of incentives and lack of trainings. Health workers in accredited facilities receive more training than workers in non-accredited ones. There is a monthly schedule for internal training sessions in the accredited facilities, besides the external training from the health directorate and the Ministry of Health. They also plan for on job trainings from health officials from the department and directorate. While on the other hand, workers in the non-accredited facilities hardly get any training, they even do not get a chance to learn from more experienced doctors working with them in the same clinic due to the load of work and unorganized flow of patients. Regarding workers incentives, health workers in accredited facilities feel more comfortable with the amount they get every two or three months as incentives, while on the other hand non-accredited health workers have a lot of doubts about the amount they receive from the head of the clinic and feel that they are not getting their rights. Such incentives are received from the Ministry of Health to the Health directorate as bulk amount for i.e. all pharmacists or all dentist in a specific clinic and then the head of the clinic distributes the amount based on the number of staff in each specialty, it is worth mentioning that the head of the clinic is less trusted in the non-accredited facilities.

## Conclusion

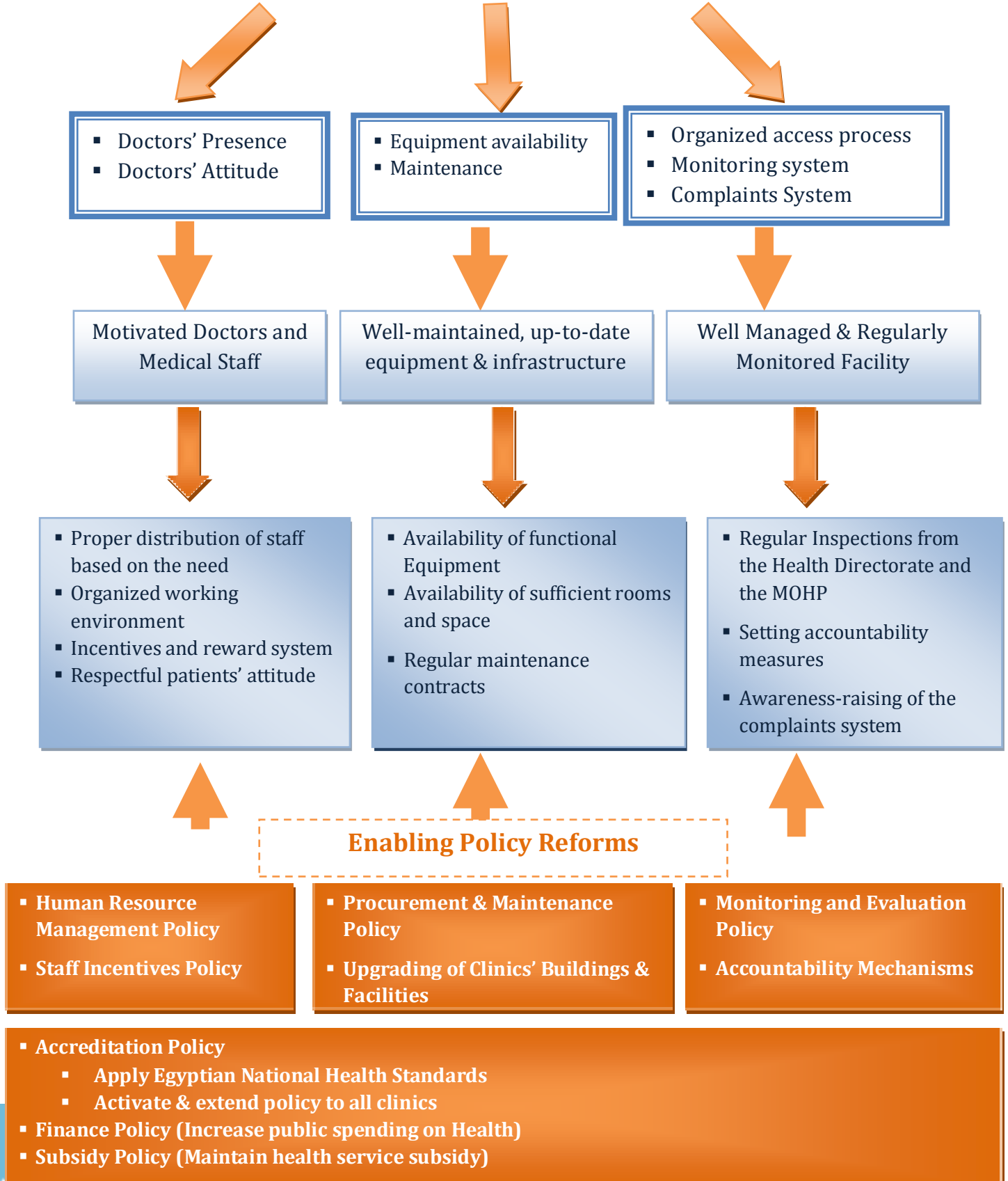
The main factors affecting doctors' motivation and hence level of productivity are; lack of equipment, lack of incentives, the staff working environment, and patients' attitudes. These impediments prevent doctors from doing their jobs, and hence results in poor quality of health services.

