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Evaluation of services provided at El Wafa Medical rehabilitation hospital In Gaza strip: clients and provider perspectives.

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نتيجة الحكم على أطروحة ماجستير

بناءً على موافقة عمادة الدراسات العليا بالجامعة الإسلامية بغزة على تشكيل لجنة الحكم على أطروحة الباحثة/ **ميرفت محمد محمود عسفة** لنيل درجة الماجستير في **كلية *التربية*/قسم الصحة النفسية المجتمعية-علوم التأهيل** وموضوعها:

"Evaluation of services provided at El Wafa Medical rehabilitation hospital in Gaza Strip: clients and provider perspectives"

وبعد المناقشة العلنية التي تمت اليوم الأربعاء 15 رجب 1430هـ، الموافق 2009/07/08م الساعة الواحدة ظهراً، اجتمعت لجنة الحكم على الأطروحة والمكونة من:

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وبعد المداولة أوصت اللجنة بمنح الباحثة درجة الماجستير في **كلية *التربية*/قسم الصحة النفسية المجتمعية-علوم التأهيل**.

واللجنة إذ تمنحها هذه الدرجة فإنها توصيها بتقوى الله ولزوم طاعته وأن تسخر علمه في خدمة دينه ووطنه.

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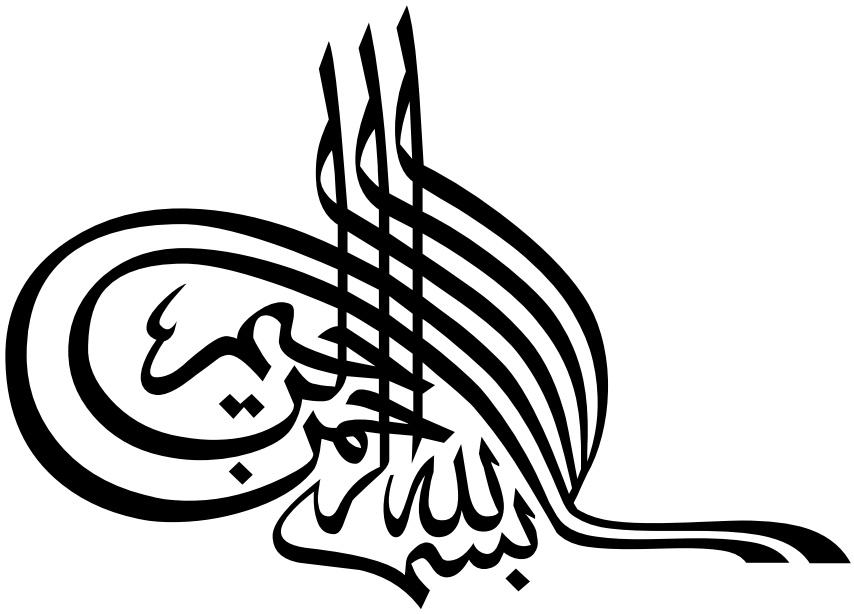

﴿ يَرْفَعِ اللَّهُ الَّذِينَ آمَنُوا مِنكُمْ وَالَّذِينَ أُوتُوا الْعِلْمَ دَرَجَاتٍ وَاللَّهُ بِمَا تَعْمَلُونَ خَبِيرٌ ﴾ صدق الله العظيم

(المجادلة: الآية 11)

ABSTRACT

Evaluation of services provided at El -Wafa Medical Rehabilitation Hospital In Gaza strip: clients and providers perspectives.

This study, to acknowledgment of the researcher, is considered the first evaluation study about the field of rehabilitation at EL-Wafa Medical Rehabilitation Hospital in Gaza strip.

Aims: to perceive clients and provider perspective about services provided in EL-Wafa medical rehabilitation hospital. **Objectives**: The specific objectives are as follows: To assess client's satisfaction toward the services provided at El Wafa Medical Rehabilitation Hospital. To assess service provider's job satisfaction To examine client's satisfaction toward the services provided at El-Wafa Medical Rehabilitation Hospital and service provider's job satisfaction taking into account selected demographic variables. To identify areas of strength and areas for improvement of the provided services. To provide the decision makers at El-Wafa Medical Rehabilitation Hospital with suggestions for future improvement and recommendations. **Methodology:** The researcher used a descriptive cross sectional design to collect the necessary information to conduct this study. Researcher used a self- built questionnaires for this study. The questionnaire was piloted in a similar sample of 15 individuals and judged by eight experts. Necessary changes were made to collect valid and reliable data and reduce possible bias. The study sample consist of 44 clients and 57 providers. Data collection took place between 1/ 8/2008 to 1/11/2008. Providers were doctors, nurses, physiotherapy, occupational therapy, social worker and psychologist. Clients were mainly strok, traumatic brain injury and spinal cord injury. **Statistical analysis:** The researcher used the SPSS to perform statistical analysis and produce results. **Results:** Clients' perspective with regards to the services provided was significant, all services were positive and satisfactory

except for social worker and psychologist services, The client's satisfaction with provided service provided in WMRH was rated as high, there is no relationship between client's satisfactions with selected socio- demographic variables, Provider's perspective regarding to services provided in WMRH was rated as low, there is no relationship between providers satisfaction with the selected socio- demographic variables, there is effective interaction between team members which was of great effect in relation to client's management and services provided and there is no relationship between client's satisfaction and provider's satisfaction, these study results are attributed to our Palestinian culture in terms of values and rules of great Islam. **Recommendation:** Development of services with defects, low performance or low consumers satisfaction such as social worker and psychologist, improving and developing of clinical practice by Evidence Based Practice and quality assurance. Resources and equipment a crucial elements of this process, job description that distinguishes between various disciplines and professions and improving the performance of all management levels; top, middle and line Improving the performance of rehabilitation team.

الملخص (مختصر الدراسة)

عنوان الدراسة: تقييم الخدمات المقدمة في مستشفى الوفاء للتأهيل الطبي في قطاع غزة : من منظور المرضى ومقدمي الخدمات.

هذه الدراسة تعتبر أول تقييم لخدمات التأهيل المقدمة في مستشفى الوفاء للتأهيل الطبي في قطاع غزة.

الأهداف : الهدف العام هو تقييم رضي المرضى ومقدمي الرعاية المباشرة عن الخدمات المقدمة لهم في مستشفى الوفاء للتأهيل الطبي،أما الأهداف المحددة للدراسة فهي كما يلي:
تقييم رضي المرضى تجاه الخدمات المقدمة لهم من مستشفى الوفاء للتأهيل الطبي،
تقييم الرضي الوظيفي لمقدمي الخدمات المباشرة للمرضى (الأطباء-المعالجين-الخدمة النفسية-الخدمة الاجتماعية-)، تقييم رضي المرضى من الخدمات المقدمة لهم من مستشفى الوفاء للتأهيل الطبي والرضي الوظيفي لمقدمي الرعاية المباشرة للمرضى مع الأخذ بعين الاعتبار العوامل الديموغرافية التي تم اختبارها، التعرف على نقاط القوة ونقاط الضعف القابلة للتحسين في الخدمات المقدمة تقديم المقترحات لصانعي القرار في مستشفى الوفاء للتأهيل الطبي للاستفادة من التوصيات والنتائج في تحسن الخدمات الممكن مستقبلا.**الطرائق العلمية المستخدمة في البحث :**
لقد استخدمت الباحثة الطريقة الوصفية العرضية (Descriptive Cross Sectional) لإجراء الدراسة الحالية وجمع المعلومات اللازمة لها ، واستخدمت الباحثة إستبانة والتي قامت ببنائها لهذا الغرض .تم اختبار الإستبانة في عينة مشابهة لعينة الدراسة وتتكون من 15 فرد ، كما تم تحكيم الإستبانة أيضا من قبل 8 محكمين ذوي خبرة في المجال ، التغيرات الأزمة تم عملها بناء على ذلك بهدف جمع معلومات ذات مصداقية وثبات عاليين وتجنب التحيز العلمي .عينة الدراسة تكونت من 44 مريض و57 مقدم رعاية ، المعلومات التي تم جمعها بين 1-8-2008 وحتى 1-11-2008 كانت من الأطباء والتمريض والعلاج الطبيعي والوظيفي والخدمة الاجتماعية والخدمة النفسية ، أما المرضى فكانوا بشكل أساسي من ذوي السكتات الدماغية وإصابات الرأس وإصابات النخاع الشوكي .
التحليل الإحصائي:استخدمت الباحثة البرنامج الإحصائي (SPSS) لتحليل البيانات والخروج بالنتائج ،
نتائج الدراسة :كان رأي المرضى بخصوص خدمات الرعاية المقدمة لهم وايجابي ، وكان المرضى راضين عن الخدمات إجمالا عدا الخدمة النفسية والاجتماعية، مستوى رضي المرضى من الخدمات المقدمة لهم في مستشفى الوفاء للتأهيل الطبي كان مرتفع، كما أظهرت النتائج عدم وجود علاقة بين رضي المرضى والتغيرات الديموغرافية التي تم اختبارها كما يعتبر مستوى رضي مقدمي الرعاية في مستشفى الوفاء منخفض وكما أظهرت النتائج عدم وجود علاقة بين رضي مقدمي الرعاية والمتغيرات

الديموغرافية التي تم اختبارها .أظهرت الدراسة وجود تفاعل ايجابي وفعال بين أعضاء فريق التأهيل ، والذي كان له أثر كبير في علاج المرضى والخدمات المقدمة لهم .

أظهرت الدراسة عدم وجود علاقة بين رضي المرضى و رضي مقدمي الرعاية، وهذا يعـزى إلـى الثقافة الفلسطينية المستمدة من القيم والتعاليم الإسلامية العظيمة.**التوصيات:** تطوير الخدمات التي تعاني من نقص أو خلل في مستشفى الوفاء للتأهيل الطبي مثل الخدمة النفسية والخدمة الاجتماعية.

تطوير الأداء السريري (الإكلينيكي) مع المرضى بناء على أسس ونتائج البحث العلمـي ، وتحـسين الجودة ، علما أن المصادر والتجهيزات عناصر مهمة لنجاح هذه العملية .صياغة الوصـف الـوظيفي والذي يجب أن يميز التخصصات والمهن العملية.تحسين أداء الإدارة على جميع المـستويات ، العليـا والمتوسطة والأساسية .تحسين أداء فريق التأهيل .

Dedication

"To my two martyred brothers Tammer and Sohaib who sacrificed their lives defending their country in the last aggression against Gaza in the long path towards freedom.

I would like to extend my deepest appreciation to my dear Parents, brothers and sisters for their prayers and support.

I would like to extend my respect and admiration to my better half, my husband Abu Mohammed and to my beloved children for their patience, courage and endless support and prayer.

Finally, to my dear friend who always stand beside me Camellea, Lastly but not the least, Special thanks to my fellow friends and colleagues at El Wafa Medical Rehabilitation Hospital, for their continuous support and encouragement''.

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LIST OF Abbreviation

AAPM&R	American Academy of Physical Medicine and Rehabilitation
CBR	Community Based Rehabilitation
CDR	Crude Death Rate
GNP	Gross National Product
GS	Gaza Strip
IMR	Infant Mortality Rate
MOH	Ministry of Health
NGOs	Non –Governmental Organization
ODP	Out-Patient Department
OT	Occupational therapy
PCBS	Palestinian Central Bureau of Statistics
PHC	Primary Health Care
PT	Physiotherapist
SCI	Spinal Cord Injuries
UNRWA	United Nation Relief and Work Agency
WMRH	El-Wafa Medical Rehabilitation Hospital
CVA	cardio vascular accident
LSD	least significance difference
CV	coefficient of variance

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CHAPTER ONE

INTRODUCTION AND JUSTIFICATION

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INTRODUCTION AND JUSTIFICATION

1.1 INTRODUCTION :

Service quality is an outcome defined as an attitude that the customer developed over time about an organization. This attitude is based on customers perception of the organizational actual performance of particular service or group of services (Cronin &Tylor, 1992).

Client's satisfaction is an essential issue of services quality in health care organizations as mentioned by Davis (1991). Vavra (1997) urged that customer satisfaction is a leading criterion for measuring the quality of health care that is actually delivered to customers through the services and by the accompanying services.

The evaluation process of health services involves the recognition of values, setting goals and measuring them, putting them into action and assessing the effect in order to achieve a high quality of services provided by health professionals (williams, 2006). The value of evaluation of study is improving, developing, providing feedback, motivating, help in decision making process and quality considerations Aspinwall (1996) state that evaluation is an ongoing process which should ideally be initated during the development and planning phase of a project. Also Simkins (2004) stated that evaluation is generally under stood as an assessment of amount or the value of something.

Bergman (1982) defined evaluation of care as the objective measuring of phenomena, as well as subjective perceptions and opinions of the feeling of care as reported by services recipients, providers and important others. The client perspective measurement may reflect a belief that as an indicator of health care quality, and concerned with how clients feel about the cost or accessibility of services, their interpersonal relationships with health care professionals.

Evaluation is largely used in societies where there is a need to find out whether certain objectives have been achieved, what effects a given measure has had, what the problem have been and whether the result stand in reasonable proportion to the effort involved (Pedler, 1996).

The process of organizing, monitoring and controlling the gathering of client's satisfaction feedback provides constant stream of information on clients demand and expectation towards the organizations products. This process contributes to having quality services where it is defined as: "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Donabedian ,1996).

People often do not get high-quality care . One study explored12 large U.S. communities and found that just over half (54.9 %) of people only were receiving the care they needed (Faye,et al.1998).

Clients satisfaction is defined as the psychological state that result from satisfaction or dissatisfaction of expectations when compared to perceptions of a discrete episode of contact with an organization. Also the researcher stated that clients satisfaction is a key component in the evaluation of the quality of care delivered (Oliver, 1981).

Quality of care from the patient's perspective, however, has been investigated only very recently, and only a few measuring instruments have explicitly been developed for the assessment of quality of care from the patient's perspective. The authors (Newsome, 1999 & Campen, 1995) considered patient satisfaction as an indicator of quality of care from the client's perspective.

In recent years, consumer satisfaction with healthcare has, gained widespread recognition as a measure of quality, especially since the publication of the 1983 NHS Management Inquiry and its call for the collation of user opinion (NHS Management Inquiry, 1983). This has arisen partly because of the desire for greater involvement of the consumer in the healthcare process and partly because of the links demonstrated to exist between satisfaction and patient compliance in areas such as appointment keeping, intentions to comply with recommended treatment and medication use.

On the other hand, Islam has praised the notion of work and stressed that the one who works to sustain his living is more pious than the worshiper who worships day and night and who has the ability to work but relies on others for his sustenance. The truest example of this concept is the fact that all God's prophets worked to sustain themselves (Islam on Line).

One of the most important factors which affect the employees performance is Job satisfaction which is defined as the positive attitudes and feelings resulting from the appraisal of ones job or job experiences (Locke,1983).

Job satisfaction is one of the significant managerial subjects because of its important role in job recruitment, retention and quality of work and it affects patient satisfaction (Terry et al., 1996).

Every career has the potential for producing personal satisfaction and dissatisfaction and much of that assessment depends on what an individual values in life. According to Locke (1969) satisfaction and dissatisfaction with some aspect of job depend on the discrepancy between what a person perceives is getting and what is desired. Foster (1999) perceived the relationship between employee and employer as a psychological contract. This contract is based on the employee carrying out certain workplace duties in exchange for the employer meeting certain employee needs. An employer has the right to expect that an employee carry out duties in a competent and appropriate manner. The employee needs recognition and proof of his value with satisfactory monetary compensation.

There is no doubt that rehabilitation professionals work hard to promote and normalize lives of those people who lost some of their abilities as walking, ambulating, seeing, hearing and achieving maximal level of independence.
For some people with intensive and special needs, rehabilitation also play a life saving role hence it prevents complications and deterioration of patient's conditions.

In Gaza strip, Rehabilitation started after the 1st Intifada in 1987. There was a rise in the interest in Rehabilitation as hundreds of patients started to accumulate with multiple physical disabilities handicaps and they were in dire need for Rehabilitation.

1.2 JUSTIFICATION OF THE STUDY:

In the first intifada (1987) and AL Aqsa intifada (2nd intifada,2000), many disabled Palestinians were forced to travel to receive rehabilitation services in the west bank or to the hospitals of the occupied territories1948.

The security chain imposed by the Israeli forces, the difficult social and political situation in addition, to the sufferings of families of the disabled in getting the permits to travel outside Gaza forced patients to look for and search alternative treatment centers inside Gaza.

The establishment of El-Wafa medical rehabilitation hospital (WMRH) as the first rehabilitation hospital in Gaza strip in 1996 relieved Gaza people as the hospital met their needs with regard to providing rehabilitation services.

WMRH and since its establishment was able to provide medical services in Gaza strip in which the population of Gaza strip is about 1.4 million (36.7% of the total population of Palestine). It is worth noting, that the prevalence of disability in Gaza strip is about 4% of the total population, from which 30-35% have physical disability (MOH, 2005).

As the main rehabilitation services provider in Gaza strip, EWMRH is always looking for improving its services to meet the continuous needs of its clients and the local community. Therefore, evaluations of its different services from the client's perspectives in addition to evaluating the service provider's perspectives towards their job were considered to be important by the hospital top management.

Therefore, services provided in WMRH will be evaluated in order to provide WMRH top management with essential information to enhance and support decision making process related to improving the quality of the processes at the hospital which eventually will have an influence on the quality of the services.

1.3 MAIN STUDY OBJECTIVE:

To evaluate the services provided at WMRH in Gaza strip taking into account the client's and the service provider's perspectives.

1.4 SPECIFIC STUDY OBJECTIVES:

1. To assess client's satisfaction toward the services provided at WMRH.
2. To assess service provider's job satisfaction
3. To investigate differences in client's satisfaction toward the services provided at WMRH and service provider's job satisfaction taking into account selected demographic variables.
4. To identify areas of strength and areas for improvement of the provided services.
5. To provide the decision makers at WMRH with suggestions for future improvement and recommendations.

1.5 RESEARCH QUESTIONS:

1. What is the level of client's satisfaction with provided services at WMRH?
2. To what extent team work services and clients participation in team decisions effective from client perspective?
3. Are there statistical significant differences in the levels of client's satisfaction taking into account selected demographic variables?
4. What is the level of job satisfaction for health care providers in WMRH?
5. Are there statistical significant differences in the levels of service provider's satisfaction taking into account selected demographic variables?
6. what are health providers perspectives with regard to continuing education program and work in general?
7. What are the recommendations for decision makers to improve rehabilitation services at WMRH?

1.6 SIGNIFICANCE OF THE STUDY:

The feedback from clients and healthcare providers concerning WMRH services will guide the attention of hospital top management to focus on the shortcomings toward enhancing the quality of its services.

The study findings are useful for rehabilitation industry. It identified strength and weakness point in practice and management from both service providers and rehabilitation consumers. Study results were helpful in corrective actions in different displaces.

Decision maker in MOH and other Rehabilitation facilities can make use of study findings and recommendations in future planning for rehabilitation services.

The study adds new scientific work and product to rehabilitation literature. Future studies may use or base on study result and recommendations.

Moreover, the study will contribute to body of knowledge in the field of rehabilitation services in Palestine as there are no other similar studies that were conducted in the field. The study instruments will also assist in helping researchers and practitioners to evaluate similar settings.

1.7 OPERATIONAL DEFINITIONS OF TERMS:

1.7.1 Evaluation: process by collecting relevant information to determine quality, effectiveness of rehabilitation programs.

1.7.2 Perspective: The clients experience, opinion, attitudes, views, perception and satisfaction about rehabilitation services they received during hospitalization. Interval scales were used based on Likert scale.

1.7.3 Client: a client is any one who is impacted by the product or process. In this study the term "client" refers to patient.

1.7.4 A health care provider: Is any one who provides health care to another persons or persons as profession.

1.7.5 Satisfaction: Is an emotional status that can be expressed by feelings. It is the reaction of the recipient towards salient aspects of the context, process and result of services experience.

1.7.6 Health care: Is the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by nursing, medical and allied health professions.

1.7.7 Rehabilitation: Is the process of helping persons to reach the fullest physical, psychological, social, vocational, a vocational and educational potential consistent with his or her physiologic or anatomic impairment, environmental limitation, and desires and life plans.

1.7.8 Medical services: The hospital's Rehabilitation doctors are concerned with dealing with a broad spectrum of disabilities. Hospital's team includes specialized physicians in the fields of neurology, rehabilitation medicine, urology and geriatric rehabilitation specialists.

1.7.9 Rehabilitation doctors services: Doctors do their daily rounds, admission assessments, and follow up evaluations. The doctors supervise each client's individualized rehabilitation plan of care and monitor the progression towards the clients short and long term goals.

1.7.10 Rehabilitation nursing services: In rehabilitation nurses intend to be as close to patients as possible. Offering services to all types of clients with physical and cognitive disabilities. The work starts from the first minute when the patient comes to us. Nurses play a vital role in drawing the individualized plan of rehabilitation for every specific client. The daily activities include daily nursing care, positioning, dressing of wounds, administration of medications, monitoring of vital signs.

1.7.11 Physiotherapy: Offers several different methods of assessment and treatment to restore normal function and minimize dysfunction. In doing so, Physiotherapists assist people with physical impairments to achieve the optimum level of health and independence.

1.7.12 Occupational Therapy: Occupational Therapy is a rehabilitation profession that collaborates with clients to enable occupation. Occupation is understood as those activities and tasks of everyday life which have meaning and purpose to people affected with physical, cognitive or affective problems. Occupation can be divided into three meaningful categories: everything people do to take care of themselves (self-care or ADL), enjoy life (leisure) and contribute to the social or economic world they live in (productivity).

1.7.13 Counseling: A social worker and a psychologist are extending a helping hand to the disabled clients and their families as well.

1.7.14 Psychological: Support in terms of counseling, reassurance are being offered to every case according to its condition.

1.7.15 Social worker: Is offering the substantial social support to the cases in a very sensitive area of their lives. The social worker also is guiding the client and his family to the community local resources of jobs, assistive devices, and medications.

1.8 CONTEXT OF THE STUDY:

This study will be conducted in Gaza strip in Palestine; therefore, the following paragraphs provide information about the geographical context, Palestinian population size, Palestinian economy, health situation and health services in addition to information about rehabilitation, rehabilitation in Gaza strip, and research sitting.

1.8.1 Geographical context:

Palestine is located in western Asia on the eastern coast of the Mediterranean Sea. It is bordered by Lebanon in north, in the east by Syria and Jordan, in the south by the Gulf of Aqaba and in the west Egypt and Mediterranean Sea. Palestine is oblong in shape. It is measuring from north to south some 430 km. Its width varies from 51 to 70 km in north and from 72 to 95 km in the middle. In the south, however, it becomes wider, extending to some 117 km. It then narrows again into a triangular shape, the tip of which touches on the Red sea (MOH, 2003).

The Palestinian areas are estimated about 28.00 square miles of the total territory or Israel. Palestine suffered from many envisions as a result of its strategic location like the Ottoman Turkish Empire prior 1917 following the British mandate period in 1948.

Thereafter, Gaza strip was under the Egyptian dominant and West Bank under the Jordanian dominant and in 1967. Jews occupation Palestine in two wars (1948 and 1967) and established there state on its land making its people spread as emigrants everywhere (see Annex 1).

In September 1993, the Palestinian liberation Organization signed an Oslo peace Agreement, Israel had to do gradual withdrawal from the west Bank and Gaza strip and that is called the Palestinian National Authority (PNA). This agreement was signed after 27 years of occupations. On 17 may 1994, Palestinians were hopeful that this process would end on independent state for them. However, following breakdown of the final status negotiations in September 2000, ALAqsa Intifada begin and Israeli violence has continued since that time. Israel has reoccupied nearly all PNA. It had ceded to the Palestinians in the West Bank during the Oslo peace process, and continues to build settlements in PNA (MOH, 2003).

PNA comprises two regions separated geographically west Bank and Gaza strip. West bank lies within an area of 5,800squared km west the Jordanian river. It has been under Israeli Military occupation, together with east Jerusalem since June 1967. West Bank is divided into four geographical regions. The north area includes districts of Nablus, Jenin and Tulkarem. The center includes the districts of Ramallah and Jerusalem, where the south areas include Bethlehem, AL-Khaliel district, and the sparsely populated Jordan valley include. Jericho. More than 60% of the population lives in approximately 400 villages and nineteen refugee camps and the reminder in Urban refugee camps and cities of which Nablus and most populous are in east Jerusalem and Alkhaliel (MOH, 2003).

Gaza strip is a narrow area and situated on the Mediterranean Sea. It's location on the crossroads from Africa to Asia made it a target for occupation and conquerors over countries where the last of these was Israel who occupied the Gaza strip from Egyptians in 1967 war. Gaza strip is a very crowded area. it is 360sequared km.The concentration of population in cities, small villages and eight refugee camps that contain two thirds of the population. Gaza Strip is divided into five governorates, namely: Gaza city, North Gaza, Midzone, Khanyounis and Rafah (MOH, 2003) (see Annex 2).

1.8.2 Population in Palestine:

In the end of 2004and according to the Palestinian central Bureau of Statistics (PCBS), the number of Palestinian population was about 3.6 million. The distribution of Palestinian population was as follows: 2.3 million (463.2%) in the west Bank and 1.3 million (36.8%) in the Gaza Strip. The highest rate of population at (13.9%) of the total population in Hebron governorate, followed by Gaza governorate (12.9%) the third area with 10.7% is ALQuds governorate and the lowest rate 1.1% of population in Jericho.

The number of Palestinian refugees in PNA is 1,541,331(42.6%). In the west Bank 656,961individuals are Palestinian refuges and they establish 28.5% out of total West Bank population. In Gaza Strip refugees are 884,376 and they establish 66.1% out of total population in Gaza Strip. According to MOH data in2004 the natural growth of population was 2.6%. In west Bank the rate reached 2.3% and 3% in Gaza PCBS estimated the natural increase rate in Palestine at 3.4% (3.2% in West Bank and 3.9 in Gaza).

The population in Palestine is 46.3% under 15 years and above 65 years, 44.4% in west Bank and 49.4% in Gaza 2% who are above 65 years, 2.2% in West Bank and 1.6% in Gaza .

The estimated number of males in Palestine at end of 2004 is 1.84 million compared with 1.79 million females. In the West Bank the number of males is 1.16 million compared with 1.13 for females but in Gaza Strip the total number of males is 676 thousand compared with 660 thousand females between 1997 and 2004, there was a slight increase in the median age of population in Palestine it increased from (16.4) years in 1997 to 16.7 years in 2004. In West Bank, the median age increased from 17.4 years to 17.7 years and, while in Gaza the median increased from 14.8 years to 15.4 years at the same period (MOH, 2004).

1.8.3 Palestinian economy:

In Palestine, during the last five years, there were high fluctuations in the Gross National Product (GNP). According to the Palestinian Ministry of Finance, the GNP was 5.454 million US$ IN 1999 and decreased to 3,720 million US $ in 2004.

Gross Domestic production was 4.517 million US $ in 1999and decreased to 3,286 million US $ in2004 .The PCBS pointed out that the number of Palestinian workers in Israel decreased from 135.000 in 1999 to 50.100 on 2004.

As a result of the bad political situation and recurrent crisis, the workers in Gaza Strip and West Bank increased from 453.000 in 1999 to 527.600 in 2004. Also the unemployment rate was 26.8% (in Gaza Strip 35.4% and in West Bank 22.9%). This percentage revealed that increase of the unemployment rate from 11.8% in 1999 to 26.8 in 2004 (MOH, 2004).