It is also worth mentioning that in accredited clinics, the staff of the Health Department and the Health Directorate continue to monitor the adherence of clinics with the National Standards of Health Quality even after the accreditation periods have expired, because they genuinely believe in its value and effectiveness for maintaining quality health services which can be attributed to their engagement in the planning and implementation of the accreditation process.

Based on the field work results, the following analytical framework was developed to highlight the major factors affecting patients' satisfaction with the service, the impediments to achieving such factors and the policy implications and reforms needed.

# Analytical Framework Based on Field Work

## Increase Patients' satisfaction with Public Health Services



The field work revealed three sets of factors of quality service provision in public health clinics:

1. Motivated doctors and medical staff, which is reflected in doctors regular presence and friendly and compassionate attitude.
2. Well-maintained up to-date equipment and infrastructure, that comes from equipment availability and maintenance.
3. Well-managed and regularly monitored facility, which is reflected in organized access to the clinics and functioning monitoring and complaints systems

Staff Motivation entails Proper distribution of staff based on needs, organized working environment, creation of incentives and reward system and respectful patients' attitude. While well-maintained equipment means that there should be a set of functional equipment, sufficient rooms and space and regular maintenance contracts. Finally well managed facility entails regular Inspections from the Health Directorate and the MOHP, setting accountability measures and awareness-raising of the complaints system.

It is hence recommended that accreditation should be introduced to non-accredited clinics and renewed where expired in the accredited clinics. It is also important to increase spending on the health sector, and maintain health services subsidy.

## Application of the Egyptian National Health Standards

As mentioned earlier in chapter (4), there are a number of National Health Standards for the quality of health service provision, upon which the Egyptian Ministry of Health and Population grants accreditation to Primary Health Care clinics. This section will shed the light on the degree of implementation of these standards in the accredited facilities and degree of importance to each quality to both the health services providers and the services recipients based on the field work.

Some of the national standards applied in accredited facilities result in making a difference in the quality of services in accredited facilities in comparison to non-accredited ones. However there are other aspects that can be seen as basic requirements for accreditation but are not implemented due to lack of enforcement and monitoring.

One of the factors that was the same in accredited and non-accredited facilities is the **Support Services**; i.e. pharmacy, radiology, and laboratory. Accredited facilities are not better off than the non-accredited ones in terms of availability of medicine, availability of advanced equipment for laboratory use, and availability of functional devices for radiology and other services. Procurement of essential drugs is a major issue of concern to all primary health care facilities; the quantities delivered to the facilities are too little they are mostly finished in the first 10-15 days of the months. All visited facilities have old and dysfunctional equipment that have been there for ages without any maintenance due to financial constraints or bureaucratic procedures. Availability of drugs is essential to maintain one of the main attracting points of low-income patients to public health clinics. It surely gives the patients the effect of a quality service since subsidized examination and medication is their highest priority.



Another factor is **Management of Information**; whereby accredited facilities should have complete and accurate medical records for all patients that are easily accessible and well organized and updated. This was hard to maintain in both accredited and non-accredited facilities, none of the visited facilities had computerized data, most of the hard copies folders are not updated and are not utilized. Patients have to pass by the registry room to get the folder which will take them some time and effort, so they prefer to head to the clinic directly without wasting time. Better information management will save time and effort for the staff and will help them quality service to patients in terms of less waiting time and better medical follow up.

Regarding **Safety** measures, it was noted that all facilities have the same level of safety measures, all equipment are sterilized using the same techniques, and most dentists have their masks and gloves on if there is enough supply. None of the facilities have any maintenance plans for the building or medical equipment due to financial constraints. However, it is worth mentioning the accredited facilities get more inspection from the health directorate on the Infection Control (IC) processes.

Accredited facilities excel more in **Patients' Rights** and **Patients' Care** than non-accredited ones; in terms of dealing with complaints, displaying signs of patients' rights, measuring patients' satisfaction through regular surveys, physicians take more time to explain to all patients the diagnosis and treatment and any follow-up steps using clear and simple language. This is lacking in non-accredited facilities as mentioned earlier due to the demotivation of health workers and the absence of operating systems. This is obvious also in **Management of the Facility**; accredited facilities have a better system of communication

between the director and staff, have more changes of receiving professional trainings. However, it is worth mentioning that the number of staff and their distribution by specialty is poor in all facilities, also the performance evaluation process is not a fair or valuable process in all facilities, which are policy issues that need to be addressed at higher levels of the organization. Better and transparent management represent a great incentive to doctors and medical staff, which is reflected in their motivation to provide quality service. Yet, better managers of the facilities need to be empowered by the health department, directorate and Ministry of Health; i.e. to be given resources and the authority to use incentives and punishment.

Finally, the **Quality Improvement** and the **Integration of Care** programs exist in the accredited facilities as a basic factor for accreditation however; they are not enforced or properly implemented. Accredited facilities have QI committees and coordinator that should meet on monthly basis to discuss priorities for improvements, but they are not functional, the same applies to the dissemination program to educate the staff and patients, some facilities occasionally conduct internal trainings to health workers where the training duration would be around 10-15 minutes, regarding educational material for patients it is currently not conducted in any facility, although the accredited facilities stated that they used to conduct such session, but have recently stopped.

## Chapter (9) Policy Implications & Recommendations

This chapter interprets the main findings of the research and introduces possible policy measures to improve the quality of public health services in low income districts hence increasing patients' satisfaction in the primary health care clinics.

The overarching policy recommendation is that the Egyptian Ministry of Health and Population needs to increase the budget allocation for primary health care as it is the gate keeper to secondary and tertiary health care, and 80% of the cases can be addressed and solved at the primary health care clinics if it provides quality service. It is equally important to maintain the subsidy policy for primary public health in order to meet the limited affordability of low-income people who would struggle to get health care if the prices of examination and medication would be increased.

If enough budget is allocated, then the second milestone policy recommendation is to activate and expand the accreditation system using the national health standards to all public health clinics, particularly in all low-income districts where the service is most needed. What cannot be measured cannot be managed; the MOHP should ensure that there are proper means of monitoring and evaluation for primary health care centers. Following are some suggestions for policy reforms to improve the quality of public health services in primary health care clinics

## Policy reforms

### I. Purchasing and maintenance Policy Reform

- ❖ To overcome the problem of dysfunctional equipment, the Ministry of Health should put in place replacement plans where a needs assessment survey would be conducted, and a long term plan for replacements for dysfunctional equipments should be put in place with deadlines and budget lines.
- ❖ Proper inventory records should be available at the department level with proper labeling of all equipments and devices in all primary health care centers, to avoid any corruption in terms of misusing or selling available equipment. Inspections on inventory should be conducted on bi-annual or annual basis by the directorate or the Ministry of Health.
- ❖ Regular maintenance checks should be conducted every 6-12 months by one maintenance company that is contracted from the health directorate to serve certain the clinics in specific districts.
- ❖ The health clinic should be able to contact the contracted maintenance company at any time without going back to the health department or the directorate of health, and the company has to take the necessary actions for repairing equipments within one week otherwise the governorate has the right to end the contract and contract an alternative company
- ❖ Every device/equipment should have a retirement plan, where the health directorate knows that in a certain number of years, some equipment will have to be replaced or retired to be sold taking into account depreciation measures.