1.8.4 Health context in Palestine:

In Palestine, health services to day will not be able to meet the challenges of diseases, without available data of the prevalence and severity of Non – Communicable Diseases (NCDs) like cardiovascular diseases, hypertension diseases, Diabetes Mellitus and accidents. MOH focuses on mortality rate to estimate the impacts of these diseases. The primary Health Car (PHC) accounts the visits of the patients to their clinics that used system not computerized, which does not reflect the real prevalence or incidence. Also, there is no information about disabilities that resulting forms the chronic diseases. This scarce of information leads to inability to estimate the direct and indirect cost; other required resources such as drugs, policy and decision-making regarding prevention and treatment. On the other hand, there is available data about cancer morbidity by cancer Registry centers in both Gaza and Beitjala that play main role in documenting, reporting and classifying cancer cases. According to data about accidents are available in MOH that provides the data about mortality and in police directorate that provides information about morbidity. Although the statistical data is rare on NCDs and the bad political situations which are affecting negatively on our lives, MOH work all efforts to organize and implement a unified health strategy for the prevention and controlling these diseases. In addition, the Palestinian health authority has strength surveillance system and succeeded in preventing and controlling many on factious diseases through the effective programs of vaccination, early detection of diseases and health education of people.

Nowadays, there is remarkable improvement in the health care services, health awareness and the living standards by decline the Crude Death Rate (CDR) in Palestine

from 4.8 deaths per 1000 population in 1997 to 4.0 in 2004. The CDR dropped from 4.9 in 1997 to 2.8 in 2004 in the West Bank while in Gaza Strip the CDR dropped from 4.7 in 1997 to 3.3 in the same period. Finally, the average of CDR between 2000-2004 was 2.9. The Infant Mortality Rate (IMR) and neonatal deaths reflected the improvement of health care services according to MOH data in 2004. The average of IMR during the last five years was 22.5 (per 1000 live births). In 2004, the IMR in Gaza Strip was 20.5 per 1000 and 14 in West Bank and this leads to a longer life expectancy. The life expectancy is 72.6 years (71.1 years for males and 74.1 years for females) (MOH, 2004).

1.8.4.1Health care services:

The health care delivery system in Palestinian community is offered by several health sectors of government, the United Nation Relief and Works Agency (UNRWA) and profit and non profit private sectors with the development of governmental health insurance.

During the last years, the Palestinian National Authority developed the health care system. MOH is the major and main health care provider with other health care providers UNRWA, Medical Services for police and General Security, health services of national and international Non Governmental Organization (NGOs) and private health sector for profit. The MOH is the health authority responsible for supervision regulation licensure and control of the whole health services as PHC, secondary health care and some tertiary care. Furthermore the MOH purchases tertiary services from other health providers' locality and abroad from Israel, Egypt, Jordan and NGOs in Gaza Strip and West Bank.

The UNRWA offers health services free of charge for all registered refugees (656.961) in the West Bank and 884.376 in Gaza Strip and plays a noticeable role in many health programs like vaccination program with cooperation of MOH, additionally curative antenatal and postnatal care and other specialized services. Moreover all refugees have the right to receive health care services from MOH in addition to rehabilitation services for 2.132 inpatients during 49.800 hospitalization days. The average bed occupancy rate at the four rehabilitation NGOs hospitals in Palestine was 86.9% and the average length of stay was 23.4 days (MOH, 2004).

1.8.4.2Rehabilitation services in Palestine:

Medical rehabilitation services in Palestine began since the beginning of the first intifada in 1987. These services became a pressing necessity because of the society needs, which caused by the intifada result as a huge number of physical disables.

The medical rehabilitation services developed by non-governmental organizations as to look after the patients leaving the general hospital to continue their programs. Difficult cases were transferred to west bank hospital to take medical rehabilitation programs and they suffered a lot due transferring across many check Israel points. In addition to high costs in the bad economic situation in which the Palestinian people suffer from the Israeli army control the check points between Gaza strip and the west bank and arrested most of the victim (disabled) who used to be the leaders of the Intifada. This lead to deterioration and psychological problems for disabled individuals. More suffer was caused because the injured patient who cannot accompany relatives career with him/ her.

After Oslo agreement west bank and Gaza strip were completely separated the disabled victims suffered more. Most of victims from Gaza strip suffered more than these in west bank because there was no medical rehabilitation as in patient in Gaza strip.

Considering all these information, decision makers developed medical rehabilitation services in Gaza strip to overcome these problems and meet the patients need in medical rehabilitation in Gaza strip. Medical rehabilitation involves organizational and no-organizational based services.

1. Out reach rehabilitation programs

2. Hospital for medical rehabilitation which contain all programs, and by these programs the patients can communicate, avoid double services and wasting between the centers so from this point , WMRH idea was created.

1.9 STUDY SETTING:

This study was carried at WMRH is the first and only nationally recognized inpatient rehabilitation hospital in Gaza Strip. It is a non-stock, nor-profit Palestinian (NGO), established in 1996 to offer medical rehabilitation services to cases recovering from post acute and chronic physical and cognitive disabilities through in and outpatient departments. The hospital rehabilitation team includes rehabilitation doctors and nurses,

physiotherapists, occupational therapists, speech therapists and communication therapy specialist, and psychologist (EL-Wafa Medical Rehabilitation Hospital Leaflit, 2007).

WMRH inpatient department has a capacity of 52 beds designated for different wards, including male, female, children, and a special care unit. Incurring a disability has devastating and long lasting effects on a person. Clients, who have experienced illness or injury of any origin, may recover physically after being managed medically but if there is a disability, there will be a need to continue care and extensive rehabilitation programs to regain or resume optimal levels of independence (EL-Wafa Medical Rehabilitation Hospital Leaflit, 2007).

WMRH uses a holistic approach that sees the patient from all aspects of their problems and life situation. The hospital interdisciplinary team sets shared goals and develops an individualized plan of care for each client.

Following the client's discharge there is notification system which allows professionals at the community based rehabilitation program to further supervise our cases in the community and provide us with feed back regarding any new problem occurring to our client for the proper intervention.

On admission every client undergoes a complete assessment by the various disciplines and a plan of care is determined. This is refined periodically according to the client's progress and needs. In addition to the above mentioned services EL-Wafa hospital invite specialists for consultation in any related field of medicine when problems arise. During emergencies, EL-Wafa hospital transfer clients to other hospitals or diagnostic centers using there own ambulance, which is fully equipped to meet medical emergencies.

On discharge, the client receives a full and comprehensive report containing recommendations such as home medication, frequency of periodic laboratory examinations and medical check ups, home adaptations, assistive devices and the follow up program of physiotherapy at home if needed. Furthermore WMRH provides assistive devices and medical aids to less privileged clients who would otherwise be unable to afford them.

Furthermore WMRH provides assistive devices and medical aids to less privileged clients who would otherwise be unable to afford them. (EL-Wafa Medical Rehabilitation Hospital Leaflit,2007).

Hospital Services:

1. Medical supervision by specialized rehabilitation doctors.
2. Rehabilitation nursing department.
3. Physical therapists concentrate on mobilization, walking, major motor and sensory impairments of the limbs.
4. Occupational therapy aimed at assessment, treatment and ennoblement of independence in activities of self-care, productivity and leisure.
5. Speech pathologists address language or articulation impairments and disorders of swallowing. Cognitive rehabilitation using different techniques that stimulate the brain through the different body senses.
6. Urinary bladder rehabilitation programs using the urodynamic machine. Psychological support to disabled clients and their families as well.
7. Sexual rehabilitation.
8. Play and Recreation Therapy Unit.
9. Cognitive rehabilitation unit (EL-Wafa Medical Rehabilitation Hospital Leaflit, 2007).

Chapter TWO
Conceptual framework

Chapter TWO

Conceptual framework

2.1 Introduction

Chapter two illustrates various issues that are related to evaluation, definition of evaluation, process, purpose and steps of evaluation. The conceptual framework of the current study consists of two parts. The first part involves evaluation from patient's perspective, relationship between patient's satisfaction and health care quality and Islamic viewpoint about disability and handicapped. The second part involves evaluation from the service provider perspective, the relationship between provider satisfaction, patient satisfaction and quality of health care delivered. In addition, chapter two explains workers right in Islam.

2.2 Evaluation process:

Evaluation is an assessment of the extent to which specific objectives have been attained. It is also the act of collecting and providing information to enable decision makers to function more intelligently (Blain et al, 1997). (William ,2006) defined evaluation as a systematic acquisition and assessment of information to provide useful feedback about some object.

Sadish,(1994) argued that the definition of evaluation should encompass more than "scientific valuing" extending also to include other key activities and practices of evaluator such as seeing the evaluation is used and providing recommendations aimed at program improvement. It is important to note that evaluation serves to identify strengths and weaknesses, highlight the good, and expose the faulty, but it cannot single handedly correct problems, for that is the role of management and other stakeholders, using evaluation findings as one tool that will help them in that process Blain et al. (1997).

2.3 Purpose of evaluation:

William, (2006) mentioned that generic goal of most evaluations is to provide "useful feedback" to a variety of audiences including sponsors, donors, client-groups, administrators, staff, and other relevant constituencies. Most often, feedback is perceived as "useful" if it aids in decision-making. But the relationship between an evaluation and its impact is not a simple; studies that seem to be critical sometimes fail to influence short-term decisions, and studies that initially seem to have no influence can have a delayed impact when more congenial conditions arise.

There is broad consensus that the major goal of evaluation should influence decision-making or policy formulation through the provision of empirically-driven feedback Carter,(2008). Talmage, (1982) stated three purposes of evaluation as follows:

1. Rendering judgments on worth of a program;
2. Assisting decision maker responsible for deciding policy; and
3. Serving a political function.

Evaluation usually uses inquiry and judgment methods, including (1) determining standards for judging quality and deciding whether those standards should be relative or absolute, (2) collecting relevant information, and (3) appling the standers to determine value, quality, utility, effectiveness, or significance Blain et al., (1997).

2.4 Steps in the Evaluation Process in health settings

2.4.1 Step 1: Focus the Evaluation

The first step in evaluating any program is deciding the focus of the evaluation that establishes for the remaining steps in the evaluation process and it encompasses four parts (Georgopoulos, 1986).

1. Identify the purpose of an evaluation
2. Creating a logic model to illustrate the linkages between program elements
3. Consulting the stakeholders in the program
1. Determining the questions the evaluation will seek to answer

There is always a specific reason to evaluate a particular program or part of a program at a particular point in time. It is important to identify the broad purpose of an evaluation up front before tackling the specific details of how the evaluation is going to take place. Identifying the purpose of evaluation is helpful to avoid losing sight of the bigger picture. There are many reasons to evaluate a program such as identifying strengths, weaknesses, opportunities and threats, sharing experiences, measuring progress, improving implementation, seeing what has been achieved so far, or making decisions about which programs or aspects of a program should be continued or discontinued (Heinemann and Zeiss, 2002). In the Purpose Statement box, briefly explain in your own words why you are evaluating your program right now.

For most evaluations, it is important to have a clear description of the program to be evaluated. A logic model is a diagram of these common elements, showing what the program is supposed to do, with whom and why. A logic model summarizes the key elements of a program (components, activities, target groups, short-term outcomes, and long-term outcomes), explains the rationale behind program activities, and shows the cause-and-effect relationships between the activities and the outcomes. In addition, it helps to identify the critical questions for an evaluation and provides the opportunity for stakeholders in the evaluation to discuss the program and agree upon its description. Logic models are also a useful means of communicating the elements of a program to policy makers, staff, external funding agencies, the media and colleagues at other health units.

The evaluation questions depend on decision-making needs and flow directly out of the program logic model. They should be unique to the particular program under evaluation; specific, measurable, actionable, relevant and timely. The evaluation cannot be all things to all people. It is crucial to limit the evaluation questions to high-priority issues only(Georgopoulos, 1986).

2.4.2 Step 2: Select Method

The second step in program evaluation is select method and it encompasses three parts, namely: setting expectations, creating data collection plan and evaluation method feasibility. Step 2 will help the evaluator to determine the best way to answer evaluation questions by focusing on the specific data needed and data collection methods employed.

Setting expectations of the program for each evaluation question can be achieved by identifying what the evaluator need to know about the program or what is expected from the program to achieve. Expectations must be realistic and based on input, age of the program, experience and current outcomes. In addition, expectations should be specific, measurable, actionable, relevant and timely. Once expectations are ready, they and evaluation questions are copied into the Methods Worksheet (Centre for Surveillance Coordination Framework and Tools for Evaluating Health Surveillance Systems: March 2004)

Creating a data collection plan is achieved by identifying where the evaluator will get information, from whom and when the data should be collected, and from how many people. To create your data collection plan, reflect on the following seven questions.

1. Is all the data you need already available?
2. What type of data collection tool would provide the data?
3. Who could provide the data, if asked?
4. Who can gather this data?
5. What is the best design?
6. From how many people or things should data be collected?
7. What is the required timeframe for data collection?

When you have answered all of these questions, you will have outlined your method for collecting the data in a data collection plan.

The last part in step 2 aims to determine the logistics and feasibility of evaluation method. For each data collection tool you plan to use, it is important to consider the various tasks involved in developing the tool, then gathering and analyzing the data. Once the necessary tasks are identified, it is important to assess their feasibility given your current resources (Heinemann & Zeiss, 2002)

2.4.3 Step 3: Develop Tools

The third step in program evaluation focuses on the development of data collection tools and it encompasses three parts, namely: finding data collection tools that meet evaluation needs, developing new data collection tools or modifying existing ones and assessing the quality of data collection tools.

Data collection tools are made up of measures. Before developing new tools, it is important to check to see if there are existing measures that meet evaluation needs. Occasionally, you may even find an entire tool that you can use. Finding existing measures and tools is challenging and time-consuming, but saves time and improves the quality of your data in the long run. If there are no existing measures or tools, you will have to create a new tool. Even if you do find existing ones, you will have to make some modifications.

Whether you create your own tool or use an existing one, it is important to assess its quality. Your evaluation is intended to produce data to assist you to make decisions about your program. You must feel confident that your decision is based on consistent measures (Centre for Surveillance Coordination Framework and Tools for Evaluating Health Surveillance Systems: March 2004)

It is rare to find an entire tool that perfectly suits your needs. Most likely you will have to borrow a few measures from one or more tools. If you are not using an existing tool in its entirety, it is important to determine whether the individual measures you intend to borrow can be used on their own. Sometimes individual measures can stand alone; other times, measures are not meaningful when they stand alone. Rather, they work within a group to measure a particular concept. This is often the case for rating scales or indices which measure complex concepts like self-esteem, anxiety or quality of life. These groups of measures must remain intact. The individual measures, however, are not necessarily

meaningful on their own. Do not assume that if you use a single measure from an existing scale that you will be measuring the same concept.

Once you have put your data collection tool together from scratch, or modified an existing one, it is critical to assess its quality. There are several ways to do this such as the content and clarity test, and stability reliability test. At a minimum, you should do the content and clarity test. If your resources permit, it would also be a good idea to examine the stability reliability.

The Content and Clarity Test examines two important aspects of quality: content (Is the tool measuring exactly what you want it to measure?) and clarity (Is the tool easy to understand?). In all evaluations, you want to have confidence in the quality of your data. Therefore, the content and clarity test should always be done for new tools and existing tools that have been modified. (Heinemann & Zeiss, 2002)

The content and clarity test is a review of the tool by two different groups of people. The first group is made up of "experts" who are knowledgeable about the general topic area of the tool. Usually about three to five "experts" is sufficient. The nature of people's expertise varies from an evaluation to another. The second group is composed of people who are similar to those who will eventually provide you with real data. The number of people required varies tremendously; it depends on the type of tool and its complexity. You must decide what will make you confident that the tool is clear and that it is measuring what it is supposed to. It is generally safe to have about 10 people review it. You may need to have more if your tool has a lot of skips. On the other hand, if the tool is very simple and your respondents are very homogeneous, five is probably sufficient. Make sure that at least two people go through each line of questioning.

If you have developed new measures, it is a good idea to test their **stability reliability**. Stability reliability refers to the consistency of a measure. Examining stability reliability involves asking a sample of people to complete a data collection tool at one point in time, and then again later on. If a measure is reliable, then the data should be consistent between the two time periods (provided there haven't been any changes in whatever is being measured). It is important to check the reliability of all of the measures in your data collection tool. Some may be reliable, others may not be. Check with your evaluation specialist or epidemiologist for the numbers required and the proper analysis techniques for interpreting the results of the stability reliability test.

2.4.4 Step 4: Gather and Analyze Data

The fourth step in program evaluation includes performing logistics plan and data analysis. The first part of the fourth program evaluation step focuses on logistical details involved in data collection. This includes selecting data collectors, preparing instructions for data collection and training data collectors. It also includes the importance of pre-testing methods and assessing data collectors. In selecting data collectors, you need to know how many the project requires, what abilities, knowledge and skills data collectors must have and how you will recruit them for the project. Few data collectors are best for reliability.

The second part of the fourth program evaluation step focuses on data analysis. There are two types of data, namely: qualitative and quantitative. Qualitative data is data collected from focus groups, interviews, observation, chart reviews, and the data collected from open-ended questions. Quantitative data is data collected from the closed-ended questions on activity logs, administrative records, registration forms, interviews, surveys and records of observations. Analysis of quantitative data is performed either by hand or computer. This depends on what your evaluation questions are seeking to answer, plus the amount and type of data that has been collected. The analysis of outcome evaluation data requires statistical tests which are best done on a computer, using special programs for statistical analysis such as the Statistical Package for the Social Sciences (SPSS) (Centre for Surveillance Coordination Framework and Tools for Evaluating Health Surveillance Systems: March 2004)

2.4.5 Step 5: Make Decisions

This is the most creative part of the evaluation process. The fifth step in program evaluation includes findings interpretation to draw conclusions and decide for recommendations and, issuing evaluation report. Findings interpretation differs from data analysis. The second simply reports the facts as they were recorded while the first helps to view the findings as a whole to understand the reason(s) for the findings. Thinking and taking time to think over the key findings is the most crucial element in interpreting findings. Making decisions involves identifying question(s); collecting, analyzing and interpreting data; developing and analyzing options; and selecting the preferred options.

Identifying questions is based on the purpose of the evaluation and conclusions. There is rarely only one answer to a problem. Consider a range of alternative options and present the pros and cons of each before choosing a course of action. There are several factors that influence the selection of the most appropriate option such as resources availability and staff availability and training.

The most important decision, when you are ready to present your evaluation to others. A report of your evaluation is a critical step, because people are anxious to get on with the changes to the program. The report is a record of the evaluation that can be used by others such as other health units, the next evaluator of the program and existing program stakeholders. You may or may not need to prepare a formal written report depending on the purpose of your evaluation and the people who will use it. (Georgopoulos, 1986).

2.5 Evaluation from the clients' perspective:

The important element of quality assessment and quality improvement in health care organization is the evaluation of services from the clients' perspectives. Clients' satisfaction or perspectives may reflect their beliefs which are considered as an indicator of health care quality (Maslin, 1991).

Ware et al.(1983) mentioned that the performance evaluation is a very challenging issue and consists of several types of evaluation instruments and the more popular one is client survey that is used in order to characterize and evaluate the agencies performance from clients perspectives. In addition, researchers spoke about the evaluation elements or categories that include the general client satisfaction, the client satisfaction with services delivery and the client satisfaction with the agency work as well as the accessibility to the service. The evaluation measures also emphasize on the client perception of what occurred. Evaluations are conceder subjective and presumed to capture a personal evaluation of care that cannot be shown by observing care directly. Moreover, rating or evaluations are considered both a measure of care and reflection of the respondent because they are influenced by the care provided, but also by the patient preferences and expectations.

The clients are the service consumer and they are the main element to effectively conduct this study. The client who receives the service is able to decid effectiveness. This

reflects the concepts and values of satisfaction as the client can be either satisfied or dissatisfied. The client satisfaction is one measure used to assess the performance of health care programs and personnel (Dearmin, 1995).

Ware et al, (1983) explained the diminution of the care that develops patients' attitudes towards service delivered. The diminution involves; interpersonal manner (how clinicians interacted with their patients); technical quality (the competence and care standers of the clinician); accessibility and convenience (issues in arranging to receive medical care); finance (payments for medical care); efficacy and outcomes (maintaining health); continuity of care (provision of care through the same clinician); and service availability (the presence of medical resource within the community).

Laferriere, (1993) outlined the diminution of patients satisfaction as technical quality of care, communication, personal relationships between client and provider, and delivery of services. Williams and Calnan, (1991) explained both technical aspect of care as equipment, competence, accessibility, continuity, compliance, pain management, waiting and consultation time. Interpersonal aspect of care includes information, decision sharing and attitude. These aspects are indicators for patient's opinion in services.

Schwarze et al. (2008) reported in their study about empowerment of patients through providing information and teaching skills and techniques to improve self-care and doctor-patient interaction with the ultimate goal of improving quality of life. Patient education and self-management programs have been supported through several national government initiatives and implemented within the healthcare setting. Assessment questionnaire used in Australia for the evaluation of self-management programs, the "Health Education Impact Questionnaire".

2.6 Patient satisfaction as an indicator of quality of care

Patient satisfaction remains an important concept for health care providers. Health care providers can no longer rely on sources of information that omit the patient's perspective in the definition of quality of health care (Nelson, 1990).

Consumer satisfaction, in its widest sense, is seen as being complex process balancing consumer expectations with perceptions of the service or product in question (Newsome, 1999). Campen et al. (1995) added, surveying the literature on the assessment of quality of care from the patient's perspective, the concept has often been operational definition as patient satisfaction. Patient satisfaction has been a widely investigated subject in health care research, and dozens of measuring instruments were developed during the past decade. Quality of care from the patient's perspective, however, has been investigated only very recently, and only a few measuring instruments have explicitly been developed for the assessment of quality of care from the patient's perspective. Both authors Newsome, (1999) & Campen , (1995) considered patient satisfaction as an indicator of quality of care from the patient's perspective.

Quality of care continues to be a major concern for health care providers and a major focus for health services research. Although many operational definitions of "quality of care" focus on the personal knowledge, skills and expertise of the clinician rather than on other aspects of the treatment experience, patient satisfaction, in our opinion, constitutes a dimension of care outside of the physical therapist's immediate control. Yet, technical quality and patient satisfaction are synergistically linked to influence the outcomes of care. Therefore, in light of the hypothesized relationships among the technical expertise of the care provider, the experience of the person receiving the care and how that person values care and measures of outcomes of the care provided, any comprehensive formulation of an operational definition of "quality" in health care should state that patient satisfaction is a necessary construct (Donabedian, 1988 & Elliot, 1992)

When patients' expectations of care are exceeded, their level of satisfaction is high. Likewise, if expectations of care exceed actual delivery, dissatisfaction will result. Satisfaction, therefore, is always relative to the patient's expectations. Satisfaction changes

when the patient's expectations or standards of comparison change, even though the object of comparison (the actual health care received) may stay constant. Thus, satisfaction measures, although they may be objective (for example, have reliability), are actually reflecting subjective phenomena and are quite distinct from other types of evaluation of the provision of care (Goldstein et al, 1999).

In addition to the importance of a patient's level of satisfaction with care as part of the patient-therapist relationship, maintaining a high level of patient satisfaction may also have an economic impact on the clinician. Patients who are satisfied with the services they have received are more likely to remain loyal to the provider such as therapist (Goldstein et al, 1999).

Review of the theoretical and empirical work on patient satisfaction with care, the most consistent finding is the characteristics of providers or organizations that result in more "personal" care are associated with higher levels of satisfaction. Some studies suggest that more personal care will result in better communication and more patient involvement, and hence better quality of care, but the data on these issues are weak or inconsistent.

Consumer satisfaction with healthcare has, in recent years, gained widespread recognition as a measure of quality, especially since the publication of the 1983 NHS Management Inquiry and its call for the collation of user opinion (NHS Management Inquiry, 1983). This has arisen partly because of the desire for greater involvement of the consumer in the healthcare process and partly because of the links demonstrated to exist between satisfaction and patient compliance in areas such as appointment keeping, intentions to comply with recommended treatment and medication use.

Vuori, (1991) study aimed to investigate the possible impact on care quality with implemented measures of patient satisfaction and whether patient satisfaction should be taken seriously as it is not know whether its measurement improves the quality of care. The researcher admitted the fact that the patients are partners in health care; they literally feel in their skin whether care received is good or bad. They are also the best judges of certain aspects of care such as amenities and interpersonal relations. The second reason is the transformation of health care from a sellers 'market to a consumers' market where the satisfaction of the patients needs is part of the definition of quality. Finally, there is the

ideological reason that in a democratic society the patients should have the right to influence decisions and activities influencing them. Measurement of patient satisfaction realizes the principle of community participation in health care.

Massoud, (1994) analyzed the quality of health care system in Palestine and highlighted the quality defect, which is reflected in the inefficiency of health care system to deliver quality care. He reported that there is general dissatisfaction among public and professionals regarding quality of health care in Palestine. Also he indicated that one of the major problems in Palestine health care system is lack of consideration of client's satisfaction. The researcher (Massoud) pointed that once clients had entered any Palestinian health care setting, he had to follow the system utilized there blindly and did not possess any right to ask, discuss or refuse treatment. Moreover, he stated that there is discomfort among public, politicians and health professionals in Palestine regarding the quality of health care. This discomfort has been demonstrated on recurrent clashes between public and health professionals, miss trust and bad communications among providers and clients.

2.7 Domains of patient satisfaction:

Wilde et al. (1993) developed a theoretical understanding of quality of care from a patient perspective using a grounded theory approach. Thirty-five interviews were conducted with a sample of 20 adult hospitalized patients (mean age: 60 years) in a clinic for infectious diseases. Patients' perceptions of quality of care may be considered from four dimensions: the medical-technical competence of the caregivers; the physical-technical conditions of the care organization; the degree of identity-orientation in the attitudes and actions of the caregivers; and the socio-cultural atmosphere of the care organization.

Several researchers (Nelson, 1990, Keith, 1998 & Davies, Ware, 1991) have posited that patient satisfaction is a multidimensional concept. Recent research (Edgman-Levitan, 1996) has indicated that little is known about which information is most important to consumers when making decisions regarding the selection of health care providers. Different types of consumers likely have different needs. Although there is no "gold

standard" for the measurement of patient satisfaction, recent research by (Nelson, 1990) is helpful in determining the areas that comprise patient satisfaction. Nelson, (1990) performed a content analysis on surveys from 18 selected health care institutions and attempted to match questions to indicators of quality as described by (Donabedian, 1996). Based on this framework, the researcher concluded that access, administrative technical management, clinical technical management, interpersonal management, and continuity of care are the domains that define patient satisfaction.

2.8 Measurement of patients' satisfaction:

Lock, (1983) defined satisfaction as "a pleasurable or positive emotional stat resulting from the appraisal of ones job or job experience". In order to measure patients' opinions of service in each domain (Goldstein, 1999) used 5-point Likert-type scales that ranged from "strongly disagree" to "strongly agree". The Likert-type scales were selected based on advantages cited by Ware and colleagues, who believed that this type of scale facilitates the task of survey completion for the respondent and allows the developer to more easily, revise the survey instrument.