Application of these systematic reforms implies more decentralization to the facility level, proper inventory management and regular monitoring from the directorate and the Ministry of Health. This will decrease the long bureaucratic procedures for maintenance of equipment, reduce the time and efforts related to the process and most importantly reduce the dysfunctional time of the scarce resources available in primary health care clinics.

## **II. Essential Drugs Policy Reform**

- ❖ In order to overcome the problem of shortage of medicine, the Ministry of Health should conduct an assessment of the average number of tickets sold on monthly basis per facility and accordingly ensure availability of the right amount of medicine. Another in-depth analysis can be conducted on the different brands of medicines to provide more of the most used ones and less of the unused drugs.
- ❖ There is a critical need to introduce some changes to the Essential Drug List; new medicines, new antibiotics so people would feel there is improvement in medicines supply and pharmacists would learn more about new medicines.

## **III. Human Resources Policy Reform**

### ***Recruitment***

- ❖ In order to address the problem of distribution of staff of different specializations to various districts and primary health care clinics; where in some areas there is overstaffing and in others there is shortage, this entails strong coordination between the Health directorate and the head of the PHC on the human resources needs, in order

to guide the systematic distribution of staff to different facilities and achieve equity in manpower distribution in different specializations and clinics.

- ❖ There is a need to decentralize the recruitment process at least for the non-medical work force, the head of the facility should be able to recruit extra cleaners as deemed necessary instead of having to wait for long recruitment and approval processes from the Ministry to recruit support staff.

### *Motivation*

- ❖ Introduce performance-based incentives and ensure their implementation based on records and a fair evaluation of staff. Different package of incentives should be provided to doctors who work in unsecure areas
- ❖ Improve the performance evaluation process to involve more dialogue between the staff and the supervisor, where areas of improvement will be discussed, certain trainings will be specified and the employee can also share some of the issues that act as impediments for his/her performance improvement.
- ❖ Assign an additional room for health workers who are not on duty, to allow more space for patients in overcrowded room. This will give better impression to patients of a quieter less crowded environment.
- ❖ Basic security measures should be provided to health workers while conducting their jobs; this involves political will and commitment to set rules to patients that they are not allowed to insult doctors and if this happens they will be prevented from getting the service. There should be a security guard at the gate who would be responsible to stop any violence or fights inside the facility

- ❖ Ensure fair training opportunities to all health workers; encourage on the job training sessions which proved to be very useful and gives a sense of added value to the recipients as indicated by all health workers interviewed
- ❖ There should be procedures for health workers to complain against their supervisors without being affected in their career. Also, the culture of reporting corruption is not there, accordingly, there should be another means of reporting corruption without the fear of getting harmed.
- ❖ Encourage and welcome new productive ideas for improvement of health services. There should be a channel of communication between health workers in the primary health care clinics and some government officials at the Ministry of Health or even the directorate, where there should be a unit or assigned department responsible for receiving any suggestions from different health workers on ways to better organize the work and be more productive.

#### **IV. Community Education Policy**

- ❖ One of the de-motivating factors for health workers is the aggressive attitude of some patients, which is in many cases due to their mistrust in the doctors' diagnosis and subscriptions. This calls for an urgent action from the Health Directorate to organize educational campaigns to all primary health care patients; where general knowledge about hygiene, nutrition, drug misuse, medical examination procedures and other important topics are communicated to them. This will have positive impact on the patients who will feel advantaged to receive such a free service, and will also decrease their mistrust in the health workers.

- ❖ It is also recommended that such educational sessions be conducted by some of the physicians or pharmacists in overstuffed clinics, which will also occupy the health workers who have little work to do and will give them a sense of motivation that they are educating the community and building trust of the patients.

## V. Monitoring and Evaluation

- ❖ The Ministry of Health and Population should renew accreditation to all accredited facilities since the accreditation period has expired, to ensure implementation of national standards of quality of health services
- ❖ It is also recommended to display the accreditation certificate so the patients would trust the facility more and make sure that the facility is regularly monitored by the Ministry of Health, which gives the patients the impression that they are looked after by a higher authority that monitors and evaluate the work of the center. It would also be useful to hang more signs indicating the patients' rights in different parts of the facility; so that the patients would feel more comfortable about the center and more confident that the health workers would abide by these lists of rules.
- ❖ Regular inspection and unplanned visits from senior officials to combat corruption, and ensure that QI and infection control measures are implemented. Inspections should not be from the health department only, there should be other inspection bodies to avoid corruption



## Future Research

- ❖ I would recommend future research to be conducted on means of improving the quality of public health facilities through examining the possible implications of increasing the fees for accessing primary health care clinics with a clear plan for improving the service to meet the patients' expectations and save them money spent on private clinics. It would be interesting to find out the reactions to an increase for the examination ticket cost to 3-5 L.E instead of 1 L.E., exceptions can exist for patients who cannot afford which most clinics have records of their situations. It is worthy of investigating whether it is acceptable by the health authorities to use the extra funds as incentives for health workers, or planned to be spent in one of the many areas that need improvement.
- ❖ It is also recommended to further research the process of accreditation to highlight the degree of medical staff involvement in the process, the value added to the clinic and staff by being accredited, how much time it takes to prepare a clinic for accreditation and the degree of motivation of staff to the process. To what extent does accreditation increase patients' accessibility; by choosing to visit accredited facilities and avoiding non-accredited ones.

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## Annexes

### Annex I

#### Interview Questions for Health Workers in Lower Income Areas in Cairo

##### Gender

- Male  Female

##### Age

- 20-30  31-40  41-50  51-above

##### Marital State

- Married  Single  Divorced  Widower

##### Specialty

##### Years in Service

- 1-5 years  5-10 years  10-20 years  More than 20 years

##### Income (is there other source of income?)

---

##### Circle the most appropriate Answer

##### A. Motivation

1. How satisfied are you with your job? Why?

- Very highly    -Highly    -Medium    -Low

2. What are the motivating factors most important to you?

3. Which of the following motivates you the most? You can pick more than one

- Job security    -Helping others    -Incentives    -Privileges (*e.g. free health care*)

4. Is there a performance evaluation system?

- Yes  No

- ❖ If yes, Tell me about it  
❖ Is it genuine? Is it effective?

5. Are there opportunities for promotion/career enhancement?

Yes  No

❖ Is it related to the performance evaluation?

Yes  No

6. When was the last time you received training

-Never -Less than 6 months ago -More than 6 months ago

*If yes:*

❖ What was it about

❖ Was it useful?

❖ Do you recommend more training to be conducted?

## **B. About the Patients**

7. To what extent do you believe in this sentence is true? "Psychological comfort is as important as Physical treatment, sometimes even more important"

-Strongly agree -Agree -Disagree -Strongly Disagree

8. Do you get offended if patients ask you questions regarding the diagnosis and treatment?  
Elaborate (*Is every patient granted specific amount of time? Do you encourage them to ask questions?*)

Yes  No  Sometimes

9. What are the measures taken to ensure patients safety in terms of hygiene?

10. From your point of view which of the following factors affect the confidence/psychology of a patient?

-Doctor's Treatment -Cleanliness of the facility -medical treatment

### C. Operations

11. Do you keep records for all patients including their health history?

- Yes  No

*If Yes:*

- ❖ Who is responsible?
- ❖ Are they electronic or hard copies?
- ❖ How effective is this process from your point of view?

12. How many staff are there in the facility? (Doctors, nurses & Admin staff)

13. Are all the staff permanent or on contract?

14. Are their roles defined and clear?

- Yes  No

15. Is there enough staff in the facility?

- Yes  No

*If No:*

- ❖ Which specialties are most needed?

16. What are the average visits per day per doctor?

17. If additional staff is needed, what's the procedure? Is it a long process that requires many approvals?

- Yes  No

- ❖ Did you ask for more staff before?

- Yes  No

*If Yes:*

- ❖ How much time did it take to bring the person on board?