2.9 Disability and Handicapped in Islam

Allah has mentioned in Quran "O people, we created you from the same male and female and rendred distinct people, that you may recognize one another. The best among you in the sight of Allah is the most righteous one." (Al-Hujurate: 13)

Islam provides guidance to mankind in all aspects of life and it urges Muslims to exert every effort to seek guidance. Therefore, a Muslim is always encouraged to pursue the truth. Allah has created people in different races, colors and having various abilities. While some of them are given certain gifts, others are deprived of these gifts and thus are disabled. This is the nature of life, according to the Divine Wisdom through which Allah governs everything.

Sheikh Yusuf Al-Qaradawi states: [In fact, man's life is a full record of hardships and tribulations. In this sense, Allah says: **"We** create man from a drop of thickened fluid to test him**"** (Al-Insaan: 2). When man looks upon these tribulations and afflictions as being a test from Almighty Allah to see his true colors, he will come to know that there is a great Divine wisdom behind all these tests. This is surely an absolute fact, whether we know it or not.]

It is also a great thing that Almighty Allah, when depriving a person of a certain ability or gift, compensates him/her for it, by bestowing upon him/her other gift that he excels others. That is why we see that those people who are deprived of sight, have very sensitive ears that they can hear very low beats or movements around them. Almighty Allah gives them excellence in many other abilities to compensate their imperfection.

Adopting this view of great Islam about disability surely provides rest and contentment to a person with the test posed on him/her by Almighty Allah. Every person should bear in mind that he can never change his inability or escape Allah's fate and thus he should try his best to make his life better by being motivated and creative. A disabled person should perceive inability as a motive to creativity and excellence in any field of life. A disabled person should make his condition an impetus towards being distinguished and prominent in the society.

In order to be an active member in the Islamic society, a handicap needs to be fully aware of his disability and surrounding challenges. The Islamic society must offer a helping hand to all those people with special needs. Islamic history has a shining record of endless examples of people who, while having some kind of disability, occupied very excellent positions and prominent status in the society. `Atta Ibn Abi Rabah, who was known of being black, lame and paralyzed person, was the greatest Mufti in Makkah. He was highly honored by `Abdul-Malik Ibn Marawan, the Muslim caliph of that time. His vast knowledge earned this prestige.

When looking at the Qur'an and Hadiths, Islam does not differentiate between the 'able' and the 'disabled'. Abdullah Ibn Umm Maktum was blind**.** He was among the first to accept Islam, and he was so devoted to the Prophet and so eager to memorize the Qur'an that he could sometimes appear to monopolize the attention of the Prophet. From that day

the Prophet did not cease to be generous to Abdullah. He often greeted him with words of humility: “Welcome unto him on whose account my Sustainer has rebuked me.” And when the Prophet arrived in Medina, he appointed Abdullah and Bilal to be Muezzins five times a day. On several occasions, the Prophet placed Abdullah in charge of Medina in his absence.

Despite being excused on account of his disability, Abdullah Ibn Maktum insisted on fixing a role for himself on the battlefield. He said, “Place me between two rows and give me the flag. I will carry it for you and protect it, for I am blind and cannot run away,” which shows how a blind Muslim thinks positively of his disability and even uses it to serve Islam! After such acts of bravery in numerous battles, Abdullah was martyred in the great battle of Qadisiyah where Muslims achieved a smashing victory; he died clutching the flag, carving a place for himself as an eternal hero. Today when his name is mentioned, the bravery and dedication are remembered, not the disability.

The great Companion `Amr Ibn Al-Jamooh is another example. He was lame and very old. His four sons, when participating in Jihad, said to him: “You have an excuse to remain at home, for you are old and you have a kind of disability.” With full confidence and trust in Allah, he said to them: “Nay, for I hope to walk in Paradise with my lame foot.” Commenting on this, the Prophet, peace and blessings are upon him, said to them: “Leave him! He is a man who seeks martyrdom.” Muslims should integrate and include those disabled in Islamic community and deal them with in the kindest way.

The Islamic government and society have an obligation to provide people with special needs with necessary services as equal as with non-disabled such as schools, rehabilitation, assistive equipment and environment adaptation so that they become good members of the society and that they benefit themselves and their families. According to the teachings of Islam, Muslims should cooperate and collaborate to provide the utmost care to those disable people, for, those persons are sources of Divine mercy and blessings being showered on us now and then. They are the weak for whose sake we are given sustenance and made victorious. In his Hadith, our Prophet, peace and blessings be upon him, said: “You are given sustenance and victory for the virtue of those who are weak amongst you.” (Sahih Al-Bukhari: 2681) We, should show mercy and care to the disabled out of both human and religious motives. In Islam, we are commanded to show mercy to

everything in this world. In the Hadith: “Show mercy to those on earth so that he who is in the heavens (i.e. Allah) bestows mercy to you.” (Sunan Abu Daoud: 4290)

According to another hadith by Al-Bukhari (5210) and Muslim (4670), disability could also be seen as a way of having one’s sins removed: “The Prophet (pbuh) said: "No fatigue, nor disease, nor sorrow, nor sadness, nor hurt, nor distress befalls a Muslim, even if it were the prick he receives from a thorn, but that Allah expiates some of his previous sins for that." http://www.ukim.org/imam.asp?CatID=17 .

2.10 Evaluation from the service provider perspective:

Employees need to know that they are valuable members of an organization. They must be respected from their administration by creating an environment that promotes job satisfaction, increases motivation and performance which contributes to higher quality of care and clients satisfaction. Lack of career perspective means lack of content related development (Logan et al, 1997).

Job satisfaction is one of the best researched concepts on work and organizational psychology for at least two reasons. First, job satisfaction is relevant for all those who are interested in the subjective evaluation of working conditions such as responsibility, task variety or communication requirements because job satisfaction is supposed to be strongly caused by such conditions. Secondly, job satisfaction is a major concern when ever outcome variables such as absenteeism, organizational inefficiency such as counterproductive behavior, are dealt with. Job satisfaction is placed as a central in work and organizational psychology which mediates the relation between working conditions in one hand and organizational and individuals outcomes on the other hand (Dormann & Zape, 2001).

Gamal, (2008) highlighted the importance of cultural diversity where attitudes and perception of job satisfaction may differ considerably. He stated that individuals may have much high satisfaction with many facets of their job but still feel overall dissatisfaction on the other hand.

Luthans & Sommer, (1999) conducted a study about managers and service providers in rehabilitation hospitals. They found that limited experience did not affect traditional organization level attitudes such as satisfaction and commitment. (Koustelios et al, 2003) found that there was a positive relationship between job security and job satisfaction. Particularly, job security was correlated with pay, promotion, job itself, and the organization as a whole.

DeVaries et al. (1998) in their study found that a positive relationship with supervisors may influence positively the job performance of employees and increase their motivation to increase their performance. Thabet, (2004) used a cross-sectional study to assess job satisfaction among hospital manager in different level of management and investigate the relationship between job satisfaction and other factors influencing job satisfaction. She found that the overall satisfaction among manager was rated as 66%. Diab, (2002) assessed the level of satisfaction among dentist and investigated the factors that have relation to job satisfaction. Self administer questioner was employed. Results showed level of job satisfaction was relatively high; 76.2%.

Many researchers identified three major perspectives about variation in job satisfaction among workers: personality differences, organizational differences and value differences (Locke, 1983 & Logan et al, 1997).

Lepnurm & Rein, (2006) pointed out that there is a substantial portion of the variance associated with career satisfaction among surgeons and psychiatrists in Canada. They used a sample of 4958 physicians across Canada, 2810 (56.7%) completed a 12-page survey between January and March 2004, following which the responding 148 surgeons and 231 psychiatrists were selected for this study. Results showed the models explained 90.4% of the variance in career satisfaction for surgeons and 81.0% of the variance in career satisfaction for psychiatrists.

DeLisa et al. (1997) evaluated physiatrist career satisfaction and current practice patterns. The 208 questionnaires (52%) returned revealed respondents' level of satisfaction with career choice, current practice, relationships with other physicians, their own residency training, and problems experienced that impede their practice. Factor analysis identified six areas of satisfaction: time demands, organizational support, current practice, current specialty, profession, and training. Problems with work consisted of four factors: external intrusions into practice, having to deal with non-rehabilitation problems, dealing with physical medicine and rehabilitation problems, and insufficient time for patients. Results showed that 75% of physiatrists were satisfied with their practice/profession. Satisfaction with current practice was greater with fewer external intrusions into practice, a larger percentage of income from traditional non-managed pay sources (including Medicaid), and variation in satisfaction was not significantly correlated with size of community, variation in rates of pay denials, workloads of greater than 50 hours per week.

Eker et al.(2004) investigated the level of job satisfaction among physiotherapists and identified the best predictors of job satisfaction. A self-administrated questionnaire survey was conducted in September 2003. Data were collected from 198 physiotherapists in 13 health care settings (five university hospitals, seven government hospitals, and one municipality hospital) located in Ankara, Turkey. Respondents were asked to complete a 31-item job satisfaction questionnaire. The response rate was 79.8%. The percentage of satisfied physiotherapists was 45.5%.

Aliu, (2006) examined the effect of socio-demographic, job, and attitudinal characteristics on overall job satisfaction and its various dimensions. Using findings from a statewide study of satisfaction and retention of 294 direct care staff in 39 assisted-living facilities (ALFs) in Georgia. The results showed that age has a negative effect on promotion satisfaction. Whites are more satisfied than non-whites with overall job, work, supervision, and payment. Urban workers are less satisfied with overall job, supervisor, coworker, promotion, and pay than their rural counterparts. Education negatively affects coworker satisfaction. Workers with children are less satisfied with supervisor relationships and pay than childless persons. Pay is positively associated with pay satisfaction.

A study of 3024 registered nurses (RNs) in 39 private psychiatric hospitals reveals that registered nurse working nights shifts are significantly less satisfied than those working other shifts (Aronson, 2005).

2.11 Service provider satisfaction as an indicator of quality of care

Employees need to know they are a valuable member of an organization, and are respected for their contributions. (Rau, 2007) pointed out that employee satisfaction - or lack of it - hinges on a productive, fulfilling relationship between staff and management; indeed, the success of any organization depends on staff members who enjoy their jobs and feel rewarded by their efforts. Ultimately, of all the people in the marketplace, healthcare consumers may suffer the most when this vital success factor is lacking.

foster, (1999) perceived the relationship between employee and employer as a psychological contract. This contract is based on the employee carrying out certain workplace duties in exchange for the employer meeting certain employee needs. An employer has the right to expect that an employee carry out duties in a competent and appropriate manner. The employee needs recognition and proof of his value with satisfactory monetary compensation.

Rathert & May, (2007) examined how work environment variables should be related to both nurse and patient outcomes. Specifically, we proposed that health care work units with climates for patient-centered care should have nurses who are more satisfied with their jobs. Such units should also have higher levels of patient safety, with fewer medication errors. Finding showed the nursing who perceived their work units as more patient centered were significantly more satisfied with their jobs than were those whose units were perceived as less patient centered. Those whose work units were more patient centered reported that medication errors occurred less frequently in their units and said that they felt more comfortable reporting errors and near-misses than those in less patient-centered units.

Michael et al. (1999) stated that satisfied employees tend to be more productive, creative and committed to their employers. Recent studies have shown a direct correlation between staff satisfaction and patient satisfaction. Family physicians who can create work environments that attract, motivate and retain hard-working individuals will be better positioned to succeed in a competitive health care environment that demands quality and cost-efficiency. What's more, physicians may even discover that by creating a positive workplace for their employees, they've increased their own job satisfaction as well.

Arne, (1977) examined the relationship between job satisfaction and the work values and job rewards associated with six dimensions of work; intrinsic, convenience, financial, relations with co-workers, career opportunities and resource adequacy. It is found that work values have independent effects on job satisfaction. The extent to which workers are able to obtain perceived job rewards is conceptualized to be a function of their degree of control over their employment situations.

Kurata et al. (1992) in a study that compared patient and provider satisfaction with medical care and waiting time in a large family medicine residency program. Result showed that in general 97% of patients and 89% of providers were satisfied with the overall medical care provided at the family health center. Approximately 8% of patients and 22% of providers were dissatisfied with waiting time, and 11% of patients and nearly 60% of providers were dissatisfied with appointment scheduling.

Jennifer et al. (2000) used cross-sectional surveys of patients and physicians to examine the relation between the satisfaction of general internists and their patients. The results showed after adjustment, the patients of physicians who rated themselves to be very or extremely satisfied with their work had higher scores for overall satisfaction with their health care (regression coefficient 2.10; 95% confidence interval 0.73–3.48), and for satisfaction with their most recent physician visit (regression coefficient 1.23; 95% confidence interval 0.26–2.21). In addition, younger patients with better overall health status and/or cared for by a physician who worked part-time were significantly more likely to report better satisfaction with both measures. Minority of patients and those with managed care insurance also reported lower overall satisfaction.

Newman et al. (2001) dealt with complex issues of nurse recruitment, retention, healthcare quality and patient satisfaction and found that nurse with satisfaction lead to better quality of patient care and satisfaction.

Akgun, (1990) identified problem areas that needed improvement so that we could create a healthier and open working environment leading to better employee satisfaction. A cross-sectional design was employed among 2500 staff at two different Baskent University hospitals. The results showed that employee satisfaction was correlated with patient satisfaction surveys performed in the same period and the result is close to 1 (Pearson coefficient = 0,93), indicating a good level of correspondence between one and the other.

Atkins et al. (1996) mentioned that there is a strong relationship between employee satisfaction and patients' perceptions of the quality of their care, measured in terms of their intent to return and to recommend the hospital to others. Employee dissatisfaction can negatively affect quality of care and have an adverse effect on patient loyalty and, thus hospital profitability. Therefore, health care marketers should regularly measure employee satisfaction as one way to monitor service quality.

2.12 Factors related to service provider satisfaction.

Literature review revealed that factors affect provider perspective include age, six, address, marital status, work experience, education, team work, environment, communication, organizational policy, salary and culture.

2.12.1 Age, years of work and job satisfaction

Diab, (2002) pointed out that age was significantly related to job satisfaction. The old dentists were more satisfied than younger as they receive allowances and motivations. (Shugers et al, 1990) reported that workers become more satisfied by getting old and adapted to work and receiving allowances. (Al-Ajmi, 2001) in a study of Saudi petroleum industry manager who found that mangers aged 31-45 years old were significantly more satisfied with their job in general than those thirty or younger.

In literature review, minor difference between gender and satisfaction factors had been found. (Shoaf & Gagnon, 1980) compared women pharmacist's job characteristics,

salary, benefits, and job satisfaction to those of their male colleagues. There was no difference in job satisfaction between two genders.

Rout, (1999) examined the source of stress associated with high level of dissatisfaction and mental health among practice manager and women general practitioners. The result showed that male employees had higher rank and higher task, team, and statues satisfaction than female employees.

2.12.2 Salary and reward

The most significant relationships that were found within the pay or salary in the Maslow's hierarchy of need ranked the salary with the basic physiological needs.

Sager et al. (1989) stated that pay has been often mentioned as motivator for performance and determinant of job satisfaction. (Lambret et al, 2001) in the study of American workers found that financial reward were positively related to job satisfaction.

Logan et al. (1997) agreed with many studies in western countries that the income was the second factor of job dissatisfaction. (DeLisa et al, 1997) in their study found that satisfaction with current practice was greater with fewer external intrusions into practice, a larger percentage of income from traditional non-managed pay sources.

2.12.3 Education level

The findings regarding the relationship between education and job satisfaction were contradictory. Some researchers stated that education has little impact on job satisfaction. Some studies show that people with higher education are more satisfied (Agho et al. 1993) whereas others suggested that people with higher education are less satisfied (Burris, 1983).

2.12.4 Burnout

Resnick & Dziegielewski, (1996) reported the results of a study conducted in 1993. Participants in the study were 144 social workers and other health professionals (who perform discharge planning functions) in short-term medical treatment settings. Due to numerous unplanned therapeutic terminations common in these facilities, an overall

correlation between therapeutic termination issues and worker satisfaction was preformed. A positive relationship between these two variables was found.

DeLisa et al. (1997) in their study evaluated physiatrist career satisfaction and current practice patterns. They emphasized that the workloads of greater than 50 hours per week causes dissatisfaction.

2.12.5 Supervisors:

De vries et al. (1998) found that a positive relationship with supervisors may influence positively the job performance of employees and increased their motivation to do work. (Darwish, 2000) in study of 474 employees from 30 facilities in United Arab Emirates showed that affective commitment mediates the influences of satisfaction with working conditions, payment, supervision and security on both affective and behavioral tendency attitudes toward change.

2.12.6 Organization culture

The organization culture is general concept which is difficult to define or explain precisely. It includes traditions, values, policies, mission, philosophy, plan, beliefs and attitudes that constitute a pervasive context for every thing we do and think in a facility of health (Diab, 2002).

Smircich, (1983) debated, although people may not be aware consciously of culture, it still has a pervasive influence over their behaviors and actions. Every facility has its own unique culture and most large facilities have mixed culture. Different people enjoy working in different types of organizational culture and they are more likely to be happy and satisfied at work if their attributes and personalities are consistent with the cultures of that part of the facility in which they are employed (Green, 1997). Lassen, (1997) & Warren, (1998) found that the collaboration decreased the cost of care, increased the quality of care of patients and increased the satisfaction of health professionals. (Gooley, 2001) found that the primary reasons cited for job satisfaction were employee discomfort with or misunderstanding of the culture and general lack of sense of belonging.

2.12.7 Job security

Job security on of the factors that affecting employee work performance and belonging. (Tovey & Adms, 1999) used a sample of 130 nurses from the English National Health Services. They founded that there was relationship between lack of job security and job satisfaction.

2.13 Workers' rights in Islam

Almighty Allah says in the Qur'an: O you who believe, stand out firmly for justice, as witnesses to Allah, even as against yourselves, or your parents, or your kin, and whether it be (against) rich or poor: for Allah can best protect both. Follow not the lusts (of your hearts), lest you swerve, and if you distort (justice) or decline to do justice, verily Allah is well acquainted with all that you do (An-Nisaa' 4:135). Justice and fair dealings are basic values of Islam that must be always emphasized among all people as it is necessary to achieve peace and harmony in the society.

Islam praised the notion of work, and stressed that the one who works to sustain his living is more pious than the worshiper who worships day and night and who has the ability to work but relies on others for his sustenance. The truest example of this concept is the fact that all God's prophets worked to sustain themselves.

Islam has given high regard for work and has regulated the rights and duties of the employer and employee. Those who work and earn their living by their own labor must be respected. Of course, the work has to be lawful and it should be done in an honest and sincere manner. Employers and employees all must be honest and must deal with each other justly. On the treatment of workers there are general and specific teachings in Islam. (History on Islam, 1999).

- **Clear and proper agreements**. All agreements, whether oral or written, must be clear and transparent. The agreements must be just and lawful. Employees should know their duties and responsibilities and they should be told their rights such as

vacations, leaves and compensations. Allah says in the Qur'an: O you who believe, fulfill your contracts (Al-Ma'idah 5:1). It is the duty of both the employers and the employees to fulfill their agreements to the best of their capacities.

- **The dignity of workers.** Islamic law allows all human beings the right to enter upon any lawful profession or occupation and to conduct any lawful trade or business. The workers should be treated with dignity and honor. No work is tedious or degrading. Our Prophet (peace and blessings be upon him) kissed the hands of a laborer who showed him his rough hands due to his hard labor. He prayed for him and spoke very highly of those who labor over against those who sit idle or go begging. Islam teaches that workers should be treated with kindness. In the Qudsi Hadith, Allah says, "O my servants, I have made injustice forbidden on me and I made it forbidden for you among yourselves, so do not engage in oppression or injustice." Prophet Muhammad, peace and blessings of God be upon him, said, "Beware of committing injustice because injustice turns into a punishment of darkness on the Day of Judgment." (Sahih Hadith; Sahih Muslim: 4674)
- **Kindness to workers**. Workers are our brothers and sisters. They are our helpers. We need them; we depend on them for many things that we cannot do for ourselves. Workers should not be given work beyond their capacity. They should have a humane and safe environment for work. They should be compensated if they are injured on the job. They should have time for work and time for themselves and their families. Children or minors should not be used for labor. Women should have proper environment for hijab without jeopardizing the rules of khalwah (privacy). They should not be employed in vocations that are unsuitable to their gender, and they must be ensured maternity benefits in their employment. Prophet Muhammad, peace and blessings of God be upon him, said, "When your cook or servant brings your meal to you, if you do not invite him to sit with you and eat, at least give him some of the meal to take. After all, it was he who prepared it." (Bukhari Collection)
- **Proper and timely wages.** Workers should be given proper and just wages. Exploitation of any person is not allowed in Islam. The Prophet Muhammad (peace and blessings be upon him) said, "Give to the worker his wages before his sweat dries" (Ibn Majah: 7576). Al-Bukhari mentioned that Prophet Muhammad said, "Allah said, 'I will be an opponent to three types of people on the Day of Resurrection: one who makes a covenant in My name but proves treacherous; one

who sells a free person and eats his price; and one who employs a worker and takes full work from him but does not pay him for his labor'".

- **Freedom to form unions**. Based on all the above principles, we can also infer that workers in Islam have a right to exercise the freedom of association and the right to form unions. Special trade unions and associations help workers in their work and socialization. They can also help workers to seek justice for their rights and bargaining power to receive proper compensations. However, employers and employees all must fear Allah in the exercise of their rights and duties. (History on Islam, 1999).

2.14 Rehabilitation :-

There is no doubt that rehabilitation professionals work hard towards promoting and normalizing lives of those people who lost some of their abilities as walking ambulating, seeing, hearing and talking to maximal level of independence.

For some people with intensive & special needs, rehabilitation is also play a life saving role hence it prevents complications and deterioration of patient's conditions.

2.14.1 What is the rehabilitation?

According to the World health organization (WHO): rehabilitation is a problem solving and educational process aimed at reducing the disability and handicap experienced by someone as a result of disease (WHO 1980).

Impairment:

Any loss or abnormality of psychological, physiological or anatomical structure or function (World health organization (WHO) classification)

Disability:

Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner, or within the range considered normal for human being. (World health organization (WHO) classification)

Handicap:

A disadvantage for an individual resulting from an impairment or disability, that limits or prevents the fulfillment of a role that is normal (depending on age, sex and cultural factors) for that individual.

(World health organization (WHO) classification.1980)

2.14.2 History of Rehabilitation

The seeds of rehabilitation were laid down during the First World War, when Thousands of handicapped people were discharged from hospitals with many deficits and without improvement in their motor and sensory abilities. While at community, these survivors developed various complications and they were repeatedly re-admitted to hospitals and a high percentage of them died within 5 years after the initial injury. To prevent these complications and to increase their life span, simple programs of physical therapy and nursing care were started, and by time it developed and grow and added new rehabilitation disciplines after the 2nd world war (Umphred, 1995).

Proper Rehabilitation as a specialty began in 1936 under the name of Rehabilitation Medicine at the Mayo Clinic, USA to treat impairments or disabilities arising from the musculoskeletal and neurological diseases or problems. The American Academy of Physical Medicine and Rehabilitation (AAPM&R) was founded in 1938 and the American Board of Physical Medicine and Rehabilitation was recognized in 1947.

After World War II, as millions died and tens of thousands of severely disabled veterans began to return home and looked for ways to lead productive lives once again, the need for this specialty grew rapidly and its mission was focused to enhance and restore functional ability and quality of life to those with physical impairments or disabilities. (Philippine Academy of Rehabilitation Medicine, 2009).

On 1944 the 1st center of SCI rehabilitation was established in the UK (Stock Mandeville Hospital) due to the huge numbers of veterans with spinal cord injury, but in the USA, Rehabilitation started some time earlier by some physicians using simple physical modalities and advocated their treatment with fresh air, water and exercise. Those physicians were considered as quack doctors.

In fact, in 1912, Rehabilitation was formally started at the University of Pennsylvania. The first Professor of Physical Therapy at the University of Pennsylvania was Dr Tait McKenzie, who led a private practice in orthopedic surgery throughout his career. Inside this university, the orthopedic surgeons were often the first to recognize the need for new approaches in the treatment of disabling conditions, from fractures and dislocations to arthritis and paralysis.

From 1914-1919, the course Physical Therapy at the University of Pennsylvania Medical School, was described as consisting of 18 lectures given by McKenzie, plus six hours of demonstrations in hydro- and thermotherapy given by Mrs. Nylin who is a trained masseur. Nylin was a graduate of the University of Pennsylvania who served as McKenzie's assistant and succeeded him at the University Hospital when he retired.

Rehabilitation reached it's maturity and started to target the needs of those people who are discharged home with handicapped during 1980s and is now considered to be a main specialty of medicine with different subspecialties.

2.15 Rehabilitation services in Palestine

In Gaza strip, Rehabilitation has a different story, just after the 1st Intifada begun, there was a rise in the interest in Rehabilitation as hundreds of patients started to accumulate with multiple physical disabilities handicaps and they were in dire need for Rehabilitation. There were no rehabilitation centers inside Gaza strip except for some OPD clinics offering physiotherapy sessions only. So if a disabled man or women wishes to receive a comprehensive rehabilitation service, he or she has to travel out Gaza strip, to the west bank, to Israeli hospital or abroad where the cost of treatment is so high and clients are surround by a different environment in a foreign land and not forgetting the great suffering while getting for security permits and over check points. For those who can't travel, they have to succumb and face the complication of their disabilities and they represent the majority of the sector of the society.

To meet this direct need for rehabilitation services, the idea of establishing a center which can offer such comprehensive services came to the minds of decision makers at El - Wafa Charitable Society. Thereafter in 1995, the decision makers established the first center of rehabilitation in Gaza Strip which is the El-Wafa Medical Rehabilitation Hospital. WMRH provides a comprehensive rehabilitation services to disabled clients in Gaza Strip while these clients are living among their families.

During the second Intifada in the Palestinian territories in 2000, the Gaza Strip was divided into five separate, small and surrounded regions. Escalating violence by Israeli solders against unarmed Palestinian people and the use of internationally prohibited weapons against unprotected civilians as well left tens of thousands of victims; martyrs, injured, handicapped and prisoners. Therefore, the need for rehabilitation programs rapidly increased. WMRH had a generous initiation toward our people where it provided services for injured and handicapped through inpatient, outpatient and outreach programs. Outreach programs covered many areas such as Rafah and Khanyoniss.

WMRH is a non-stock, non-profit Palestinian NGO, established in 1996 to offer medical rehabilitation services for cases recovering from post acute physical and cognitive disabilities through in and out patient departments. The Rehabilitation team includes rehabilitation doctors, nurses, physiotherapists, occupational therapists, speech and communication therapy specialists and psychologist. The capacity of inpatient department is 50 beds, designated for different wards, including male, female and children. After discharge of the clients a notification system allows professionals at the community based rehabilitation program to follow-up patients after discharge.

Currently, there are many facilities working in the field of rehabilitation of SCI individuals within the Gaza Strip. These facilities are governmental, non-governmental (NGO), UNRWA and military. There are some private clinics as well. There are also many CBR programs working in the Gaza Strip with the aim of community inclusion or integration of handicapped. (face interview, 2008).

Community based rehabilitation (CBR) in the West Bank and Gaza Strip aims to improve the quality of life of disabled individuals through increasing of their participation in the local activities and services, providing them equal opportunities, assurance of their rights and improving delivered services.

The CBR in the West Bank and Gaza Strip was established in 1990 by a team that formed from seventeen Non-governmental Organizations (NGOs). These NGOs have been working many years in the field of primary health care and rehabilitation in different zones and local communities. Currently the CBR has four regional programs: three in the West Bank and one in the Gaza Strip.

Each region manages its program; therefore, it performs program planning, controlling, supervision and staffing through a committee that is formed from participating NGOs, two members from each one. The program manger in each region is accounted into by its own community and he/she has three assistant supervisors; middle management level. These assistant supervisors support, facilitate and coordinate the activities of rehabilitation workers. Rehabilitation workers are and must be selected from the local community where they work and they activate their communities to manage disability

problems with the aim to develop community and support disabled individuals and their families.

The central program office which involves in its staff general program coordinator, manager from "Diakonia NAD" and two managerial assistants work to support, coordinate services and link strongly the four regional programs. The CBR is funded by Diakonia NAD and Norwegian Institute for Disable Individuals.

The CBR currently is active in 94 sittings and provides services to 500,000 populations. The CBR has two phases, based on development plans. The first phase was based on vertical and central development of the program and it finished. The second phase is based on the horizontal and non-central development. These strategies are hoped to meet the expected ongoing community development and enable local communities to manage their CBR. The regional communities will continue the endeavors of training, coordination and development of CBR delivered services.

Currently, there are different societies working in the field of rehabilitation of the individuals with SCI in the society, many governmental and non-governmental clinics in each area in GS, PT clinics related to government and UNRWA and Private clinics. Also, There are many societies working in the CBR programs in GS, towards reintegrate them in the society and to live there life normally.

2.16 Summary

The researcher defined the evaluation process which is a main aspect in the present study. According to the literature reviewed, evaluation has different definitions. The researcher defines evaluation as an assessment of the extent to which specific objectives have been attained. It is also the act of collecting and providing information to enable decision makers to function more intelligently. Evaluation involves five steps, namely: Deciding the focus of the evaluation that establishes for the remaining steps in the evaluation process; selecting method; Development of data collection tools; Performing logistics plan and data analysis; and Findings interpretation to draw conclusions and decide for recommendations and, issuing evaluation report.

Patients reflect the ability of service providers to meet their needs. Effective and efficient health care delivery depends on proper interaction, cooperation and collaboration of patients, medical personnel and administration. Many authors discussed and highlighted the importance of patient's perspective, service providers' satisfaction/stakeholders and facility administration when evaluating the quality of health care.

In many countries, rehabilitation is a young discipline in medicine and health sciences; however, its importance and significant inputs in terms of patients, health care, research and literature are well known and recognized worldwide. Handicaps and workers dignity and rights are deeply rooted in Islam. Islamic history is thriving and flourishes with creative handicaps.

CHAPTER THREE

LITERATURE REVIEW

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LITERATURE REVIEW

3.1 INTRODUCTION:

This chapter presents literature review related to patient and provider perspectives with regards to providing rehabilitation services.

3.2 STUDIES RELATED TO CLIENTS:

3.2.1 Study on patient satisfaction in the government allopathic health facilities of Lucknow district, India (Kumari et al, 2009) :

This study determined the areas and causes of low satisfaction among the patients and suggests methods for improvement. Materials and Methods: Multistage stratified random sampling was used to select the government allopathic health facilities of Lucknow district and systematic random sampling for the selection of the patients for the interview. Results: The accessibility was difficult in 42% patients and waiting time more than 30 min for 62.5% of those attending the tertiary level health facility. The satisfaction with the duration of the outpatient department (OPD) (64.6%) and the presence of signboards (46.6%) was also found to be low. The overall satisfaction regarding the doctor-patient communication was more than 60% at all the levels of health care facilities but that with the examination and consultation was less than 60% at the primary level as compared to more than 80% elsewhere. The most important motivating factor for the visit to the tertiary (48.2%) and secondary level (71.9%, 67.1%) of health facilities was the faith on doctors or health facility. Conclusions: The level of patient satisfaction is severely deficient in several areas and needs improvement for the achievement of optimal health of the people.

3.2.2 Quality of care and emotional support from the inpatient cancer patient's perspective (Singer et al, 2009):

This study examined Quality of care and emotional support from the inpatient cancer patient's perspective, methods: Multi center prospective study was conducted (n = 396 cancer patients; t1 = after admission to hospital, t2 = before discharge). Quality of care was measured with the quality of care from the patient's perspective questionnaire, and emotional distress was measured with the hospital anxiety and depression scale. Additional

questions regarding emotional support wished (at t1) and provided (at t2) were administered. result: The patients reported that the domains of care most important to them were as follows: respect and commitment of the physicians, information before procedures, care equipment, and medical care. The areas where improvements are most obviously needed were nutrition, participation, clarity about who is responsible for personal care, and having the possibility of speaking in private with nurses and psycho-oncologists. Fifty-six percent of the patients were highly emotionally distressed, 84% wanted support from physicians, 76% from nurses, 33% from psychologists, and 7% from a pastor.

3.2.3 Outpatients' Satisfaction with Physiotherapy Services at Al-Shifa Hospital and Al-Wafa Medical Rehabilitation Hospital in Gaza (Hilles, 2008):

This study focuses on patients' opinions and reactions regarding physiotherapy services. This study is to evaluate the level of outpatients' satisfaction with physiotherapy services in outpatient's physiotherapy departments at Al-Shifa Hospital and Al-Wafa Medical Rehabilitation Hospital in Gaza. The researcher prepared in this study a patient satisfaction instrument according to literature review which consists of seven domains of patients' satisfaction based on likert scale of 5-points was used to assess the level of patients' satisfaction with physiotherapy services, including (49) items, also group of open-ended questions and descriptive questions. result of the study showed are significant statistical differences between patients satisfaction level of Al-Wafa Medical Rehabilitation Hospital (100%).

3.2.4 Study on the Impact of Social Worker Staffing (Joan, 2008):

This study looks at the impact of social workers' involvement with end-stage renal disease patients receiving haemodialysis three times week. Since social workers attend the unit five days a week, patients who received treatment on Tuesdays, Thursdays and Saturdays had access to their social worker for only two days, compared to the three days for patients who were treated on Mondays, Wednesdays and Fridays. The findings from a survey of 62 patients found that the 31 who had a third less access to a social worker had statistically significant poorer quality of life on four of the five domains measured, as well as clinically indicated levels of depression.

3.2.5 Perceived needs and satisfaction with care in people with multiple sclerosis: A two-year prospective study (Ytterberg et al, 2008):

This study explored the perceived needs and satisfaction with care amongst multiple sclerosis over a two-year period, by using 219 outpatients at a multiple sclerosis specialist clinic .The data was analyzed for the whole sample and on an individual level, as well as in subgroups with regard to sex and disease severity. Results: There were no statistically significant variations in the proportion of PwMS with perceived needs concerning different health-related services during the study period. However, individual variations were found with regard to both perceived needs and satisfaction with care. Few PwMS perceived a continuous need for a specific service. However, the majority perceived a need for rehabilitation, assistive devices, transportation service for the disabled, psychosocial support/counseling and information on social insurance/vocational rehabilitation at least sometimes. Severe MS was associated with a greater perceived need for almost all the services studied and women experienced a need for psychosocial support/counseling to a greater extent than men. In relation to the different categories of health care staff, PwMS were most satisfied with nurses with regard to all dimensions of care. They were least satisfied with the availability of psychosocial support/counseling; and information about social insurance/vocational rehabilitation.

3.2.6 Provider-patient dialogue about Internet health information: an exploration of strategies to improve the provider-patient relationship (Bylund et al, 2007):

This study examined patients' experiences talking to their providers about internet health information. Methods: Participants (n=770) recruited from internet health message boards completed an online survey, including questions focusing on a recent interaction with a provider about internet health information. RESULTS: Face-saving patient introduction strategies were associated with providers validating patients' efforts. Providers' validation of patients' efforts was associated with higher patient ratings of satisfaction, validation, and reduced concern, while providers' disagreement with the information was associated with lower ratings. The provider taking the information seriously was associated with higher patient satisfaction.

3.2.7 Quality assurance in outpatient medical rehabilitation - concept and results of a pilot project to develop a quality assurance program for musculoskeletal and cardiac diseases (Farin et al, 2007):

The purpose of this study to develop a quality assurance program for outpatient medical rehabilitation in musculoskeletal and cardiac diseases. Methods: The quality of structure was assessed by defining and applying basic and detailed criteria; a version of peer review for outpatient treatment was developed to test the quality of process. The quality of results was determined by means of a prospective study with two or three measurement times and implementation of generic and disease-specific measurement instruments. The process was tested on n=1475 patients with musculoskeletal diseases and n=843 patients with cardiac diseases. Result: The level of the quality of structure in the participating centers is quite high; 89-93% of the structure features required were fulfilled. The peer review indicated that the process had 25-40% serious shortcomings in cardiology and 15-20% for musculoskeletal diseases.

3.2.8 out Patient Satisfaction at a Super Specialty Hospital in India (Jawahar, 2007):

This study was conducted to know the satisfaction level of patients and also get a feedback about the services provided in the outpatient departments. The patients were randomly selected and a questionnaire was developed to evaluate patient satisfaction about the outpatient department services, logistic arrangement in the outpatient departments, waiting time, facilities, and perception about the performance of staff, appointment system, and behavior of staff, support service and any other suggestions of patients. Out of 200 patients surveyed, 90-95% of patients were satisfied with the service offered in the hospital. About the question on guidance received from the hospital, 60% said that the staff of the hospital always guided them. The guidance was provided to 59% of the patients by the Medico Social Workers and 40% of patients by the security staff.With regard to the privacy in consultation, 97.5% of the patients were satisfied. This study also showed that some of the patients waiting time were prolonged and the friendliness of the nursing staff needs to be improved.

3.2.9 Approaches to patient education: emphasizing the long-term value of compliance and persistence (Gold &McClung, 2006):

The purpose of study to explain lack of compliance is associated with poor clinical healthcare costs. Although poor compliance and persistence are common across many disease states, they may be particularly poor in treatment for asymptomatic chronic diseases. Patient education has been demonstrated to significantly improve compliance with medication across a broad range of conditions and disease severities. Result: patients received educational materials, referral for bone densitometry, and physician consultation, 67% were compliant with treatment after 6 months. Patient satisfaction with treatment has been linked to compliance with therapy; by improving patient care through fulfilling expectations for physician visits and providing frequent feedback, the healthcare provider can dramatically improve compliance.

3.2.10 Factors contributing to patients' satisfaction with medical rehabilitation in Germany (Haase &Lehnert-Batar, 2006):

The objective of this study was to quantify overall patient satisfaction, through the identification of the particular aspects of patient satisfaction that were most likely to cause patients to recommend the rehabilitation hospital to others. The research entailed analyzing secondary data from a quality improvement programmed for medical rehabilitation, conducted from 1997 until 2004, in seven rehabilitation hospitals in Germany. Overall patient satisfaction and several potential predictors were examined in relation to 120,825 patients who had received inpatient medical rehabilitation. Recommending the rehabilitation hospital to others is a measure of overall patient satisfaction with the rehabilitation. Logistic regression was used to identify the factors that predicted patient satisfaction or dissatisfaction at discharge from the rehabilitation hospital. Overall satisfaction was mainly determined by the general atmosphere in the hospital, successful rehabilitation and the medical care. The general atmosphere was strongly associated with admission procedures, accommodation, catering, service, organization and nursing care. In conclusion, the results suggest that in order to increase the rate of recommendation, rehabilitation hospitals should aim for not only high quality in medical care, but also the creation of a pleasant atmosphere.

3.2.11 An Exploratory Study of Client Perceptions of Internet Counseling and the Therapeutic Alliance (Leibert et al, 2006):

This study examined advantages and disadvantages of online counseling, and satisfaction with relationships and treatment service and satisfaction with online counseling for comparison to past studies of clients using traditional face-to-face counseling. Methods: Socio-demographics were collected on 81 self-selected clients using online counseling, and self-reported therapeutic alliance. Online clients were predominantly female, were already regular Internet users, and enjoyed the convenience and anonymity of the service. They were satisfied with their relationships and treatment online but not as satisfied as clients who have undergone traditional face-to-face counseling. The main disadvantage, the loss of nonverbal information, was offset by the advantage of anonymity when sharing shameful personal information.

3.2.12 An Exploratory Study of Client Perceptions of Internet Counseling and the Therapeutic Alliance (Mazer et al, 2006):

This study examined occupational therapists' (OT) and physiotherapists' (PT) perceptions regarding waiting time and the quality and quantity of the services they provide for children with disabilities. A survey was sent by post to all pediatric OTs and PTs in Quebec, Canada. A Service Delivery Questionnaire included questions regarding therapist/client characteristics, waiting times and quality and quantity of services provided. Quality of services was rated higher by PTs, experienced therapists and those using more methods of keeping up-to-date. The frequency and duration of services varied according to profession, type of clientele and setting. According to clinicians directly involved in the provision of rehabilitation services, long delays exist for children waiting for rehabilitation services, and perceived quality of services differs according to specific therapist and client characteristics.

3.2.13 Patient satisfaction with treatment for chronic pain: predictors and relationship to compliance (Hirsh et al, 2005):

The purpose of this study was to identify the predictors of patient satisfaction with treatment of chronic pain. The relationship between patient satisfaction and compliance with treatment recommendations was explored. Methods: One hundred eighty patients (84 men and 96 women) seeking treatment of chronic pain at University of Florida pain clinics

were recruited for this telephone follow-up study. result: Satisfaction ratings were generally high, with ratings of satisfaction with care significantly higher (T_{179}=9.58, P<0.001) than ratings of satisfaction with improvement. Aspects of the patient-provider interaction, pain relief, and anxiety at treatment onset predicted satisfaction with care these same variables, with the exception of anxiety, also predicted satisfaction with improvement. Those patients who were more satisfied with their improvement were also more compliant with treatment recommendations, and this relationship was stronger for health care provider-rated compliance.

3.2.14 Satisfaction of patients with physicians and nurses (Jovanoviae, 2005):

This study explored level of satisfaction of patients with physicians and nurses and to provide in formation of patient's expectation of healthcare professionals at the Institute of Oncology Sermska Kamenica. The data were collected from the patients of four various hospitals departments using a survey questionnaire designed by Institute of Public Health of Serbia and Ministry of Health of the Republic of Serbia. That included eight items regarding physicians and nurses were selected from this questionnaire. The sample was every eligible patient discharged from the Institute of Oncology Sermska Kamenica, from 1-5 November 2004, sample 65.the finding confirm positive feedback of the most surveyed patients with health care professionals. However, the result showed different level of satisfaction of patients with physician and nurses. The study concluded that the survey results showed that patients had mostly positive level of satisfaction with physicians and nurses; these results can be used to prioritize patient-centered improvements in healthcare in this Institute.

3.2.15 An evaluation of the domiciliary occupational therapy service in palliative cancer care in a community trust: a patient and careers perspective (Kealey &McIntyre, 2005):

This study evaluate the domiciliary occupational therapy service in palliative cancer care in a community trust: a patient and careers perspective. . A sample of 30 patients and their primary informal careers were selected using purposive sampling. A structured interview was carried out with both the patients and their careers to obtain views. Results suggest that although both patients and their careers value the service provided and report high levels of satisfaction, there are gaps identified in service provision and a lack of clear information among patients and their careers about the role of the occupational therapist and the range of services they can provide. There is a need to build upon the good work being done by domiciliary occupational therapists in the area of palliative cancer care and increase education and resources to ensure that a patient-centered, holistic, approach to care is used, addressing both the needs of the patient and their careers.

3.2.16 Clients satisfaction with nursing care provided at selected hospital in Gaza strip (Abu Saileek, 2004):

This study assessed level of client's satisfaction with nursing care in two major governmental hospitals in south Gaza. By using cross sectional design, the researcher selected his own sample randomly from both hospitals; 159 subjects from European Gaza Hospital and 268 from Nasser Hospital, the response rate waes93.6%.standarized structured questionnaire was developed containing six domain of satisfaction with nursing care (information and interaction, availability/attentions and openness, comfort and environment, nursing skills and professionalism, organization culture, counseling and advising). Result of this study revealed that there was significant relation was70.1% in both hospitals, where satisfaction level in European Gaza Hospital was 61.7%.finally this study showed that there was significant relationship between the level of client's satisfaction and socio-demographics. The study recommended some information in order to improve quality of nursing services in hospitals that will influence the level of client's satisfaction.

3.2.17 Client-centered rehabilitation: client perspectives (Cheryl -Cott, 2004):

The purpose of this study is to understand the important components of client-centre rehabilitation from the perspective of adult clients with long-term physical disabilities. Method: Focus groups were conducted with adult clients who had completed at least one course of rehabilitation in the publicly-funded rehabilitation system in Ontario. Results: The major theme underlying all of the participants' comments was the need for better transitions between rehabilitation programs and the community. The findings demonstrate that client-centre rehabilitation encompasses much more than goal-setting and decision-making between individual clients and professionals.

3.2.18 Quality assessment in rehabilitation centers: the indicator system 'Quality Profile' (Farin et al, 2004):

This study measured the quality of rehabilitation centers ('Quality Profile' of rehabilitation centers). Method: In each centre, structural, process and outcome quality, including patient and employee satisfaction, are measured. Process quality is determined by means of a peer review procedure that includes examination of 20 randomly selected cases on the basis of discharge reports and therapy plans. The medical outcome is measured by a prospective study with three measurement time points and a sample of approx. N=200 patients per centre. result: Overall, the level of quality of the medical rehabilitation in the institutions participating in the study considered high. However, on almost all quality dimensions, even after a risk adjustment there are clear differences between centers, which need for improvements in quality in some centers.

3.2.19 Patient's satisfaction with nursing care in Jordan (Alasad & Ahmead, 2003):

The purpose of this study investigates patient's satisfaction with nursing care at a major teaching hospital in Jordan. The sample size was 266 in-patients participated. Patients were recruited from the medical, surgical, and gynecological wards. The methods of analyses were used Pearson correlation, one- way analysis of variance(ANOVA), and logistic regression. The result showed that patients in surgical wards associated with lower level satisfaction than patients in medical or gynecological wards. Gender, educational level, and having other disease were significant indicators for patient's satisfaction with

nursing care. Methodological challenges, implications to nursing practice, and recommendations to nursing research are discussed.

3.2.20 Parent's satisfaction with medical and social assistance provided to children with Down's syndrome (Reimand et al, 2003):

This study investigate the extent of parent's satisfaction with medical and social services in Estonia provided for the Down's syndrome individuals and their families. 59 Down's syndrome parents from 1999 to 2001, answered questionnaires in which their satisfaction to medical and social services were assessed. The result showed that satisfaction with the quality of the information about Down's syndrome is low; most parents were not satisfied with the social and rehabilitation benefits. This study suggested that Down's syndrome families need more medical information about this syndrome. More work need to be done in the area of rehabilitation and social assistance.

3.2.21 Patient satisfaction with outpatient physical therapy: instrument validation (Beattie et al, 2002):

This study conducted a pilot study to develop and test an instrument used to determine which variable are associated with the satisfaction of patients receiving outpatient physical therapy. 191 patients participated, and 1,868 patients then participated in the main phase of this work. The authors developed a survey instrument, the patients responded to global questions concerning general satisfaction with physical therapy. Content validation of the instrument was investigated using correlation, analysis of principal components, and factor analysis. Reliability was measured using the standard error of measurement. Concurrent validity was investigated by correlating summary score of the final survey instrument with global measures of satisfaction. The result showed the reliability was best for a 10- item questionnaire. The patient were more satisfied that reflect a high-quality interaction with the therapist(e.g., time, adequate explanations and instructions to patients).Environmental factors such as clinic location, parking, time spent waiting for the therapist, and type of equipment used were not strongly linked with overall satisfaction with care. The study conducted the time of the therapist spend with patients and the behavior of the therapists are important for patient satisfaction, the authors emphasis on cost-cutting, high patient volume, and the use of " care extenders" may jeopardize satisfaction.

3.2.22 Patient satisfaction with nursing care in the context of health care (Johansson et al, 2002):

This study evaluate and improve the quality of care provided. In the description of nursing care, researcher used Henderson's nursing care model. The results describe eight domains that have an influence on patient satisfaction with nursing care: the socio-demographic background of the patients, patients' expectations regarding nursing care, the physical environment, communication and information, participation and involvement, interpersonal relations between nurse and patient, nurses' medical-technical competence, and the influence of the health care organization on both patients and nurses. These factors influence satisfaction with nursing care, from the patient's perspective.

3.2.23 Patient evaluation of the care and rehabilitation process in geriatric hospital care (Krevers et al, 2002):

The purpose of this study was to gain a deeper understanding of how elderly persons experience and evaluate the care and rehabilitation process. Methods: Qualitative interview data from elderly patients were analyzed using a grounded theory approach. The patients were interviewed twice, at the beginning of geriatric hospital care and some weeks after discharge. Result: The patient-perceived outcome of the care and rehabilitation process reflected two dimensions; the effect on their health and the quality of the process. This indicated the importance of using a process perspective in the assessment and the interpretation of patient-perceived outcome of care and rehabilitation, and that patient expectations of illness and the patient character must be taken into consideration.

3.2.24 Patient Satisfaction Surveys for Critical Access Hospitals (Powell, 2001):

This study assess patient satisfaction for critical access hospital Methods: there are two broad categories of surveys: the questionnaire and the interview. Questionnaires are typically paper-and-pencil instruments that the patient completes but also can include computerized versions that are accessed at the site through the Internet. Interviews are completed by the interviewer and are based on what the patient says. The following section discusses the various types of surveys and the advantages or capabilities and the disadvantages or limitations of each type. Typically, patient satisfaction surveys are completed on an ongoing basis or accumulated until you have a sufficient number of completed surveys (150-200).This report presents the results of the Community Hospital Patient Satisfaction Survey compiled by Mountain States Group, Inc., in October 2001. The survey instrument was distributed to all patients of Community Hospital by mailing a cover letter, survey, and postage paid return envelope to all discharged patients within one week of their discharge. A follow-up postcard was sent to patients two weeks following the initial mailing to remind them to return the survey. For this report, 400 patients received the survey and 200 returned the survey (response rate 50%). Overall satisfaction with physician services was 2.41 on a 5 point scale. Patients generally were more satisfied with the physician's ability, thoroughness, skill, and aftercare instructions than with their responsiveness to questions, explanation of tests, procedures, and treatments, and courtesy and respect given.

3.2.25 Domiciliary occupational therapy for patients with stroke discharged from hospital (Gilbertson, 2000):

This study to establish if a brief program of domiciliary occupational therapy could improve the recovery of patients with stroke discharged from hospital. Design: Single blind randomized controlled trial. Setting: Two hospital sites within a UK teaching hospital. Subjects: 138 patients with stroke with a definite plan for discharge home from hospital. Intervention: Six week domiciliary occupational therapy or routine follow up. Main outcome measures: Nottingham extended activities of daily living score and "global outcome" (deterioration according to the Barthel activities of daily living index, or death). Results: By eight weeks the mean Nottingham extended activities of daily living score in the intervention group was 4.8 points (95% confidence interval 0.5 to 10.0, P=0.08) greater than that of the control group. Overall, 16 (24%) intervention patients

had a poor global outcome compared with 30 (42%) control patients (odds ratio 0.43, 0.21 to 0.89, P=0.02). These patterns persisted at six months but were not statistically significant. Patients in the intervention group were more likely to report satisfaction with a range of aspects of services. Conclusion: The functional outcome and satisfaction of patients with stroke can be improved by a brief occupational therapy program carried out in the patient's home immediately after discharge. Major benefits may not, however, be sustained.

3.2.26 Patient satisfaction in rehabilitation of musculoskeletal diseases--effect of patient characteristics, treatment, evaluation schedule and correlation with treatment outcome (Bührlen-Armstrong et al, 1998):

This study evaluate factors on which patient satisfaction with the rehabilitation measure depends. Socio-demographic factors, diagnosis at admission, characteristics of treatment, and the time of evaluation were considered. Data collection was conducted in four German rehabilitation hospitals. Patient satisfaction was assessed in 1832 patients with an orthopedic rheumatologic disease as first diagnosis three months after discharge, using a postal questionnaire. Result no relevant correlation existed between patient satisfaction and result of the treatment.

3.2.27 Consumer satisfaction with nursing care in a rural community hospital emergency department (Clark et al, 1996):

This study mentioned that African American consumer were less satisfied with discharge teaching than white consumer holds implication for nursing practice and advice nursing staff to spend more time on discharge teaching with rural African American consumer.

3.2.28 Patient satisfaction: an indicator of quality in disablement services centers (Smith et al, 1995):

This study develop a patient satisfaction system for disablement services centers and to report on how the initial findings have been used in audit to improve their quality of care and services. Methodology: Interview survey of randomly selected users attending in three centers. Methods123 patient amputees in the development phase, selected by cluster sampling. Result: The questionnaire included 16 core topics contributing to quality of care and services, including comfort of limbs, appointments, and interpersonal aspects of care, a system of support and counseling, and organization. Survey demonstrated high satisfaction scores for aspects of interpersonal care, organization, and physical surroundings of the centers and lower satisfaction for counseling services, comfort of the limb and the number of alterations made before the limb was considered acceptable.

3.2.29 Evaluation of attitudes and views of doctors, nurses and patients towards occupational (Jawdsheikh, 1992):

This study evaluate the attitudes and views of doctors, nurses and patients towards occupational therapy. The survey was completed over ten months. During the period there was one rotational change of junior medical staff, so 20 doctors contributed to the project; 6 senior house officers, 6 registrars, 3seniorregistrars, 5 consultants and 48 patients. The result showed59% were not informed of the occupational therapy referral; 46% of the patients were not consulted by their doctor or nurse before being referred and 61% were not aware that occupational therapy was part of their treatment. Nonetheless 91% were happy to attend OT but only55% felt it was relevant to their illness.

3.3 Summary of literature review:

After reviewing the literatures, the researcher found that there are many studies that evaluated rehabilitation services from patient perspective. The researcher tends to high light on these studies in the following points:

Objectives of the studies: the majority of previous studies to evaluate level of satisfaction from patient perspective in rehabilitation hospitals .for example (Haase&Lehnert-Batar 2006and Kumari et al,2009) to quantify overall patient satisfaction, through the identification of the particular aspects of patient satisfaction. that study was similar with (Singer et al,2009, Farin et al, 2007,Farin et al, 2004 and Johansson et al, 2002) the aims of these study to evaluate and improve the quality of care provided.

Samles of the studies: some studies consist small sample like (Joan ,2008)sample was 62 subject also,(Kealey &McIntyre,2005)the study population was 30 subject. (Abu Saileek,2004)the sample was159 subjects and 268 from two hospital,(Libert et al ,2006) the sample was 81 clients (Haas&Lehnert-Batar,2006) take sample 120 patients and (Smith et al,1995) the sample was 123.While the (Buhrlen,1998) take large number 1832 patients.

Instruments of studies: literature showed that similar instrument used for evaluation e.g (Singer et al, 2009, Smith et al, 1995, Buhrlen, 1998, Faller et al, 2000, and Mazar et al, 2006) was used self administered questionnaires. in some studies like(Kumari et al,2009 ,Farin et al, 2004, and Krevers et al, 2002) used qualitative interview. (Cherly-cott, 2004) was used focused group. Instrument highlights the following dimension that have an influence on patient satisfaction: the socio- demographic, expectation regarding rehabilitation team, the physical environment, interpersonal relation, communication and education.