18. Do you think the facility is well equipped with basic equipments?

- Yes  No

If No

❖ What are the basic equipment needed?

19. Is there a complaints system?

- Yes  No

*If Yes:*

- ❖ How does it work?
- ❖ Is it announced to the patients? (how? Oral or note on the wall?)
- ❖ Have there been measures to improve service based on any pervious complaint?

20. Do the drugs and medical supplies cover the PHC need?

21. What are your suggestions to improve quality of health services provided in this facility?



## Annex (II)

### Interview Questions for Patients in Lower Income Areas in Cairo

#### Gender

- Male  Female

#### Age

- 20-30  31-40  41-50  51-above

#### Marital State

- Married  Single  Divorced  Widower

#### Source of Income

- Employed  Unemployed  other source of income

#### Level of Education

- Illiterate  Primary education  Secondary  University
- 

#### **Circle the most appropriate Answer**

##### A. Accessibility

1. How often do you visit this health facility?

- Once a month  -Twice a month  -More than Twice a month  -More than a month

2. How much do you pay for a visit?

- Expensive  -moderate  -cheep (compared to your income)

3. How much do you spend monthly on health issues (medicine, health service, etc) (as a percent of the income)

4. What is the average consultation time?

5. Is there a possibility for a follow up visit?

- Yes  No

❖ Is it free of charge?

- Yes  No

6. Is the only facility in your neighborhood?

- Yes  No

*If No*

- ❖ How many other facilities are there?
- ❖ Why do you choose to come to this one?

## **B. Operations**

7. How long do you wait for your turn? Is it organized process (first come first serve?)

8. Do you always find someone at the receipt area?

- Always  Most of the time  Never

9. How can you define their attitude?

- Welcoming  Indifferent  Aggressive

10. Do they keep personal file for you including your medical history?

11. Is all your information kept confidential?

## **C. Health Workforce Attitude, Efficiency & Competency**

12. How can you define the doctors' attitudes?

- Friendly    -Unfriendly    -Professional    Aggressive

*Probing questions*

*Elaborate more*

- ❖ *Does he/she give you the time to describe your case?*
- ❖ *Does he/she explain to you in details what is wrong with you?*
- ❖ *Do they give you time for questions?*
- ❖ *Do they treat you with respect and sensitivity?*
- ❖ *Can you call them in case of emergency?*

13. Do you feel any discrimination in treatment between male and females patients?  
(elaborate)

- Yes  No

14. Are the available doctors' qualifications sufficient to your needs? Or more specialties are needed?

- Sufficient  Need more specialties (like what?)

15. Have you ever been wrongly diagnosed?

- Yes  No

If "Yes" what did you do? Did you confront the Doctor, did you seek other alternative?

#### **D. Infrastructure**

16. How can you rate the Cleanliness of the facility?

-Clean -Very clean -Not Clean -Very unclean

❖ Does Doctor use gloves and sterilized utilities

- Yes  No

❖ Is there is a toilet?

- Yes  No

❖ How clean is the toilet?

-Clean -Very clean -Not Clean -Very unclean

17. How can describe the waiting are?

-Pleasant -Moderate -Annoying

*Related questions:*

❖ Are there enough seats?

- Yes  No

❖ It is very hot? Is there a fan or air conditioning?

18. Do you receive the prescribed medications from PHC facility or from private pharmacy?

❖ What is the percentage of receiving the prescribed medicine from PHC facility to private pharmacies?

19. Are the equipments and medicines available?

Yes  No

If “No” what do you do? From where do you get them? Are they more expensive?  
Do you seek other facilities where there is more availability of medicine?

#### **E. Accountability and Responsiveness**

20. What is it that most matters to your from the below?

-Doctors Attitude -Cleanness of the facility -Waiting Time -Cost -Other

21. How do you grade the overall service? Why?

Extremely Satisfied  Satisfied  Dissatisfied  Extremely Dissatisfied

22. If you have a complaint, do you know where to submit it and how to follow up on it?

Yes  No

If “yes” have you ever submitted a complaint?

Yes  No

If “yes” what was the outcome? If “no” why?