The results of the studies: result was slightly similar to each other like (Kumari et al, 2009) state level of patient satisfaction is severely deficient in several areas and needs improvement for the achievement of optimal health of the people. also (Singer et al, 2009) reported that the domains of care most important to them were as follows: respect and commitment of the physicians, information before procedures, care equipment, and medical

care (Farin et al, 2004) showed the level of quality consider high.(Haase &Lehnert-Batar, 2006) showed that showed aim for not only medical care , but also to the creating a pleasant atmosphere.

(Smith et al, 1995) showed high satisfaction for aspects of inter personal care but lower satisfaction for counseling services. On other hand (Cheryl -cott, 2004) recommend for better transition between rehabilitation programs and the community. (Clark et al, 1996) mentioned that the residency place have effect of the level of satisfaction. (Abu Saileek, 2004) showed that there was significant relationship between the level of client's satisfaction and socio-demographics, other study of (Jovanoviae, 2005) results showed that patients had mostly positive level of satisfaction with physicians and nurses.

3.4 STUDIES RELATED TO SERVICE PROVIDER :

3.4.1 Perceived Complexity of Care, Perceived Autonomy, and Career Satisfaction among Primary Care Physicians (Katerndahl et al, 2009):

This study examine relationships of both perceived autonomy and perceived complexity of care with career satisfaction. Methods: This secondary analysis used 3 consecutive surveys of family physicians, internists, and pediatricians from the Community Tracking Survey. Two-way analysis of variance assessed interaction effects of perceived complexity of care and perceived autonomy on satisfaction. Logistic regression analysis identified physician characteristics, practice characteristics, practice improvement strategies, perceived complexity, and perceived autonomy that accounted for variance in career satisfaction among physicians. Results: Although 24% to 27% of physicians felt perceived complexity of care expected was greater than it should be, 83% to 86% felt free to make clinical decisions. Approximately 80% of physicians were satisfied with their careers. Differences in probability of career satisfaction were highly significant ($P < .001$) for both perceived complexity of care and perceived autonomy as well as their interaction. A multi physician practice; the ability to obtain high quality ancillary services (such as physical therapy, home health care, and nutritional counseling); managed care revenue, lower levels of perceived complexity of expected care; and perceived autonomy were consistently associated with satisfaction.

3.4.2 Low Job Satisfaction among Physicians in Egypt (Gamal, 2008):

This study reported the job satisfaction among physicians is an important concern from the perspective of physician and patients. Physicians job satisfaction is interrelated with the quality of health care, the quality of the workforce attracted to medicine as a career , patient satisfaction with the services they receive patient compliance, and continuity of care. Moreover the researcher pointed dissatisfaction lead to increased turnover, each of which raises cost to the medical system . the researcher used randomly selected physician from the Egyptian ministry of health and population hospital all participants fill a self administered questioners which include data ,socio-demographic characteristic and job satisfaction regarding salaries , administration system , management, career satisfaction, relation ship with college, social support, opportunities for promotion. Result showed that only 429% of the physician reported job satisfaction. The over all current satisfying domains were not significantly associated with material statues or educational level,

however it was significantly associated with specialty. Neither age nor gender was significantly associated with the degree of job satisfaction.

3.4.3 Variations in provider capacity to offer accessible health care for people with disabilities (Bachman et al, 2007):

This study reported social workers are likely to practice in a range of health care settings, their training focusing on human behavior in the social environment could help providers develop strategies to improve access to care for people with disabilities. A social work framework of understanding the individual in a social environment may be the most appropriate perspective for creating innovative strategies for addressing the complex, multidimensional needs of people with disabilities who experience limited access to care.

3.4.4 The relationship between the dimensions of self-leadership behavioral-focused strategies, job satisfaction and team performance (John & Politis, 2006):

This study examines the relationship between the dimensions of self-leadership behavioral-focused strategies, job satisfaction and team performance. It also evaluates the extent to which job satisfaction mediates the influence of self-leadership behavioral-focused strategies on team performance. Used a questionnaire-based survey of employees from a manufacturing organization operating in Australia. A total of 304 useable questionnaires were received from employees who are engaged in self-managing activities. Finding showed there are three major findings in this research. First, the relationship between self-leadership behavioral-focused strategies and job satisfaction is direct, positive and significant. Second, the relationship between job satisfaction and team performance is positive and significant. Finally, the results have clearly shown that job satisfaction mediates the relation between self-leadership behavioral-focused strategies and team performance.

3.4.5 The relationship between job satisfaction and demographic variables for healthcare professionals (Kavanaugh et al, 2006)

This study to examine the association between job satisfaction and demographic variables, such as years in profession, of healthcare professionals in an in-patient rehabilitation hospital setting. Methods: A total of 128 employees were surveyed using a 47-item opinion survey to assess demographic variables and overall job satisfaction, as well as nine

facets of job satisfaction by use a convenience sample. The findings indicate that years in profession (professional experience) is associated
with job satisfaction in a defined pattern.

3.4.6 Early healthcare provider communication with patients and their workplace following a lost-time claim for an occupational musculoskeletal injury (Kosny et al, 2006):

This study examines the association between return-to-work approximately one month post injury and early, proactive healthcare provider communication with the patient and workplace. Methods: In this cross-sectional study 187 Ontario workers completed a telephone survey 17-43 days post injury. All had accepted or pending lost-time claims for back, neck or upper extremity occupational musculoskeletal injuries. on self-reported return-to-work. Fourteen potential confounders were also tested in the model including sex, age, income, education, occupational classification, worksite size, co-morbidity, psycho-physical work demands, pain, job satisfaction, depression, and time from injury to interview result: The healthcare provider giving a patient a return-to-work date 95% and giving a patient guidance on how to prevent recurrence and re-injury 95% were positively associated with an early return-to-work. Contact by the healthcare provider with the workplace was associated with return-to-work.

3.4.7 Predictors of Job Satisfaction among Staff in Assisted Living (Liu, 2006):

The study examines the effect of socio-demographic, job, and attitudinal characteristics on overall job satisfaction and its various dimensions. 294 direct care staff in 39 assisted-living facilities (ALFs) in Georgia was share in the study. researcher used structured interviews, the length of the interviews ranged from 45 minutes to one and a half hours.The results show age has a negative effect on promotion satisfaction. Whites are more satisfied than non-whites with overall job, work, supervision, and pay. Urban workers are less satisfied with overall job, supervisor, coworker, promotion, and pay than their rural counterparts. Education negatively affects coworker satisfaction. Workers with children are less satisfied with supervisor relationships, and pay than childless persons. Pay is positively associated with pay satisfaction. Perceived workload is negatively associated with overall

job satisfaction and each of its dimensions. Finally, perceived autonomy is positively associated with promotion satisfaction.

3.4.8 Predictors of burnout and job satisfaction among Turkish physicians. Leadership & Organization (Ozyurt et al, 2006):

This study investigate levels of job satisfaction and burnout among Istanbul physicians, and the relationships between demographic characteristics, job characteristics, job satisfaction and burnout. Methods: data collected from a randomly selected sample group of 598 physicians from different health-care institutions in Istanbul. A questionnaire regarding sociodemographic characteristics of the physicians, the Maslach Burnout Inventory (MBI) and the Minnesota Job Satisfaction Questionnaire (MSQ) were all administered during face-to-face interviews. Results showed there are job satisfaction was inversely correlated with emotional exhaustion and depersonalization, and positively correlated with personal accomplishment. Under multilevel regression, the most significant and common predictors of all burnout dimensions and job satisfaction were the number of vacations at individual level, and public ownership of healthcare facilities at group level. Number of shifts per month was also a significant predictor of all burnout dimensions.

3.4.9 Relationships Between Adult Workers' Spiritual Well-Being and Job Satisfaction (Robert, et al, 2006):

This study studied the relationships between adult workers' spiritual well-being and job satisfaction. Two hundred participants completed 2 instruments: the Spiritual Well-Being Scale and the Minnesota Satisfaction Questionnaire Short Form. result showed spiritual well-being, religious well-being. And existential well-being to be positively related to job satisfaction. With a forced-entry multiple regression analysis, overall spiritual well-being was found to have a moderate influence, existential well-being had a much stronger influence and religious well-being had a minimal influence all on, general job satisfaction.

3.4.10 Communication skills training for doctors increased patient satisfaction (Trumble et al, 2006):

Study purpose to examine changes in patient's satisfaction after participation their doctor in a brief educational intervention on medicolegal risk management. A questionnaire completed by ambulatory patients, measuring satisfaction with their doctors communication skills before and three months after the doctor participated in three hour workshop on medicolegal risk management. The number of doctors was 75 obstetrician and gynaecologists and 99 general practitioners were each rated by 60 of their patients following a consultation in their clinical rooms. The findings showed patients satisfaction as evidence by change to "complete satisfaction" with doctors communication skill's and over all satisfaction with the clinical encounter. The participants had high initial patient satisfaction ratings and these were found to have improved across all parameters three months after the educational intervention. The researcher pointed to value of this study, the educational intervention lead to improve doctors communication skills as evidence by enhance patient satisfaction in all key aspects, including those most frequently associated with patient complaint, litigation and adverse outcome.

3.4.11 Use of a Consumer-Led Intervention to Improve Provider Competencies (Alexander et al, 2005):

The purpose of this was study to evaluate the effectiveness of an innovative, consumer-led intervention, Staff Supporting Skills for Self-Help, which was designed to improve provider quality .Methods: The study was conducted at five large community mental health provider organizations in two western states. The intervention included education, clinician-client dialogues, ongoing technical assistance, and support of self-help. It focused on client-centered care, rehabilitation, and recovery. A one-year controlled trial evaluated the effect of the intervention on clinicians' competencies, care processes result: showed significantly greater improvement in education about care, rehabilitation methods, natural supports, holistic approaches, teamwork, overall competency, and recovery orientation.

3.4.12 Dispersed leadership predictor of the work environment for creativity and productivity (John & politis, 2005):

This study examines the relationship between the dimensions of dispersed – self-management – leadership and a number of work environment dimensions conducive to creativity and productivity. The study involves a questionnaire-based survey of employees from a high technology organization operating in the United Arab Emirates (UAE). A total of 104 useable questionnaires were received from employees who are engaged in self-managing activities. Findings showed there are three major findings in this research. First, the relationship between dispersed leadership and the "stimulant" dimensions of the work environment for creativity is positive and significant. Second, the relationship between dispersed leadership, with the exception of encouraging self-reinforcement, and the "obstacle" dimensions of the work environment for creativity is negative and significant. the findings have clearly shown that the "stimulant" dimensions of the work environment for creativity have a positive and significant impact on both creativity and productivity.

3.4.13 Job satisfaction among Norwegian general practitioners (Nylenna et al, 2005):

The aim of this study to explore the level of job satisfaction among general practitioners (GPs) and to compare it with that of hospital doctors. Design: Postal questionnaire among Norwegian doctors. Results show Norwegian GPs reported a high level of job. The reported level of satisfaction was highest for their opportunities to use their abilities, cooperation with colleagues and fellow workers, variation in work, and freedom to choose own method of working.

3.4.14 Team types, perceived efficiency and team climate in Swedish cross-professional teamwork (Thylefors et al , 2005) :

Study aims to identify the dominant types of team organization in cross-professional Swedish human service organizations and the relationship between team type and perceived efficiency as well as team climate as an aspect of work satisfaction. A questionnaire was responded to by 337 individual professionals from 59 teams. A moderate positive correlation was found between team type and perceived efficiency as well as team climate. No differences were found between professions or organizational domiciles with respect to team type.

3.4.15 Incorporating organizational justice, roll states ,pay satisfaction and supervisor satisfaction in a model of turnover intentions (DeConinck and stilwell, 2004) :

This study found of advertising managers in United States that the manager who perceived that they had been fairly reward and procedural justice were more satisfied with their pay. And also they more satisfied with their supervision.

3.4.16 Predictors of Job Satisfaction among Physiotherapists in Turkey (Eker, 2004):

The aim of this study was to investigate the level of job satisfaction among physiotherapists, and to identify the best predictors of job satisfaction. A self-administrated questionnaire survey was conducted in September 2003. Data were collected from 198 physiotherapists in 13 health care settings (five university hospitals, seven government hospitals, and one municipality hospital) located in Ankara, Turkey. Respondents were asked to complete a 31-item job satisfaction questionnaire. The response rate was 79.8%. The percentage of satisfied physiotherapists was 45.5%. There were no significant satisfaction differences between genders or between age groups. Specific job satisfaction dimensions indicate that highest dissatisfaction levels occur in the area of salary and advancement.

3.4.17 Job security and job satisfaction among Greek fitness instructors (Koustelions et al, 2003) :

A study of relation between job satisfaction and job security in a sample of 97 Greek fitness instructors, 18-42 years of age, showed that there was a positive relationship between job security and job satisfaction. Particularly, job security was correlated with pay, promotion, job itself, and the organization as a whole.

3.4.18 An analysis of job satisfaction among physician assistants in Taiwan (Liu et al, 2003):

Study was examine the environmental and socio-demographic factors that influence job satisfaction and job-related communication among physician assistant PAs in Taiwan. The data source, a self-administered mail survey, was sent to 196 PAs working within medical facilities in northern, central, and southern Taiwan. The response rate to the survey was 71.01%. There was a strong correlation between communication satisfaction and job

satisfaction among respondents. The PAs' overall position in the hospital, relationships with coworkers (doctors, nurses, and other medical staff), and ability to perform his or her duties while working with the supervising physician were the major environmental factors that influenced job and communication satisfaction. In addition, the number of working years and marital status were important demographic factors influencing job satisfaction.

3.4.19 Unfairness at work as predictor of absenteeism (Bore et al , 2002):

In his study of unfairness at work as predictor of absenteeism found that unfairness at work may lead to temporarily withdraw from the organizational as the employees do not want to be at work. He found also that different stressor may lead to stress symptoms which make employees unable to come to their work and that there was direct relationship between unfairness at work and absenteeism.

3.4.20 The Relationship of Role- Related Variables to Job Satisfaction and Organizational Commitment. (Lopopolo, 2002):

This study examined changes in physical therapist role behaviors, levels of stress, occupational commitment, job satisfaction, and commitment to the organization following restructuring were identified through a survey of 273 hospital-based physical therapists, and Results, six role behavior dimensions reflecting professional and organizational responsibilities were identified from the data. After controlling for sample demographics, the professional role behaviors, specifically those reflecting interaction and integration with other practitioners, appeared to exert a small, but positive, influence on job satisfaction and commitment to the organization. In addition, occupational commitment had a positive influence, whereas stress had a negative influence on job satisfaction and commitment to the organization.

3.4.21 Continuing education: survey of the Royal Australian Collage of Dental Surgeons (Sambrook et al, 2001):

This study determine the level of continuing education activity in dentistry .used postal questionnaires and sent them to all fellows of royal Australasian college of dental surgeons in 1998. The result showed, approximately 25% of collage fellows reported little or no continuing education activity. The survey revealed that inactive fellow was more

likely to be older and in general practice. According to this, the researchers concluded that specific plan should be developed to help the low continuing education activity group.

3.4.22 The age and job satisfaction relationship (Bernal et al, 1998):

Study of large national probability sample of 1,095 workers. By used questionnaires . He found that there was a significant, but, weak positive linear age / job satisfaction relationship. That is age failed to explain a substantial proportion of linear variance in job satisfaction measure. This indicates that age, as a chronological variable, is not a viable predictor of job satisfaction.

3.4.23 Job satisfaction Among Gaza Nurse Educators Factors and Implications (Hammad, 1997):

This study reported the level of job satisfaction among Gaza nurses educators; those were 44 who represented the total educators work in Gaza collages of nursing. The researcher used self-administered questionnaires and in-depth semi structured interviews. He found that the level of job satisfaction was 65.9%. he ranked the satisfying factors as the highest in descending order of preference as follows: sense of achievement, recognition of achievement, sense of autonomy, salary, workload, unqualified managers, poor communication and work environment.

3.4.24 Job satisfaction, work motivation, and life satisfaction among Saudi managers (Maghrabi and Hayajneh, 1993):

A study conducted of two groups of managers with sample size of 120 to determine whether there are significant difference in job motivation, job satisfaction and life satisfaction among both male and female Saudi managers. They found that male groups have job motivation and job satisfaction than female groups.

3.5 Summary of literature review:

After reviewing the literatures, the researcher found that there are many studies that evaluated services they receive from provider perspective. The researcher tends to high light on these studies in the following points:

Objects of the studies:

Through the literature review the researcher find many different objective to many researcher but in general all studies search job satisfaction with organization variables and relation with socio demographic variables and job satisfaction.(Gamal, 2008 ,Trumble et al, 2006,Kavanaugh et al, 2006)examined the association between job satisfaction and demographic variables. On other way (John & Politis, 2006)examines the relationship

between the dimensions of self-leadership behavioral-focused strategies, job satisfaction and team performance. Other study of (Ozyurt, et al ,2006)Investigate levels of job satisfaction and burnout among Istanbul physicians. Moreover**,** **(**Lopopolo, 2002) examined changes in physical therapist role behaviors, levels of stress, occupational commitment, job satisfaction, and commitment to the organization.

Population of the studies:

Most of study consist large number of study population like (Gamal, 2008) used 429subjects. 304subject in study of (John & Politis, 2006).on other hand study of(Kavanaugh et al, 2006) have 128 subjects. (Lopopolo, 2002) also collect the data through 273 subjects.

Instrument of studies:

The most of researchers used the same way for collecting data they used self administered questionnaire like (Gamal, 2008, John & Politis, 2006, Trumble et al, 2006) . In other hand (Liu, 2006) used structured interviews to collect data.

The result of the studies:

Gamal, 2008 Result showed that the physician reported job satisfaction. (Liu, 2006) state pay is positively associated with pay satisfaction. (John & Politis, 2005,) founded the relationship between dispersed leadership and the "stimulant" dimensions of the work environment for creativity is positive and significant.on other hand (Liu, 2006) founded that the education negatively affects coworker satisfaction. **,** in addition to **(**Lopopolo, 2002) occupational commitment had a positive influence, whereas stress had a negative influence on job satisfaction and commitment to the organization. Finally the most of study finding showed that pay and relationship between employee and supervisor the main variables affects job satisfaction.

Researcher opinion:

These studies gave researcher broad idea about evaluation studies , how write questioner , methods ,and researcher choose from literature many variables which are compatible with our culture and religion.

This study is unique in that it involved both service recipients (clients) and providers (health professionals) and ended with suggestions for improvement that were drawn from focus groups.

CHAPTER FOUR

METHODOLOGY

CHAPTER FOUR
METHODOLOGY

4.1 Introduction:

This chapter presents the study methodology which includes: study design, study population, time of study, sample size ,sampling method, instrumentation, pilot study, data collection, validity and reliability of instrument and ethical considerations, data entry and analysis, eligibility criteria and finally limitations of the study .

4.2 Study design:

The design used in this study was descriptive analytical cross-sectional study that helps researcher to have a sample once at fixed time.

A cross- sectional research design involves the simultaneous collection of data from different subjects at different stages of the same phenomenon to provide a total representation of the phenomenon (nursing research, 1995).

4.3 Study populations:

1- All clients admitted to El- Wafa medical rehabilitation hospital between 1/ 8/2008 to 1/11/2008.The population was 44 clients.
2- All professionals providing direct care to the client. (Physicians, nurses, physiotherapists, occupational therapy, psychologist, social worker) .The population was 60 providers.

4.4 Time of study:

The study data collection started in 1/8/2008 and ended in 1/11/2008.

4.5 Samples size

1- Sample size for clients was 44 subjects whom were selected conveniently between 1/8/2008 and 1/11/2008.
2- Sample size for service provider working in WMRH was 57 subjects whom were selected as quota sample. **Quota sampling** involves the nonrandom selection of elements based on the identification of specific characteristics to increase the samples representativeness. Quota sampling is based on the identification of certain

strata within the population and the proportional representation of each of those strata in the sample (nursing research, 1995).

4.6 Eligibility criteria:

4.6.1 Inclusion criteria

- Clients (males and females) who were admitted to the hospital for more than two weeks.
- All service providers working directly with clients for more than 6 months.

4.6.2 Exclusion criteria

- Clients who stayed in the hospital less than two weeks.
- Service providers who did not have direct contact with clients.
- Service providers who are working in hospital for less than 6 month.
- Service providers and patients who refused to participate in the study.
- Comatose clients.

4.7 Reasons for selecting the sample:

The total number of beds in WMRH is 52 beds in both male and female inpatient departments, but due to the type of cases and health insurance, the clients stay in the patients departments from two weeks to two month and some cases stay for long time as years. So the admission to the hospital is not daily**.** 50 questionnaires were distributed to the research population (clients) but 44 questionnaires were received (response rate=88%). The quota sample selected the population with size sixty employees. Sixty questionnaires were distributed to the research population but fifty seven questionnaires were returned (response rate =95%).

Response rate for both samples (clients and providers) was very high.

4.8 Data entry and analysis:

Data collected from the questionnaires were quantitative. Statistical analysis was done by using the Statistical Package for the Social Sciences (SPSS). Different statistical analyses were used. They include:

1. Frequencies and percentages
2. Coefficient of variance(CV) test

3. L S D Multiple Comparisons test
4. One way ANOVA test
5. Pearson Correlation Coefficient for data

4.9 Sampling method:

Two different non-probability sampling methods were used; quota sampling for service provider and convenience sampling methods for clients.

4.10 Study instruments:

The researcher used self-report structured questionnaire to collect data from clients (patients/family) and self-administered structured questionnaire for service providers.

The researcher used also focus group methods to collect feedback on study result (see annex 3).

4.11 Questionnaires design:

The researcher developed two different instruments; one for the client (structured face to face questionnaire) and another for service provider (self-administered structured questionnaire) (See annex 4+5).

First: The client's questionnaire. It consists from 3 parts:

The first part: consist from 11 questions which are related mainly to socio-demographic data (age – sex- marital status –address (residency place) - education –reason of admission –time of admission - way of payment).

The second part: consist from six domains: evaluation of physician services, nursing services, physiotherapy services, occupational therapy services, social worker services and psychologist services (see table 4-1).

The number of questions in each discipline is different due to the fact that each domain has specific functions and duties with the clients wherein the study is concerned.

Table (4-1)
Domains and items of client's questionnaire

No.	Domains	Number of items
1.	Physician	9
2.	Nurses	6
3.	Physiotherapy	10
4.	Occupational therapy	10
5.	Social worker	6
6.	Psychologist	6

The third part: consist of 13 questions which are related to home visit, home adaptation and CBR programs. There are two open-ended questions for improvement suggestions

The service provider questionnaire. It consisted from 3 parts, they are

The first part: consists from 11 questions which are related mainly to socio-demographic data (age – sex- marital status- governorate - education –qualifications –experience).

The second part: consist from seven domains of evaluation of organizational culture, supervisors, team work, work schedules, salary, continuous education and general satisfaction (see table 4-2).

Table (4-2)
Domains and items of service providers' questionnaire

No	Domains	# Questions	Questions numbers
1.	Organization	6	1, 2, 3, 4, 5, 6,
2.	Supervisors	8	7,8,9,10,11,12,13,14
3.	Team work	8	15,16,17,18,19,20,21,22
4.	Work schedules	4	23,24,25,26
5.	Continuing education	2	27,28
6.	Salary	3	38,39,40
7.	General satisfaction	11	29,30,31,32,33,34,35,36,37,41,42

The third part: consist from nine questions which are related to containing education, time of work, overtime work, job security and two open-ended questions for suggestions to improve the level of work. The numbers of questions in each displine are different to the fact that each domain has specific functions and duties with the clients wherein the study is concerned.

4.12 Pilot study:

Pilot study usually is used to examine the clarity, ambiguity, length and suitability of questionnaire items before the data collection process starts (Pilot, 2004). In this study, two pilot studies were conducted.

For clients: The pilot study was conducted in 15 patients who received rehabilitation services at El-Wafa Medical Rehabilitation Hospital at least two weeks and more.

For service provider: the pilot study was conducted in 14 service providers. They perceive working conditions at WMRH.

4.13 Data Measurement

In order to select the appropriate method of analysis, the level of measurement must be understood. For each type of measurement, there are appropriate methods that can be applied. In this research, interval scales were used based on Likert scale (See table 4-3).

Table (4-3)
Likert scale used in the instruments of the study

Level of agreement	strongly agree	agree	uncertain	disagree	strongly disagree
scale	5	4	3	2	1

The individuals taking part interviews were asked to provide their opinions using the above scale that ranged from 1 to 5, where "1" means "Strongly disagree" and "5" means 'Strongly agree".

4.14 Psychometric properties of the study instruments:

4.14.1 Validity: Validity refers to the degree to which an instrument measures what it is supposed to be measuring (Polit, 2004). Validity has a number of different aspects and assessment approaches. There are two types of validity were used in this study: content validity and construct validity.

4.14.2 Content Validity: It is concerned with item sampling adequacy – that is, the extent to which a specific set of items reflects a content domain (Polit, 2004). Content validity evidence was assured in this study by consulting experts. They were requested to evaluate

and identify whether the questions agreed with the scope of the items and the extent to which these items reflect the concept of the research problem. Necessary changes were made according to their feedback. see annex(6)

4.14.3 Construct validity: It is directly concerned with the theoretical relationship of a variable to other variables (Polit, 2004). Internal consistency measures were calculated as an evidence for validity. Correlation coefficients were calculated and tested at the 0.05 & 0.01 levels between items of each domain and total score of domain in addition to calculating total score of each domain with total score of all items. See annex (7)

4.15 Reliability

The reliability of an instrument is the degree of consistency which measures the attribute; it is supposed to be measuring. The less variation an instrument produces in repeated measurements of an attribute, the higher its reliability. Reliability can be equated with the stability, consistency, or dependability of a measuring tool. (Polit, 2004).

Two reliability evidences were gathered in this study. The first is Cronbach's Coefficient Alpha, and the second is Split-Half methods.

4.15.1 Cronbach's Coefficient Alpha

This method is used to measure the reliability of the questionnaire between each field and the mean of the whole fields of the questionnaire. The normal range of Cronbach's coefficient alpha value between 0.0 and + 1.0, and the higher values reflects a higher degree of internal consistency.

Table No.(4-4)
Cronbach's Coefficient Alpha for client's questionnaire

Section	No. of Items	Cronbach's coefficient alpha
Doctor Department	9	0.8633
Nursing Department	6	0.7452
Physiotherapy department	10	0.9192
Occupational therapy	10	0.9632
Social worker	6	0.9421
Psychologist	6	0.9515
Total	47	0.9578

4.15.2 Split- Half Method

This method depends on calculating Pearson correlation coefficient between the means of odd questions and even questions of each field of the questionnaire. Then, correcting the Pearson correlation coefficients can be done by using Spearman Brown correlation coefficient of correction.

Table No. (4-5)
Half Split Method for client questionnaire

Section	person- correlation	Spearman-Brown Coefficient	p-value
Doctor Department	0.6702	0.8025	0.000
Nursing Department	0.6593	0.7947	0.000
Physiotherapy department	0.8846	0.9388	0.000
Occupational therapy	0.8955	0.9449	0.000
Social worker	0.7695	0.8697	0.000
Psychologist	0.8410	0.9136	0.000
All items	0.7527	0.8589	0.000

Correlation is significant at the 0.05 level (2-tailed) , (0.01 < p-value < 0.05)
Correlation is significant at the 0.01 level (2-tailed), (p-value < 0.01)

From the above, one can conclude that the evidences collected showed that questionnaires were reliable.

Table No.(4-6)
Half Split Method for provider questionnaire

Domains	Total number of items	Correlation	corrected correlation coefficient	p-value	Significant level
organization	6	0.7546	0.8601	0.000	**
Supervisors	7	0.7214	0.8382	0.000	**
Team work	4	0.6255	0.7696	0.000	**
Work schedules	2	0.6214	0.7664	0.000	**
Cont. education	2	0.6057	0.7544	0.000	**
Salary	3	0.6654	0.799087	0.000	**
Commitment to organizatio	10	0.7658	0.8674	0.000	**
TOTAL	34	0.7234	0.8395	0.000	**

* Correlation coefficient is significant at the $\alpha = 0.05$
* * Correlation coefficient is significant at the $\alpha = 0.01$

Table No.(4-7)
Cronbach's coefficient alpha for provider questionnaire

Domains	Total number of items	Cronbach's coefficient alpha
organization	6	0.8897
Supervisors	7	0.8547
Team work	4	0.7985
Work schedules	2	0.7564
Cont. education	2	0.7654
Salary	3	0.7958
commitment to organization	10	0.8954
All sections	34	0.8688

4.16 Ethical considerations

1. An approval letter from Helsinki ethical committee in Gaza strip was obtained (see annex 8).
2. An approval letter was obtained from the administration of WMRH to facilitate the study (see annex 9).
3. Consent form for every client was included in this study (see annex 10).
4. Consent form for every service providers included in this study (see annex 11).
5. Confidentiality was maintained through out the study.

4.17 Difficulties which faced the researcher:

- Stress and frustration due to the difficult social, economic and political situation was a major limitation.
- Lack of literature as hard copy. Most of articles are given for charge which increases the cost of study.
- Cutting of the electricity continuously affect the work on this study.

CHPTER FIVE
RESULT AND DISSUCTION

CHPTER FIVE
RESULT AND DISSUCTION

5.1 INTRODUCTION:

This chapter presented the core result of the study regarding client's perspective including firstly, the sociodemographic characteristic of the subjects of the study population, secondly the variables that establish the main construct of the evaluation process for rehabilitation services that mainly affecting satisfaction. Finally the researcher discusses the result in the light of study literature review.

5.2 DESCRIPTIVE ANALYSIS FOR THE STUDY VARIABLES:

5.2.1 Demographic characteristics:

The following graph describes the main demographic and economic status characteristics of the study participants which consist of 43 subjects. The variables include: Age Gender, Address, Marital status, Number of family members, Average of monthly income (NIS), times of admission, type of payment, and cause of admission.

5.2.1.1 Age

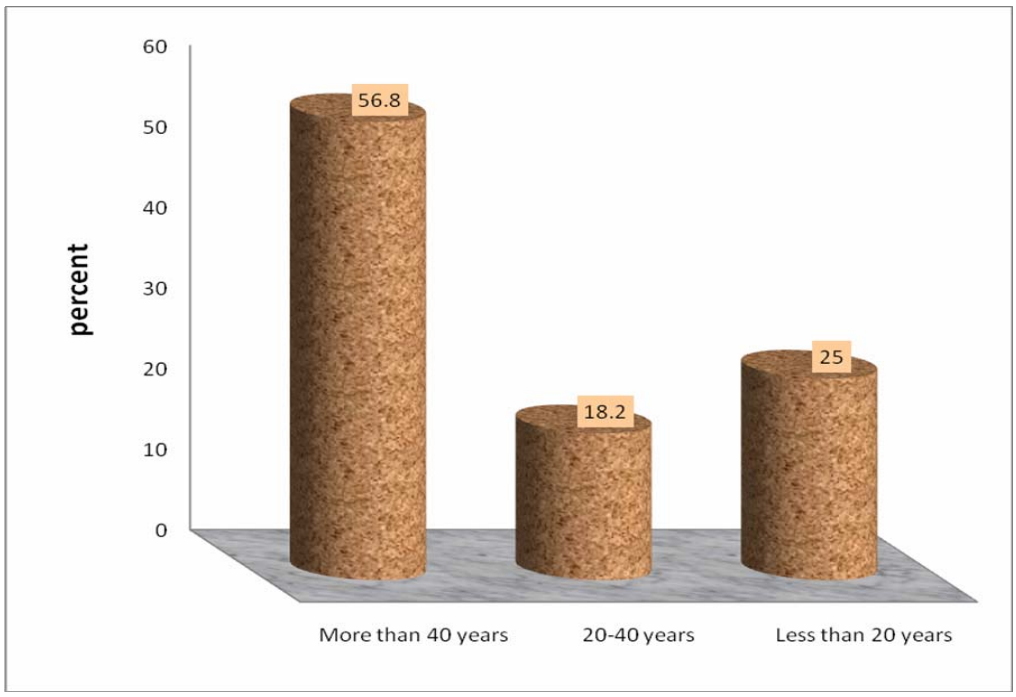


Figure **(5.1)distribution of the study sample by age**

Figure (5.1) shows that 25.0% from the study sample their ages was less than 20 years old. 18.2% from the sample their ages were between 20-40 years old and 56.8% from the sample their ages more than 40 years old.

5.2.1.2 Gender:

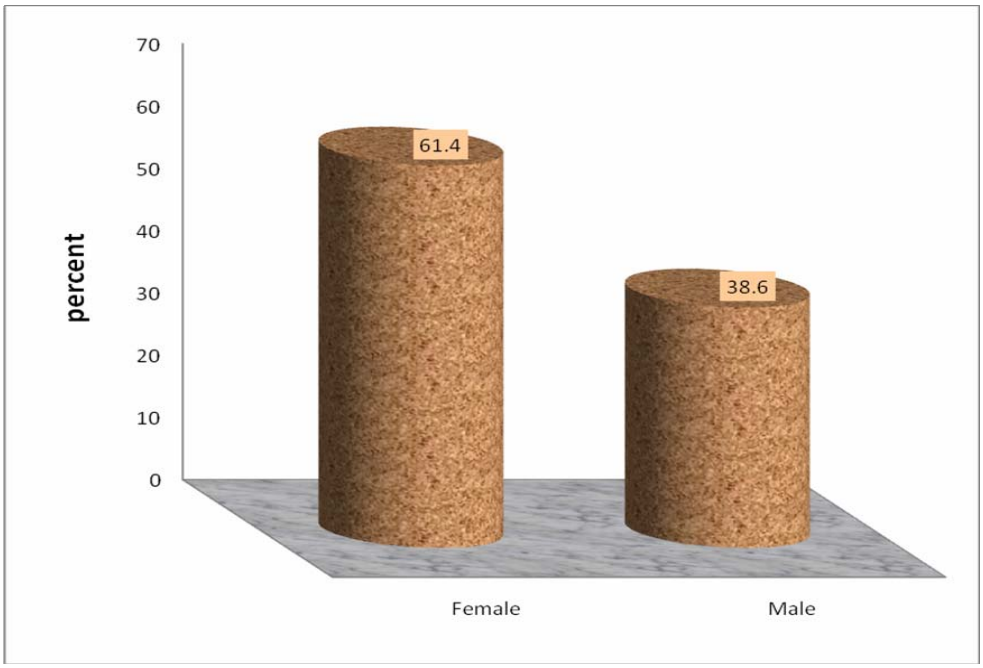


Figure (5.2)distribution of the study sample by gender

Figure (5.2) shows that 38.6% from the sample are male and 61.4% from the sample are female.

The capacity of the female department is 21 beds and male department is 29 bed but the most of admitted patient into male department were spinal cord injured who need long term of care. Female department most of admitted clients old CVA and they come for family training mainly and are admitted for 2-4 week only.

5.2.1.3 Address

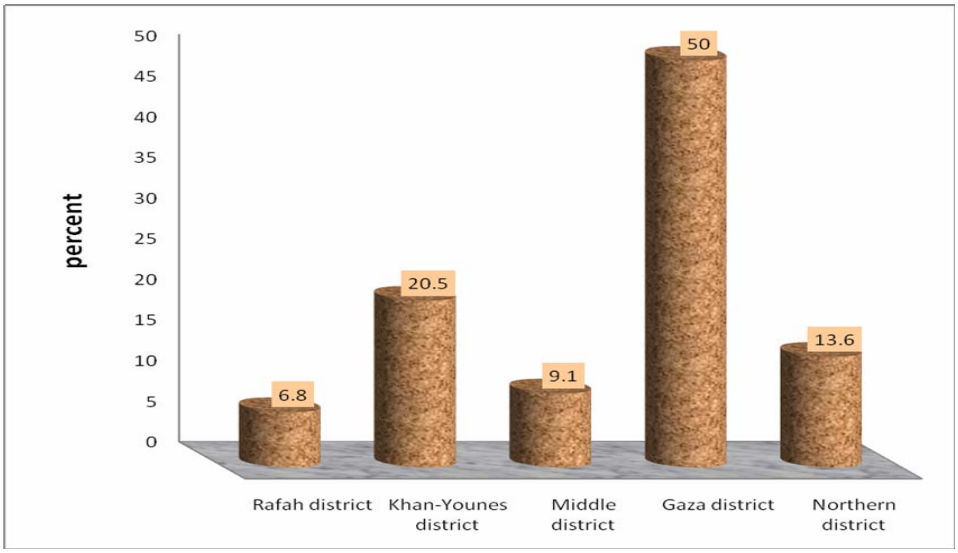


Figure (5.3)distribution of the study sample by address

Figure (5.3) shows that 13.6% from the sample were from northern district, 50.0% from the sample were from Gaza district, 9.1% from the sample were from middle district, 20.5% from the sample were from Khan-Younes district and 6.8% from the sample were from Rafah district.

Shifa hospital is the largest in Gaza strip. Most of cases treated in shifa hospital were many doctors are specialists and oriented relatively to rehabilitation, therefore; most of rehabilitation clients come from Gaza district

5.2.1.4 Marital status:

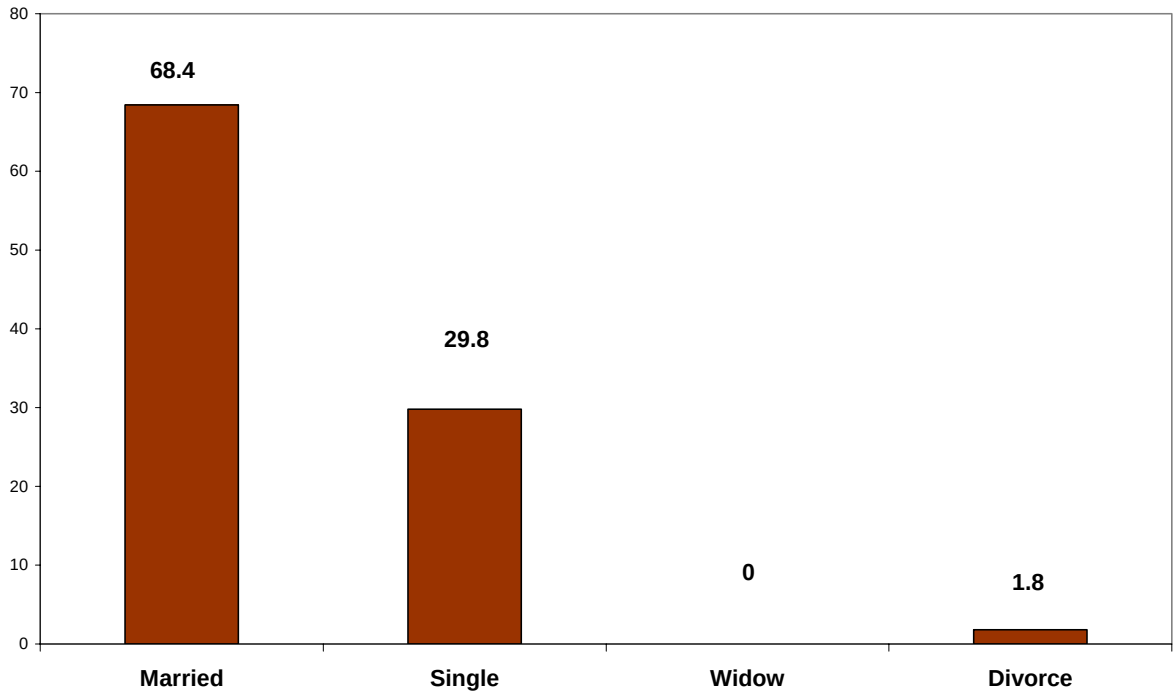


Figure (5.4)distribution of the study sample by marital status

Figure (5.4) shows that 31.8% from the sample were single, 40.9% from the sample were married, 25.0% from the sample were widow and 2.3% from the sample were divorce.

5.2.1.5 Number of family members

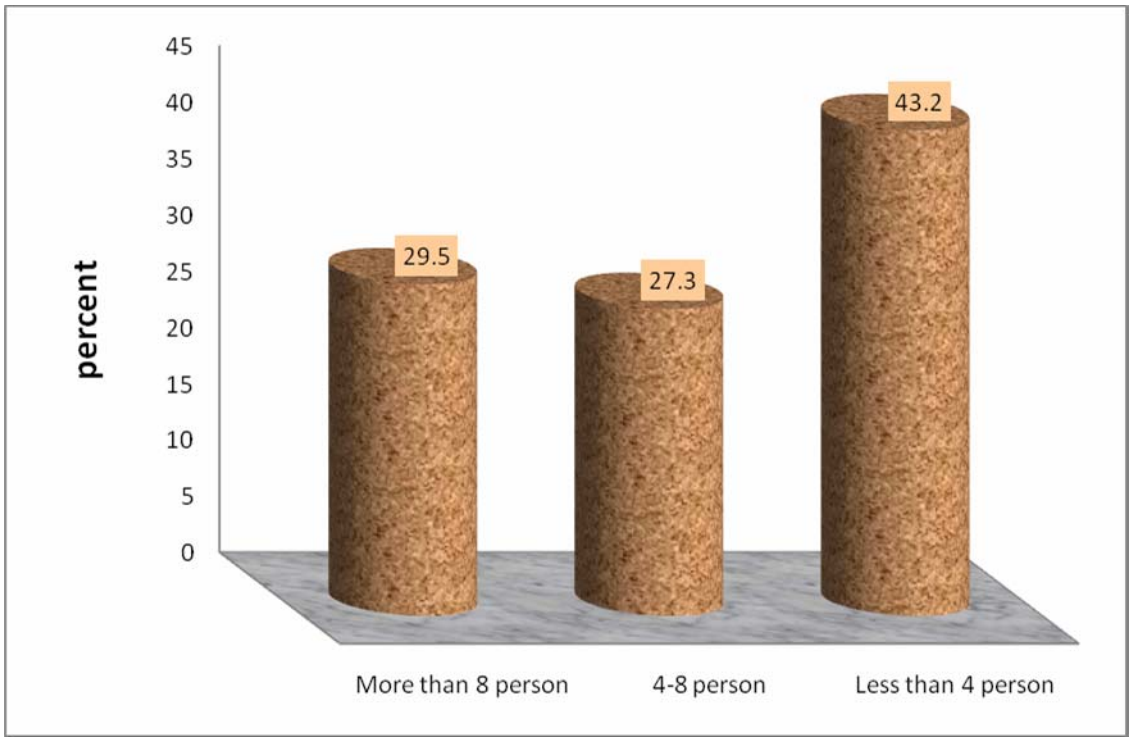


Figure (5.5) distribution of the study sample by number of family members

Figure (5.5) shows that 43.2% from the sample their family numbers was less than 4 person, 27.3% from the sample their family numbers were 4-8 persons and 29.5% from the sample their family numbers were more than 8 persons.

About 84% of the sample were more than 20 years old according to the culture in Gaza strip marriage age is relatively 20-25 years, therefore; the family number is big.

5.2.1.6 Average of monthly income(NIS)

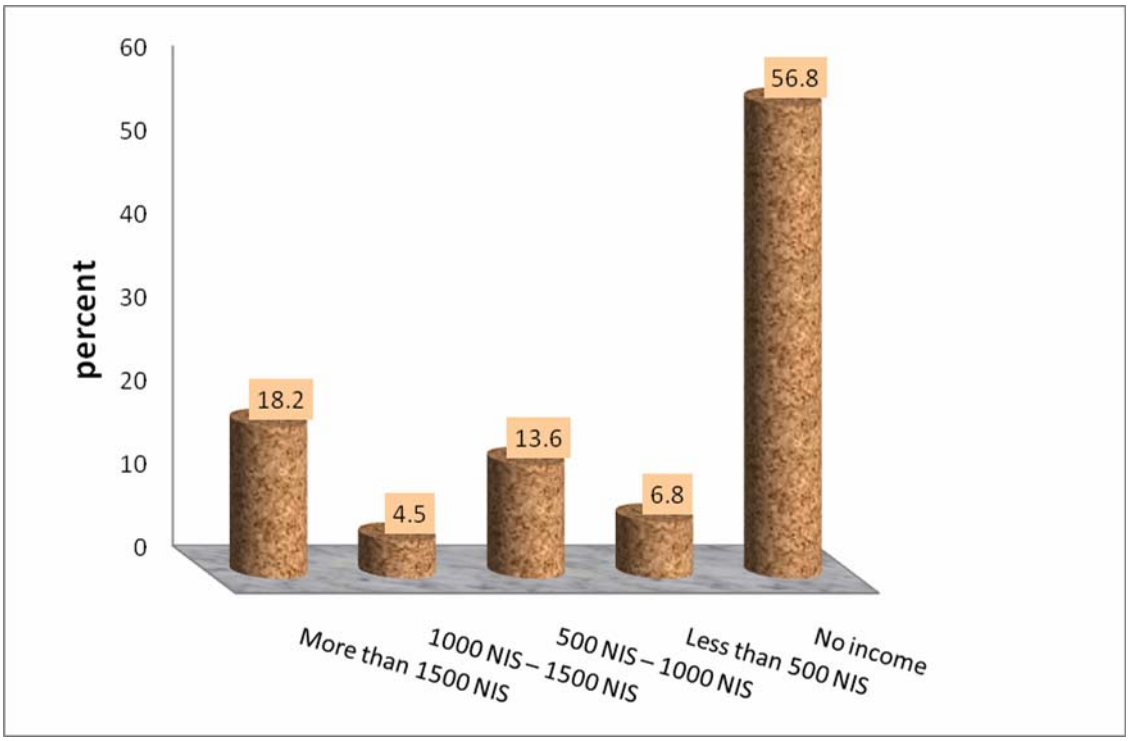


Figure (5.6)distribution of the study sample by average of monthly income

Figure (5.6) shows that 56.8% from the sample has no income, 6.8% from the sample their income was less than 500NIS, 13.6% from the sample their income was 500NIS -1000NIS, 4.5% from the sample their income was 1000NIS-1500NIS and 18.2% from the sample their income more than 1500NIS.

About 86.2% of sample had income less than 1000NIS which reflects the bad economic status in G.S.

5.2.1.7 Level of qualification.

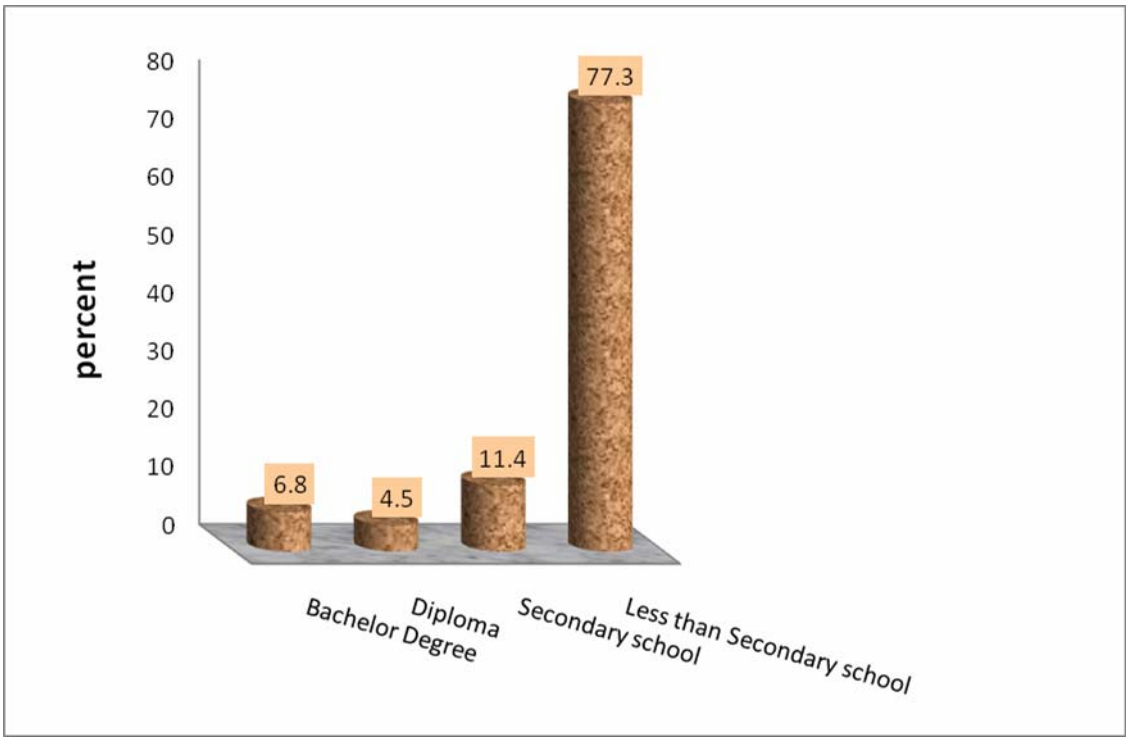


Figure (5.7)distribution of the study sample by level of qualification

Figure (5.7) shows that 77.3% from the sample were less than secondary school, 11.4% from the sample were secondary school, 4.5% from the sample were diploma holders and 6.8% from the sample were bachelor degree holders.

The majority of participant clients (77.3%) in the study low education and this explains the difficulty to understand rehabilitation process. This lead to some complains against the team. Despite of that clients are still satisfied as will explained latter.

5.2.1.8 Times of admission

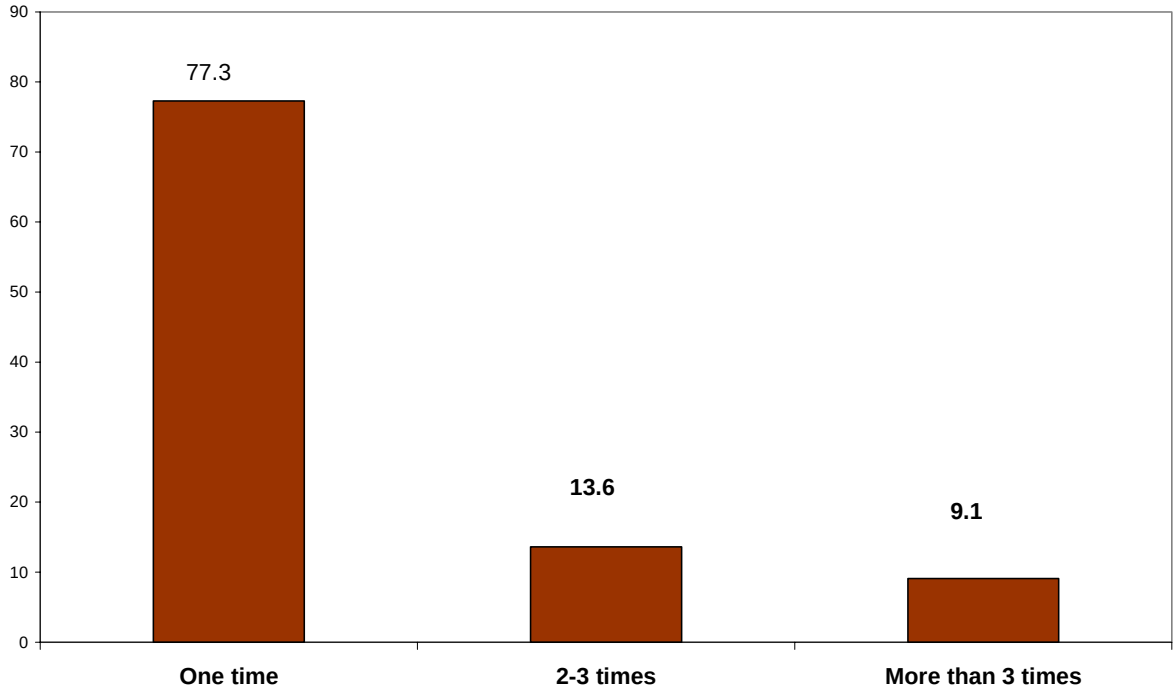


Figure (5.8)distribution of the study sample by times of admission

Figure (5.8) shows that 77.3% from the sample were admitted once, 13.6% from the sample were admitted 2-3 times and 9.1% from the sample were admitted more than 3 times.

This percentage reflects that the rehabilitation program is well established before discharge and family training program is well done. Therefore; readmission counted for less than one fourth admission(22.7%).

5.2.1.9 Cause of admission

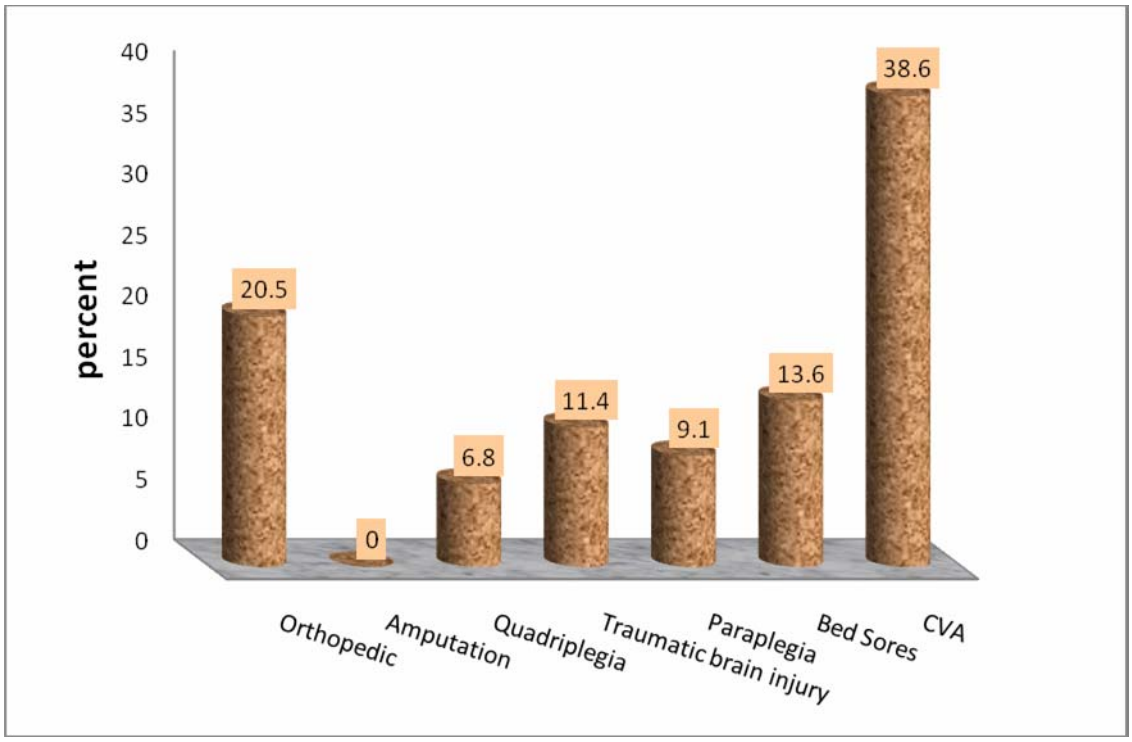


Figure (5.9)distribution of the study sample by cause of admission

Figure (5.9) shows that 38.6% from the sample were stroke (CVA) clients, 13.6% from the sample were bed sores clients, 9.1% from the sample were paraplegia clients, 11.4% from the sample were traumatic brain injury clients, 6.8% from the sample were quadriplegia and 20.5% from the sample were orthopedic cases

This mean that EL-Wafa hospital deal with large variety of rehabilitation diagnosis.

5.2.1.10 Type of payment of hospital fees

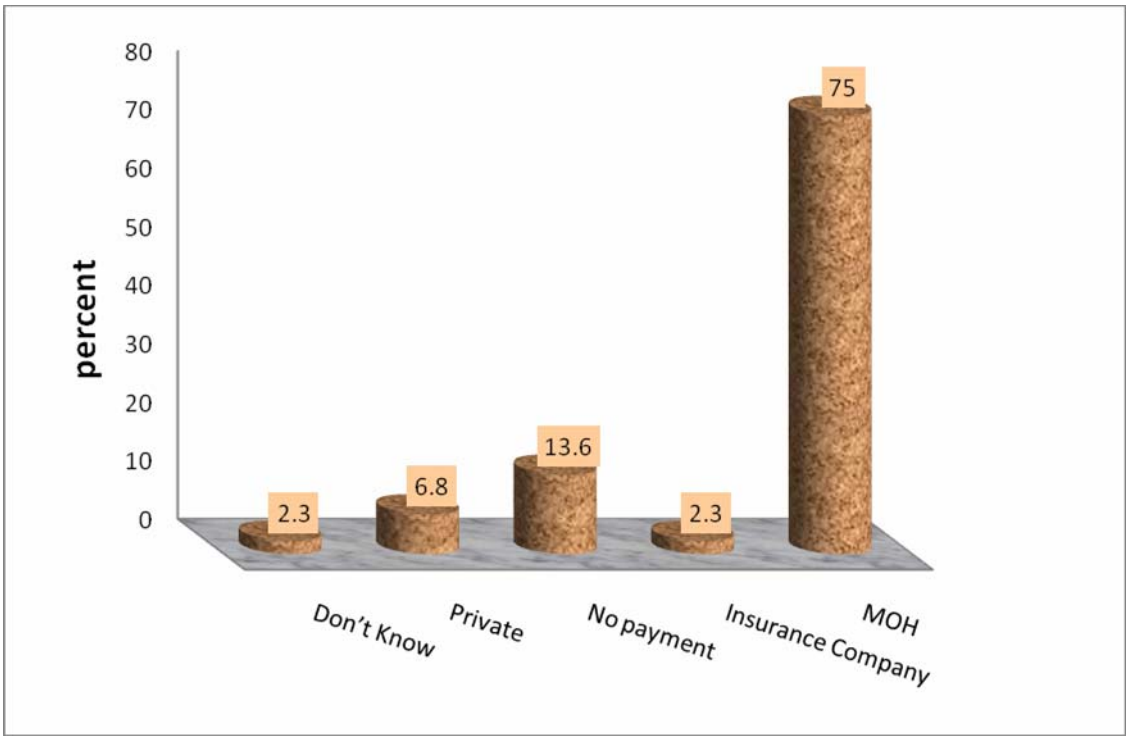


Figure (5.10)distribution of the study sample by type of payment

Figure (5.10) shows that 75.0% from the sample were covered by MOH, 2.3% from the sample were covered by insurance company,13.6% from the sample were free of charge and 6.8% from the sample were private clients and 2.3% from the sample didn't know the source of coverage for their hospitalization fees .

MOH a main consumer of rehabilitation services from EL-Wafa hospital ; it is responsible for then quarters of referral. Few cases come as private or free of charge (6.8%,13.6%). This could be attributed to low income of participants in study and therefore they ready on MOH to cover their hospitalization fees.

5.3 RESULT AND DISCUSSION:

5.3.1.Result of the first research question:

First question: What is the level of client's satisfaction with provided services at El-Wafa Medical Rehabilitation Hospital?

To answer this question the researcher studies each rehabilitation individually, namely: doctors, nurses, physiotherapist, occupational therapy , Psychologist and social worker services.

The client's opinion toward doctor services:

☒ **Interpretation the result of the first domain:**

Table(5-1)

Show the result of opinion of the sample about the doctor services.

Item	mean	Standard deviation	weight mean
Doctor is skillful	4.11	0.689	82.27
Doctor give me information about the possible side effect of treatment	3.45	1.109	69.09
Doctor give me information about the possible benefits about treatment	3.55	1.066	70.91
Doctor describing procedures to me prior to do them	3.59	1.019	71.82
Doctor explain treatment alternative with me	3.23	1.344	64.55
Doctor discus my treatment plan with my	3.75	0.991	75.00
Doctor helpful	4.23	0.605	84.55
Doctor explain to me my condition	4.00	0.778	80.00
Doctor understand what I say	4.14	0.824	82.73
All items	3.78	0.634	75.66

This domain was measured by 9 items .starting with item " Doctor is skillful" up to the item" Doctor understand what I say ". Results showed a significant and positive opinion of client toward the doctor's services. As a general for all items of the field (Doctor services) the mean is 3.78 and weight mean is 75.66 which is greater than 60%. This means there is a significant positive opinion of client toward the doctor services .This could be attributed to the fact that the organization has good and qualified doctors who care with clients .In addition, medical professionals possess good communication skills which facilitates way of explaining treatment plan step by step to clients and, therefore,

share the clients in therapeutic plan. Such a positive and constructive relationship is crucial for successful rehabilitation intervene.

Congruous with study result of Jovanoviae, (2005) who explore level of satisfaction of patients with physicians and nurses and provided information about patient's expectation from healthcare professionals at the Institute of Oncology Sermska Kamenica. with 65 subjects. The survey results showed that patients had mostly positive level of satisfaction with physicians.

Kumari et al. (2009) determined the areas and causes of low satisfaction among the patients and suggested methods for improvement. The overall satisfaction regarding the doctor-patient communication was more than 60% at all the levels of health care facilities, but satisfaction with the examination and consultation was less than 60%.

In addition Powell, (2001)assessed patient's satisfaction for critical access hospital. Overall satisfaction with physician services was positive. Patients generally were more satisfied with the physicians ability, thoroughness, skill and aftercare instructions than with their responsiveness to questions, explanation of tests, procedures and treatments, and courtesy and respect given.

The client's opinion toward nursing services:

☒ **Interpretation the result of the second domain:**

Table(5-2)
Show the result of opinion of the sample about the nursing services

Item	mean	Standard deviation	weight mean
Nurses explain treatment side effect to me	3.50	1.191	70.00
Nurses give me complete daily care	4.57	0.661	91.36
Nurses deal with me according my treatment plan	4.32	0.740	86.36
The nursing morning care badly affects the work of other teams	2.02	1.045	40.45
Nurses respect my privacy	4.39	0.689	87.73
Nurses organize their work with other team members	4.27	0.758	85.45
All items	**3.84**	**0.518**	**76.89**

The mean for nursing services was 3.84 and the weight mean was 76.89 which is greater than " 60%. Client are positive toward nursing services. Through the According to findings presented, client opinion from the service provided by the nursing staff are positive, nursing staff presents quality professional performance. The quality of work submitted differ from any other hospital; the nursing staff is the only who continue with the client throughout the day and make all daily care everyday compensating patient making up client's family. Despite a shortage of nursing, the administration is trying to fix the ratio "nursing to clients numbers". Sometimes the ratio less than need. Client's comfort and quality of care are tested especially when door are open and hear any complaint and solve it.

The study results are consisted with Abu Saileek, (2004) who assessed level of client's satisfaction with nursing care in two major governmental hospitals in south Gaza. By using cross sectional design,159 subjects from European Gaza Hospital and 268 from Nasser Hospital share in the study, result revealed that the level of satisfaction is 70.1% in both hospitals ,where satisfaction level in European Gaza Hospital was 61.7% while in the current study it is 71.73%.

Jovanoviae, (2005) explored level of satisfaction of patients from physicians and nurses in healthcare at the Institute of Oncology Sermska Kamenica. with 65 subjects. The survey results showed that patients had mostly positive level of satisfaction with nurses.

In addition, Clark et al. (1996) mentioned that African American consumer were less satisfied with discharge teaching than white consumer. Nursing staff was recommended to spend more time on discharge teaching with rural African American consumer.

On other hand Alasad and Ahmead, (2003) investigated patient's satisfaction with nursing care about major teaching hospital in Jordan. The sample size was 266 in-patients. The result showed that patients in surgical wards associated with lower level satisfaction than patients in medical or gynecological wards.

The client's opinion toward Physiotherapy services:

☒ **Interpretation the result of the third domain:**

Table(5-3)
Show the result of opinion of the sample about the physiotherapy services

Item	mean	Standard deviation	weight mean
I receive PT sessions daily	4.27	1.149	85.45
Physiotherapists coordinate sessions time with other team	4.02	1.089	80.45
physiotherapist spend enough time with me	3.86	0.955	77.27
I have more than one session per day	2.86	1.407	57.27
My session don in the Gym.	2.89	1.466	57.73
Physiotherapists use electric equipment during sessions	3.09	1.491	61.82
The equipment used in PT sessions are available	3.18	1.369	63.64
Physiotherapists cooperative with other team	3.75	1.222	75.00
Physiotherapists deals kindly with me	4.39	0.993	87.73
Physiotherapists respect of my privacy	4.34	0.963	86.82
All items	**3.67**	**0.912**	**73.32**

Interpretation the result of the third domain:

For all items of the field physiotherapy services the mean is 3.67 and weight mean is 73.32 which is greater than 60%. There is positive opinion of client toward the Physiotherapy services. The role of physiotherapists is very important as the rest of the roles of the team. Availably of competent team who is doing accurately, perfecting work, help, clients understand the nature and extent of progress and to what extent an addition to assist the patient to recover physically. This increases confidence in the therapist and leads to satisfaction with the roles.

This result is in agreement with the finding of Hilles, (2008)who examined outpatients' satisfaction with physiotherapy services at Al-Shifa Hospital and El-Wafa Medical Rehabilitation Hospital in Gaza by using 51 subjects from El-Wafa hospital and 100 subjects from Al-Shifa hospital. The result of the study showed significant differences between patients satisfaction level of Al-Wafa Medical Rehabilitation Hospital and Al-Shifa Hospital, whereas (100%)in WMRH and 83% in Al-Shifa Hospital. However, in both facilities physiotherapy services ere satisfactory.

Consistent with Hilles study ,their was another study of(Beattie et al. (2002) who conducted a study to develop and test an instrument used to determine which variable are associated with the satisfaction of patients receiving outpatient physical therapy. 1,868 patients participated in the main phase of this work. The result showed that patient were more satisfied which reflected a high-quality of interaction with the physical therapists.

The current study results are consistent with Mazer et al.(2006) who examine occupational therapy and physiotherapy perceptions regarding waiting time and the quality and quantity of services provided to children with disability. In both studies, experienced therapists rated quality of service provided as high.

The client's opinion toward Occupational therapy services:

☒ **Interpretation the result of the fourth domain:**

Table(5-4)

Show the result of opinion of the sample about the occupational therapy services

Item	mean	Standard deviation	weight mean
I receive occupational therapists (OT) sessions	4.02	1.248	80.45
Occupational therapists coordinate sessions time with other team	3.70	1.250	74.09
Occupational therapists share me in the decisions taken for me	3.68	1.216	73.64
Occupational therapists spend enough time with me	3.75	1.164	75.00
My session don in the occupational therapy department.	3.52	1.355	70.45
Occupational therapists use assisted equipment during sessions	3.48	1.372	69.55
The equipment used in OT sessions are available	3.48	1.372	69.55
Occupational therapists cooperative with other team	3.73	1.246	74.55
Occupational therapists deals kindly with me	4.16	1.055	83.18
Occupational therapists respect of my privacy	4.14	1.091	82.73
All items	**3.77**	**1.084**	**75.32**

For all items of the field occupational therapy services the mean is 3.77 and weight mean is 75.32 which is greater than 60%. There is a significant positive opinion of client toward the Occupational therapy services .

Disabled person face many obstacles to achieve daily care by his/herself therefore, occupational therapy role is very important in how to regain the client's function or teach them alternative methods to assist them be independent in daily care. If this goals achieved, the self-confidence increases because recalled what missed and he /she is a human being capable to do daily activities. In addition, improvement of functions leads to improve trust between occupational therapy and clients.

These study findings are consistent with the result of Gilbertson, (2000) who aimed to investigate if a brief program of domiciliary occupational therapy could improve the recovery of patients with stroke discharged from hospital. Patients in the intervention group were more likely to report 95% satisfaction with a range of aspects of occupational therapy services.

Other study of Kealey and McIntyre, (2005) evaluated the domiciliary occupational therapy service in palliative cancer care in a community trust: a patient and careers perspective. A sample of 30 patients and their primary informal careers were selected using purposive sampling. Participants reported report high levels of satisfaction.

On other hand, the study of Jawdsheikh, (1992) evaluated the attitudes and views of doctors, nurses and patients towards occupational therapy. The results showed 59% were not informed of the occupational therapy referral; 46% of the patients were not consulted by their doctor or nurse before being referred and 61% were not aware that occupational therapy was part of their treatment. Nevertheless, 91% were happy to attend occupational therapy but only 55% felt it was relevant to their illness.

The client's opinion toward Social worker services:

☒ **Interpretation the result of the fifth domain:**

Table(5-5)
Show the result of opinion of the sample about the social worker services

Item	mean	Standard deviation	weight mean
social worker follow my case with other team	3.14	1.488	62.73
I know the social worker	3.14	1.637	62.73
The social worker visited me in my bed	3.25	1.572	65.00
I request a certain help from the social worker	2.84	1.430	56.82
I have received a certain service from the social worker	2.64	1.526	52.73
The social worker keep my privacy	3.50	1.533	70.00
All items	**3.08**	**1.377**	**61.67**

For all items of the field social worker the mean equals 3.08 and the weight mean equals 61.67. There is no positive opinion of client toward the Social worker services.

Social Worker is able to offer financial counseling to patients and their families and provide them with resources that provide assistance throughout their treatment. Social service include :transportation, home care/respite care and assistance with medication/insurance needs. Social worker is very important member of rehabilitation tem . Clients and family misunderstand the role of social worker and they expected the more from social worker .

Relevant to social worker services the study of Reimand et al. (2003) investigated the extent of parent's satisfaction with medical and social services in Estonia provided for the down's syndrome individuals and their families. The study used a sample of 59 down's syndrome parents. The result showed that most parents were not satisfied with the social and rehabilitation benefits.

Congruous with the study result of Reimand the study of Joan , (2008) who investigated the impact of social workers' involvement with end-stage renal disease patients receiving haemodialysis. The researcher used a survey to collect data from 62 clients and found that the 31 who had a third less access to a social worker had statistically significant poorer quality of life.

Other study of Jawahar, (2007) was conducted to know the satisfaction level of patients and get feedback about the services provided in the outpatient departments. The result about the question on guidance received from the hospital; 60% said that the staff of the hospital always guided them. The guidance was provided to 59% of the patients by the Social Workers .

The client's opinion toward Psychologist services:

☒ **Interpretation the result of the six domain:**

Table(5-6)
Show the result of opinion of the sample about the psychologist services

Item	mean	Standard deviation	weight mean
psychologist follow my case with other team	3.20	1.564	64.09
I know the psychologist	3.34	1.524	66.82
The psychologist visited me in my bed	3.39	1.543	67.73
I request a certain help from the psychologist	2.57	1.531	51.36
I have received a certain service from the psychologist	2.59	1.530	51.82
The psychologist keep out my privacy	3.55	1.532	70.91
All items	**3.11**	**1.391**	**62.12**

For all items of the field psychologist services, the mean equals 3.11 and the weight mean equals 62.12. There is no significant positive opinion of client in the Psychologist services.

Emotional support is a crucial part of patient satisfaction and should be provided by several members of the rehabilitation team, especially, psychologist. The most important problem facing clients is long stay in the hospital, in addition to the philosophy of hospital that no career stay with clients from his family except if they help in treatment plan. Psychological problems and complain increase especially, during evening and night shifts. Psychologist is very helpful for clients to cope with the new situation, but only one psychiatrist in EL-Wafa medical rehabilitation hospital can't meet the needs of patients in male and female departments. Therefore, the mean satisfaction of clients from psychologist is low compared with other departments such as medical, nursing, occupational and physiotherapist.

Congruous with the study result of Ytterberg et al. (2008) who explored the perceived needs and satisfaction with care amongst multiple sclerosis over a two-year study. They used a sample of 219 outpatients at a multiple sclerosis specialised clinic. The results showed that least satisfied with the availability of psychosocial support/counseling.

Consistent with Ytterberg et al. (2008) the study result of Smith et al. (1995) that examined patients satisfaction system for disablement services centers and report on how the initial findings have been used in audit to improve their quality of care and services Smith et al. (1995) used a sample of 123 amputees patient in the development phase who were selected by cluster sampling. The results showed that the lower satisfaction for counseling services.

Other relevant study of Singer et al. (2009) examined quality of care and emotional support from the inpatient cancer patient's perspective. 56% of the patients were highly emotionally distressed and 33% wanted support from psychologists.

In contrary, the study of Jawahar, (2007) which was conducted to evaluate the satisfaction level of patients and also get a feedback about the services provided in the outpatient departments in finding regard to the privacy in consultation. 97.5% of the patients were satisfied.

The level of satisfaction with care varied and areas with potential for improvement identified a need to increase psychosocial support and counseling service.

5.3.2 RESULT OF THE SECOND RESEARCH QUESTIONS:

Second question: To what extent team work services and clients participation with team decision effective from client perspective?

☒ **Interpretation the result of second question:**

Table No.(5-7)
Team work services

Are you ready to go for home visit	Frequency	Percent
strongly agree	11	25.6
Agree	0	0.0
Uncertain	4	9.3
Disagree	11	25.6
strongly disagree	17	39.5
The decision to go for home visit was taken by	**Frequency**	**Percent**
Hospital team	8	22.2
Yourself	6	16.7
Together	22	61.1
Did the hospital team train your family to deal with you	**Frequency**	**Percent**
Yes	28	71.8
No	11	28.2
Did you face any problem while you were on home visit?	**Frequency**	**Percent**
Yes	22	52.4
No	20	47.6
Did you speak with the hospital team about the problems?	**Frequency**	**Percent**
Yes	10	45.5
No	12	54.5
If yes the hospital team help you in finding solutions?	**Frequency**	**Percent**
Yes	16	72.7
No	6	27.3
Are you dependant on your self on daily living activity	**Frequency**	**Percent**
Yes	27	61.4
No	17	38.6
The percent dependant on your self on daily living activity	**Frequency**	**Percent**
Yes 25%	4	14.8
Yes 50%	16	59.3
Yes 70%	6	22.2
Yes 100%	1	3.7

Table No.(5-8)
Clients opinion twored visit

Your family is visiting you	Frequency	Percent
Yes	33	75.0
No	11	25.0
If yes they visit you every	**Frequency**	**Percent**
Day	27	81.8
two days weekly	3	9.1
once weekly	3	9.1
The cause	**Frequency**	**Percent**
Difficult transportation to the hospital	2	18.2
No time	1	9.1
The location of the hospital	3	27.3
Economic status	3	27.3
Others	2	18.2

Table No. (5-8) shows that 75 % from the sample agree that the families are visiting them , but 25 % reported that they were not visited by their families.

The location of the hospital is very far from the city and near the boarders with "Israel" which adds danger to situation. .This reason was the main problem for visitors and transportation especially reason during aggression on Gaza. The families couldn't vist their clients until aggression finished.

Table No.(5-9)
Home adaptation

Are the rehabilitation team visit your home to evaluate if the home suitable for your case or not?	Frequency	Percent
Yes	5	11.4
No	39	88.6
Are the rehabilitation team assist you to defend community based program after discharge?	**Frequency**	**Percent**
Yes	10	24.4
No	31	75.6

A rehabilitation team which includes (a physician, case managers, rehabilitation nurses, occupational therapists, physical therapists, speech/language pathologists, and psychologist social worker) is responsible for client from admission until discharge, starting with evaluation, goal setting and finally family training.

Family training starts since admission to prepared client for discharge. All the team members work together to develop a treatment plan that meets the patient's short and long-term goals.

Effective interaction between team members has been associated with greater efficiency and decreased workloads, improved clinical outcomes, reduced patient morbidity, improved job satisfaction , retention and improved patient satisfaction.

Through the literature review the researcher found that the study of John and Politis , (2006) which explored the relationship between the dimensions of self-leadership behavioral-focused strategies, job satisfaction and team performance.

The study evaluates the extent to which job satisfaction mediates the influence of self-leadership behavioral-focused strategies on team performance. The result was team performance is positive and significant. Another relevant study of Thylefors et al. (2005) the result showed a moderate positive correlation was found between team type and perceived efficiency as well as team climate.

Table No.(5-10)

On this axis the researcher put all the question related to team work in this table

Question	Percent
Nurses organize their work with other team members	85.45%
Physiotherapists coordinate sessions time with other team	80.45%
Occupational therapists cooperative with other team	75.44%
Social worker follow my case with other team	62.73%
Psychologist follow my case with other team	64.09%

Table (5-10) indicate that a positive opinion about team work from clients perspective.

Relevant to family training that was done by rehabilitation team, high percentage of the study sample was satisfied with family training program started from home visit till discharge. This explains the low percentage of re-admission to EL-Wafa hospital.

Home visit is the first step in discharge plan and primarily to facilitate a timely, safe and successful discharge from hospital and put the patient in the real world.

Consistent with study result of McDonagh and Southwood, (2006) who showed that a significant improvements were reported by adolescent and parent ratings at 6 and 12 months and for most secondary outcome measures with no significant deteriorations between 6 and 12 months. Continuous improvement was observed for both adolescent and parent knowledge with significantly greater improvement in the younger age groups at 12 months (P = 0.002).

On the other hand Atwalet al. (2007) disagreed with the research result. This study revealed that the older adults are not fully prepared to undertake home visits, but carers offer them reassurance about the discharge process.

Social Workers play a key role in assisting patients to integrating into the community. This involves working with the patient , family and community, to access appropriate resources and link with a support network within their community. The study result indicate negative opinions about transition to community based rehabilitation. This is due to, as mentioned before misunderstanding of the real role of social worker which need to do more to meet the essential need of the client life.

Congruous with the result of Mitchell and Swinkels, (2008) about prevention and management of delayed transfer of older people from hospital to community settings is an enduring issue in industrialized societies and is the subject of many recent policies in the United Kingdom. Findings showed that participants actively or passively relinquished their involvement in the processes of discharge planning because of the perceived expertise of others and also feelings of disempowerment secondary to poor health, low mood, dependency, lack of information and the intricacies of discharge planning processes for complex community care needs.

Also home adaptation is another team duties**,** home adaptations is very important in improving safety of disabled people. Physical changes occur in disabled person need change in his/her environment according to new situation .such as home adaptation , work environment adaptation.

Adaptation is recommended all rehabilitation team members. Rehabilitation team recommend the need of clients according to disability and ability. Then enjoiners engineers put the plan for applying the recommendations to achieve plan. Finally, this is expensive and no donor or society responsible for the money that is needed for this adaptation. On the other hand, the closure adds more obstacle to home adaptation. This explains the negative perception about home adaptation services.

Heywood, (2001)in study found appositive impact of home adaptation which includes reducing the need for hospital and residential care. The researcher suggests effective use of public money and increase investment, particularly from health budgets, because of adaptation demonstrable preventative effect.

Table No.(5-11)
Continuing treatment after discharge

Did you want continuo in treatment after discharge?	**Frequency**	**Percent**
Yes	40	90.9
No	4	9.1
Total	44	100.0

Table No. (40) shows that 90.9% from the sample agree to continue treatment after discharge, but 9.1% does not agree. That interpret the result of satisfaction of team work that lead to about 90.9% wants to continuo the treatment plan in WMRH in despite of clients not satisfied with some services.

5.3.3 RESULT OF THE THIRD RESEARCH QUESTIONS:

Third question Are there statistical significant differences in the levels of client's satisfaction taking into account selected demographic variables? In order to answer this question the researcher explore some variables such as gender, age ,marital stats, level of qualification, type of payment and cause of admission monthly income related to clients opinions.

Table No.(5-12)
T dependant test for respondent of the sample on department regarded to gender

Department	Gender	N	Mean	Std. Deviation	T	P-value
Doctor Department	**Male**	17	3.8758	0.6971		
	Female	27	3.7243	0.5971	0.768	0.447
Nursing Department	**Male**	17	3.8137	0.5770		
	Female	27	3.8642	0.4871	-0.312	0.757
Physiotherapy department	**Male**	17	3.8588	0.9118		
	Female	27	3.5444	0.9086	1.116	0.271
Occupational therapy	**Male**	17	3.9059	0.9858		
	Female	27	3.6778	1.1514	0.675	0.503
Social worker	**Male**	17	3.5490	1.2044		
	Female	27	2.7901	1.4192	1.827	0.075
Psychologist	**Male**	17	4.0196	0.8698		
	Female	27	2.5309	1.3580	4.021	0.000
TOTAL	**Male**	17	3.8473	0.6554		
	Female	27	3.4224	0.6305	2.144	0.038

at degrees of freedom "43" and significant level 0.05 equal 2.02 The critical value t

An independent t-test used to compare the domain of clients' perspective regard to the gender. Table (5-12) illustrates that males and females had similar means scores as a whole with overall and all domain of services except for occupational therapy, social worker, and psychologist. The result showed no statistical significant differences were recorded between both gender regarding total of services.

☒ **Interpretation the result :**

The researcher believes that both male and female have a similar services from similar qualified therapists in the same circumstances.

Finding of this study are similar with Hillis, (2008) study result that found no statistical significant difference between both genders regarding satisfaction with physiotherapy. The finding are consistent with result study of Al-Hindi, (2002) who found that there are no significant differences between two genders and clients satisfaction. Moreover, the finding are emphasized by Abu Saileek, (2004) who studed who cited clients satisfaction with nursing care in Gaza strip and explored that there are no statistically significant difference between two genders of clients and their satisfaction.

Table No.(5-13)

One way ANOVA test for respondent of the sample on department regarded to age

Department	Source	Sum of Squares	df	Mean Square	F	Sig.
Doctor Department	Between Groups	0.876	2	0.438	1.095	0.344
	Within Groups	16.407	41	0.400		
	Total	17.283	43			
Nursing Department	Between Groups	1.461	2	0.731	2.977	0.062
	Within Groups	10.061	41	0.245		
	Total	11.522	43			
Physiotherapy department	Between Groups	4.942	2	2.471	3.283	0.048
	Within Groups	30.857	41	0.753		
	Total	35.799	43			
Occupational therapy	Between Groups	2.944	2	1.472	1.267	0.292
	Within Groups	47.615	41	1.161		
	Total	50.559	43			
Social worker	Between Groups	7.313	2	3.657	2.019	0.146
	Within Groups	74.270	41	1.811		
	Total	81.583	43			
Psychologist	Between Groups	13.670	2	6.835	4.032	0.025
	Within Groups	69.501	41	1.695		
	Total	83.172	43			
total	Between Groups	2.523	2	1.261	3.121	0.055
	Within Groups	16.570	41	0.404		
	Total	19.092	43			

The critical value F at degrees of freedom "2,41" and significant level 0.05 equal 3.23

Table No.(5-14)
Multiple Comparisons L S D test

department	Mean Difference	Less than 20 years	20-40 years	More than 40 years
Physiotherapy department	**Less than 20 years**		-0.39545	0.458545
	20-40 years	0.395455		0.854
	More than 40 years	-0.45855	-0.854	
Psychologist	**Less than 20 years**		-0.39773	0.927273
	20-40 years	0.397727		1.325
	More than 40 years	-0.92727	-1.325	

One way ANOVA was used to evaluate the differences between the age group regarding the services they received. Results in table No.(5-13) showed no difference between respondents about each department (Doctor Department, Physiotherapy department, Occupational therapy, Social worker) regard to
age except physiotherapy and psychologist services as show in table (5-14) comparisons regarded age group between 20-40 years.

☒ **Interpretation the result**

Most researche findings indicated that expectations change and show differences between different age group. Zourob, (2007) in his study, results reveled a significant statistical differences between age of mother and general satisfaction. Result showed that those mothers who were at the 17-25 years age group have lower score of perspectives, while the age group who more than 34 years reported the higher score of perspective diminution. Mousa, (2000) in his study also reported that the level of satisfaction increased as age was decreased and older people in Palestine context tend to be less satisfied than younger people.

On other the hand Abu Saileak, (2004) founded that there was a significant relationship between satisfaction and age and other socio- demographic variables.

Table No.(5-15)
One way ANOVA test for respondent of the sample on department regarded to address

Department	Source	Sum of Squares	df	Mean Square	F	Sig.
Doctor Department	Between Groups	0.4463	4	0.1116	0.258	0.903
	Within Groups	16.8365	39	0.4317		
	Total	17.2828	43			
Nursing Department	Between Groups	0.5153	4	0.1288	0.456	0.767
	Within Groups	11.0068	39	0.2822		
	Total	11.5221	43			
Physiotherapy department	Between Groups	1.8808	4	0.4702	0.541	0.707
	Within Groups	33.9181	39	0.8697		
	Total	35.7989	43			
Occupational therapy	Between Groups	0.9110	4	0.2277	0.179	0.948
	Within Groups	49.6479	39	1.2730		
	Total	50.5589	43			
Social worker	Between Groups	4.8749	4	1.2187	0.620	0.651
	Within Groups	76.7084	39	1.9669		
	Total	81.5833	43			
Psychologist	Between Groups	4.9495	4	1.2374	0.617	0.653
	Within Groups	78.2222	39	2.0057		
	Total	83.1717	43			
total	Between Groups	0.8469	4	0.2117	0.453	0.770
	Within Groups	18.2454	39	0.4678		
	Total	19.0923	43			

The critical value F at degrees of freedom "4,39" and significant level 0.05 equal 2.61

Regarding address (residency place) the researcher used one way ANOVA test. The results of table (5-15) showed that there was no statistical difference related address regarding all diminution of services .

☒ **Interpretation of the result:**

According to address, the result of this study was consistent with Hillis, (2008) cited that there was no statistical significant differences between residency place and patients satisfaction.

On other hand, Zourob, (2007) found that there was significant relationship between mother perspective and governorates. The results showed that the population who live in Khan Younis have higher positive attitudes with the child health services than those whom lives in Rafah. Moreover, the study of Al-Hindi, (2002) reported that there was no significant statistical relationship between client satisfaction and governorate.

Other relevant study of Clark et al. (1996) mentioned that African American consumer were less satisfied with discharge teaching than white consumers holds implications for

nursing practice and advise nursing staff to spend more time on discharge teaching with rural African American consumers.

Table No.(5-16)
One way ANOVA test for respondent of the sample on department regarded to Marital status

Department	Source	Sum of Squares	df	Mean Square	F	Sig.
Doctor Department	Between Groups	1.8059	2	0.9029	2.392	0.104
	Within Groups	15.4770	41	0.3775		
	Total	17.2828	43			
Nursing Department	Between Groups	0.7247	2	0.3623	1.376	0.264
	Within Groups	10.7974	41	0.2634		
	Total	11.5221	43			
Physiotherapy department	Between Groups	2.1072	2	1.0536	1.282	0.288
	Within Groups	33.6917	41	0.8217		
	Total	35.7989	43			
Occupational therapy	Between Groups	0.0110	2	0.0055	0.004	0.996
	Within Groups	50.5479	41	1.2329		
	Total	50.5589	43			
Social worker	Between Groups	11.0049	2	5.5024	3.196	0.051
	Within Groups	70.5785	41	1.7214		
	Total	81.5833	43			
Psychologist	Between Groups	28.8278	2	14.4139	10.875	0.000
	Within Groups	54.3439	41	1.3255		
	Total	83.1717	43			
total	Between Groups	2.0848	2	1.0424	2.513	0.093
	Within Groups	17.0074	41	0.4148		
	Total	19.0923	43			

The critical value F at degrees of freedom "2,41" and significant level 0.05 equal 3.23

Table No.(5-17)
Multiple Comparisons L S D test

department	Mean Difference	Single	Married	Widow
Psychologist	**Single**		-0.746*	1.254
	Married	0.746*		2.000
	Widow	-1.254	-2.000	

As shown in table (5-16) one way ANOVA test used to evaluate the differences between the marital status of the clients regarding the services they received. The results showed that there is are no difference between respondents about each domain regarded marital status except for psychologist comparisons as show in table (5-17) regarded married.

☒ **Interpretation of the result:**

Compared with Hillis, (2008) study, the results reveals that there is no statistical significant difference between marital status and patients satisfaction. On the other hand Abu Saileek, (2004) study revealed that there is statistical differences between marital status and patients satisfaction, married clients reported higher satisfaction level than single clients.

Table No.(5-18)
One way ANOVA test for respondent of the sample on department regarded to Level of qualification

Department	Source	Sum of Squares	df	Mean Square	F	Sig.
Doctor Department	Between Groups	2.9304	3	0.9768	2.722	0.057
	Within Groups	14.3525	40	0.3588		
	Total	17.2828	43			
Nursing Department	Between Groups	2.3041	3	0.7680	3.333	0.029
	Within Groups	9.2180	40	0.2305		
	Total	11.5221	43			
Physiotherapy department	Between Groups	2.6722	3	0.8907	1.076	0.370
	Within Groups	33.1267	40	0.8282		
	Total	35.7989	43			
Occupational therapy	Between Groups	5.8662	3	1.9554	1.750	0.172
	Within Groups	44.6927	40	1.1173		
	Total	50.5589	43			
Social worker	Between Groups	6.3777	3	2.1259	1.131	0.348
	Within Groups	75.2056	40	1.8801		
	Total	81.5833	43			
Psychologist	Between Groups	8.6400	3	2.8800	1.546	0.218
	Within Groups	74.5317	40	1.8633		
	Total	83.1717	43			
total	Between Groups	1.7895	3	0.5965	1.379	0.263
	Within Groups	17.3028	40	0.4326		
	Total	19.0923	43			

The critical value F at degrees of freedom "3,40" and significant level 0.05 equal 2.84

Regarding Level of qualification test, the result of table (5-18) showed that there was no statistical difference between Level of qualification regarding all diminution of services . One way ANOVA test was used.

☒ **Interpretation of the result:**

Compared with result of the study of Zourob, (2007) which show that the mothers perspective scores increased as the educational level of mothers increased, the high

scores reported by the highly educated mothers (college or university) while the lower scores reported by the illiterate mothers. The higher educated mothers have had higher positive views with nearly 94% regarding the over all perspective. Moreover, the study of Al-Hindi, (2002) showed that the respondents with higher level of educational attainment (13 years and more) tended to be more satisfied than others.

On other hand(Abu Shuaib,2005) mentioned that the illiterate women reported the higher scores of perception, while those women who had high education level reported the lowest score of perceptions.

Table No.(5-19)

One way ANOVA test for respondent of the sample on department regarded to Cause of admission

Department	Source	Sum of Squares	df	Mean Square	F	Sig.
Doctor Department	Between Groups	1.1566	5	0.2313	0.545	0.741
	Within Groups	16.1262	38	0.4244		
	Total	17.2828	43			
Nursing Department	Between Groups	1.1610	5	0.2322	0.852	0.522
	Within Groups	10.3610	38	0.2727		
	Total	11.5221	43			
Physiotherapy department	Between Groups	4.5060	5	0.9012	1.094	0.379
	Within Groups	31.2928	38	0.8235		
	Total	35.7989	43			
Occupational therapy	Between Groups	4.5700	5	0.9140	0.755	0.588
	Within Groups	45.9889	38	1.2102		
	Total	50.5589	43			
Social worker	Between Groups	1.7252	5	0.3450	0.164	0.974
	Within Groups	79.8581	38	2.1015		
	Total	81.5833	43			
Psychologist	Between Groups	7.5863	5	1.5173	0.763	0.582
	Within Groups	75.5854	38	1.9891		
	Total	83.1717	43			
Total	Between Groups	1.3536	5	0.2707	0.580	0.715
	Within Groups	17.7387	38	0.4668		
	Total	19.0923	43			

The critical value F at degrees of freedom "5,38" and significant level 0.05 equal 2.46

Result shown in table No.(5-19) for each department, there is no difference between respondent about each department (Doctor Department, Nursing Department, Physiotherapy department, Occupational therapy, Social worker ,Psychologist) regarded to cause of admission.

☒ **Interpretation of the result:**

Regarding the cause of admission and clients perspective regarding services they received, the findings showed that there is no difference between cause of admission and perspective toward services they received. The study conducted by Hillis, (2008) showed that the patients with neurological condition reported higher satisfaction level that patients with orthopedic and other condition.

Consistent with Hillis,(2008) study, Abu Saileek, (2004) reported that the clients who had chronic illness represented percentage (37.3%) and were more satisfied with nursing care than others while the client with injures represented percentage only (14.8%) and were less satisfied.

Other study of Shondoff and Penny, (1987) showed that there was a significant relationship between the degree of disability and general satisfaction.

On the other hand, no relevant literature was found to interpret the researcher result. Most of the available studies search of relation between socio-demographic variable with satisfaction rather than cause of admission.

Table No.(5-20)
One way ANOVA test for respondent of the sample on department regarded to type of payment

Department	Source	Sum of Squares	df	Mean Square	F	Sig.
Doctor Department	Between Groups	1.6083	4	0.4021	1.000	0.419
	Within Groups	15.6745	39	0.4019		
	Total	17.2828	43			
Nursing Department	Between Groups	1.4737	4	0.3684	1.430	0.242
	Within Groups	10.0484	39	0.2577		
	Total	11.5221	43			
Physiotherapy department	Between Groups	5.7364	4	1.4341	1.860	0.137
	Within Groups	30.0624	39	0.7708		
	Total	35.7989	43			
Occupational therapy	Between Groups	6.1008	4	1.5252	1.338	0.273
	Within Groups	44.4580	39	1.1399		
	Total	50.5589	43			
Social worker	Between Groups	8.2673	4	2.0668	1.099	0.371
	Within Groups	73.3161	39	1.8799		
	Total	81.5833	43			
Psychologist	Between Groups	5.1296	4	1.2824	0.641	0.637
	Within Groups	78.0421	39	2.0011		
	Total	83.1717	43			
Total	Between Groups	2.0907	4	0.5227	1.199	0.327
	Within Groups	17.0016	39	0.4359		
	Total	19.0923	43			

The critical value F at degrees of freedom "4,39" and significant level 0.05 equal 2.61

The F values for all department together equal 1.199 which is less than the critical value 2.61 and the p-value equal 0.327 which is greater than 0.05. That means there is no difference between respondents perspectives and there is no difference between respondents about each department (doctor department, nursing department, physiotherapy department, occupational therapy, social worker, psychologist) regarded to type of payment.

☒ **Interpretation of the result:**

The study result showed as in table (5-20) that 75.0% from the sample are covered financially by the MOH, and 2.3% from the sample the type of payment are covered financially by insurance company and 6.8% from the sample are covered financially as private cases. That means that all financial covers without pay from the family it self. So the results showed there is no difference of the respondent about services they received and type of payment.

Hillis, (2008) study results disagreed with this research results that Hills, (2008) showed that there is statistical significant difference between the payment sources of medical care regarding the overall satisfaction and all domain of satisfaction. And also the patients who were self paid reported higher satisfaction level than patients with health insurance.

In contrary Abu Saileek, (2004) founded that the patients who were medically insured represented higher percentage (86%) and reported higher satisfaction while the clients' who self paid care represented the lowest percentage (9.5%) and reported low satisfaction.

Table No.(5-21)
One way ANOVA test for respondent of the sample on department regarded to monthly income

Department	Source	Sum of Squares	df	Mean Square	F	Sig.
Doctor Department	Between Groups	0.6618	4	0.1654	0.388	0.816
	Within Groups	16.6211	39	0.4262		
	Total	17.2828	43			
Nursing Department	Between Groups	1.5569	4	0.3892	1.523	0.214
	Within Groups	9.9652	39	0.2555		
	Total	11.5221	43			
Physiotherapy department	Between Groups	1.4190	4	0.3548	0.402	0.806
	Within Groups	34.3798	39	0.8815		
	Total	35.7989	43			
Occupational therapy	Between Groups	1.2715	4	0.3179	0.252	0.907
	Within Groups	49.2874	39	1.2638		
	Total	50.5589	43			
Social worker	Between Groups	5.9824	4	1.4956	0.772	0.550
	Within Groups	75.6010	39	1.9385		
	Total	81.5833	43			
Psychologist	Between Groups	17.9488	4	4.4872	2.583	0.052
	Within Groups	65.2230	39	1.6724		
	Total	83.1717	43			
Total	Between Groups	0.7579	4	0.1895	0.403	0.805
	Within Groups	18.3344	39	0.4701		
	Total	19.0923	43			

The critical value F at degrees of freedom "4,39" and significant level 0.05 equal 2.61

As general the result shown in table (5-21) there is no difference between respondents about each department (nursing department, doctor department, occupational therapy, social worker, psychologist department) regarded to monthly income.

☒ **Interpretation of the result:**

Despite of critical political situation that increasing unemployment ratio and decreasing income for most of Palestinian families due to siege the result showed there is no difference between the client perspective toward services and income.

On the other hand, results of Al –Hindi, (2002) in astudy of clients satisfaction found that there was a significant relationship between financial status and level of satisfaction.

Reidy et al. (2004) showed that low income families were more satisfied than those with higher income. The researcher agrees Reidly et al. (2004) rather than results of the study. While dealing with deferent types of families during hospitalization, family with high income has low satisfaction.

Table No.(5-22)
One way ANOVA test for respondent of the sample on department regarded to family members

Department	Source	Sum of Squares	df	Mean Square	F	Sig.
Doctor Department	Between Groups	0.7184	2	0.3592	0.889	0.419
	Within Groups	16.5644	41	0.4040		
	Total	17.2828	43			
Nursing Department	Between Groups	0.1171	2	0.0585	0.210	0.811
	Within Groups	11.4050	41	0.2782		
	Total	11.5221	43			
Physiotherapy department	Between Groups	3.2535	2	1.6267	2.049	0.142
	Within Groups	32.5454	41	0.7938		
	Total	35.7989	43			
Occupational therapy	Between Groups	1.1454	2	0.5727	0.475	0.625
	Within Groups	49.4135	41	1.2052		
	Total	50.5589	43			
Social worker	Between Groups	1.9246	2	0.9623	0.495	0.613
	Within Groups	79.6588	41	1.9429		
	Total	81.5833	43			
Psychologist	Between Groups	5.9519	2	2.9759	1.580	0.218
	Within Groups	77.2199	41	1.8834		
	Total	83.1717	43			
Total	Between Groups	0.8516	2	0.4258	0.957	0.392
	Within Groups	18.2407	41	0.4449		
	Total	19.0923	43			

The critical value F at degrees of freedom "2,41" and significant level 0.05 equal 3.23

Regarding to family members result shown in table (5-22) there is no difference between the respondents about each department (doctor department, nursing department, physiotherapy department, occupational therapy, social worker, psychologist) regarded to family members.

☒ **Interpretation of the result:**

Palestinian family members which in nature is extended and big if compared with other countries. This is consist in relation to income and satisfaction in our countries. So no study examined this variable in relation with the level of satisfaction, but from the researcher opinion, the big families needs higher income to accomplish their responsibilities. This revel that smaller families are more satisfied.

Table No.(5-23)

General client perspective toward all dimensions in study

Item	mean	Standard deviation	weight mean
Doctor Department	3.78	0.634	75.66
Nursing Department	3.84	0.518	76.89
Physiotherapy department	3.67	0.912	73.32
Occupational therapy	3.77	1.084	75.32
Social worker	3.08	1.377	61.67
Psychologist	3.11	1.391	62.12
All domain	3.59	0.666	71.73

The result showed that the weight mean for all domains of the field equal 71.73%. This means the clients are satisfied with services introduced for them in WMRH.

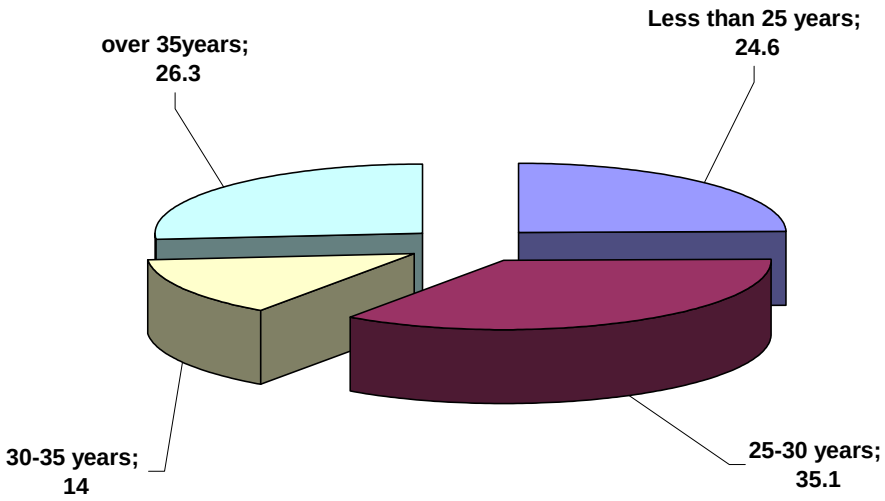
Part 2: analysis and interpretation of provider questionnaire

5.4 DESCRIPTIVE ANALYSIS FOR THE STUDY VARIABLES:

5.4.1 Demographic characteristics:

The following graphs present the main demographic characteristics of the study related to participant rehabilitationes providers which consisted from 57 subjects. The variables include: age, gender, governorate, marital status, level of qualification, number family members, main profession, years of experience, average of monthly income.

5.4.2 Age of providers:



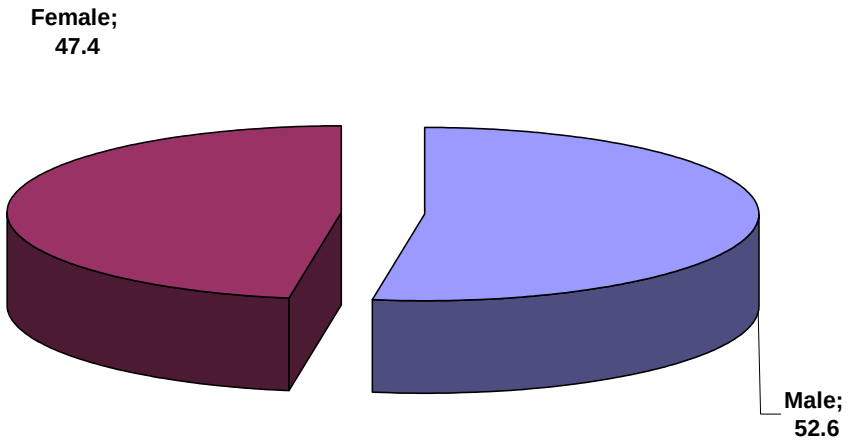
Figure(5-11): distribution of the study sample by age

Figure(5-11) shows that the percentage of providers in the study was as follows: 24.6% from the sample was less than 25 years old, and 35.1% from the sample was 25-29 years old, 14% from the sample 30-34 years old and 26.3% from the samples was 35 years old or more**.**

This states that most of care providers in the hospital are from the young ages and they are new graduates. WMRH staff usually looks for new work with better circumstances. This

explains the reasons of" turnover" that always happens in the hospital. Most of employees in the hospital are looking for job security in their opinion in the governmental sector.

5.4.3 Gender:

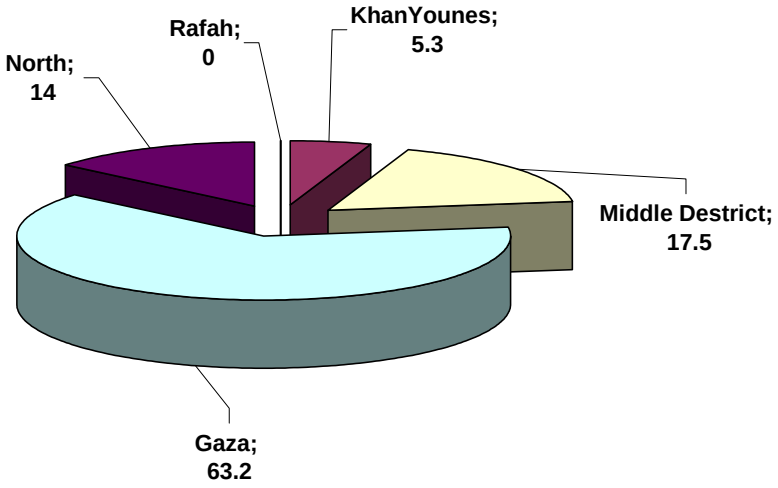


Figure(5-12) distribution of the study sample by gender

Figure (5-12) shows that the providers were male (52.6%) and 47.4% from the sample were females.

The hospital has a specific philosophy adopted the idea of depending on male in performing administrative work. It is noticeable that most of males are practitioner. Moreover, the capacity of male department is more than female department (29 beds for male department V.S 22 beds for female department.

5.4.4 Address:

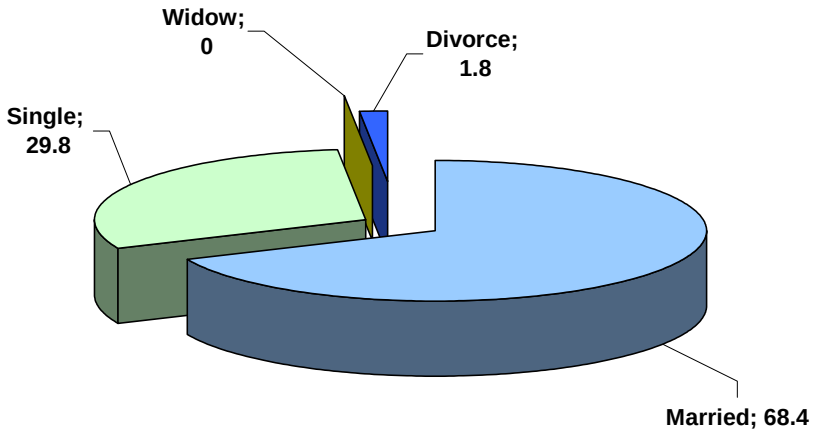


Figure(5.13) distribution of the study sample by address

Figure (5-13) shows that 14.0% from the sample come from northern district, 63.2% from the sample come from Gaza district, 17.5% from the sample come from middle district and 5.3% from the sample come from Khan-Younes**.**

The majority of hospital staff (63.2%) is from Gaza district. This fact is attributed to the hospital strategy in that staff selection takes place according to criteria. A main criterion, of course after qualifications, is accessibility. In this way the hospital ensures accessible staff during emergencies and less transportation expenditure. Moreover, staff selection from nearby grantees better staff compliance and commitment. However, this strategy didn't stop nor reduced turnover. It might achieved some goals such as compliance, not more.

5.4.5 Marital status:

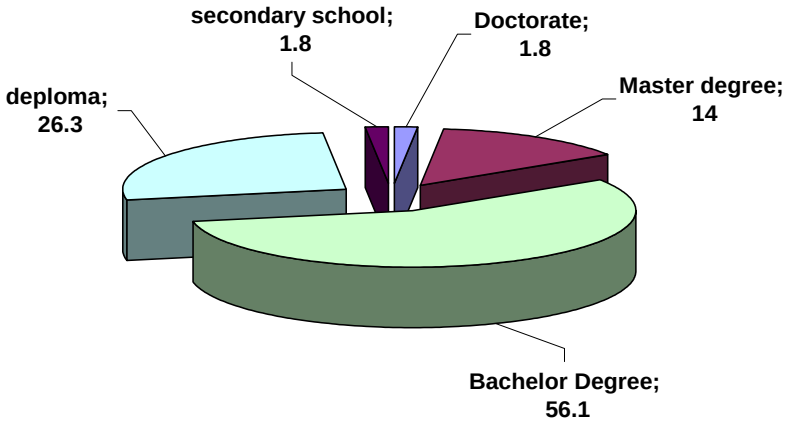


Figure(5.14) distribution of the study sample by marital status

Figure (5-14) shows that 29.8% from the sample are single, 68.4% from the sample are married and 1.8% from the sample are divorce.

The majority of employees are married and most of their ages between 25-35years old. This is attributed to the fact that 59,6% from the employees, always seek to develop themselves and look for new work opportunities that give them more money and security.

5.4.6 Qualifications:

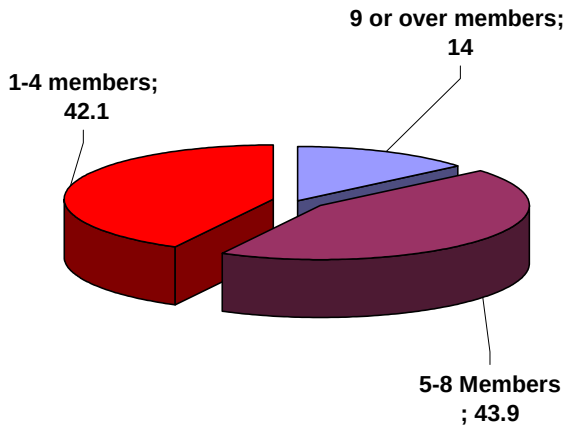


Figure(5.15) distribution of the study sample by qualifications

Relevant to provider qualifications figure (5-15) shows that 1.8% from the sample are secondary school graduates, 26.3% from the sample are diploma holders, 56.1% from the sample has level of qualification are " bachelor degree, and 14.0% from the sample has master degree, 1.8% from the sample has doctorates.

The hospital has different academic and non academic degrees. Employees seek to develop their level of education. This explains the percentage of qualified employees who have master degrees. Before five years there was only one who has master degree. This encouraged the concept of the importance of education which adopted by the hospital and its staff.

5.4.7 Number of your family members including yourself:



Figure(5.16) distribution of the study sample by Number of family members

According to figure (5-16), 42.1% from the sample has a family that consist of 1-4 members, 43.9% from the sample has a family that consist of 5-8 members and 14.0% from the sample has a family that consist of 9 or over members.

These study findings explain the fact that 57.9 of employee have 5 children or more which increases the burden on family ,especially in this time of expensive prices. This encourages the concept of turnover in the hospital. Most of employee in the hospital have another work in other place. Type of contracts in the hospital facilitate this.

5.4.8 Profession:

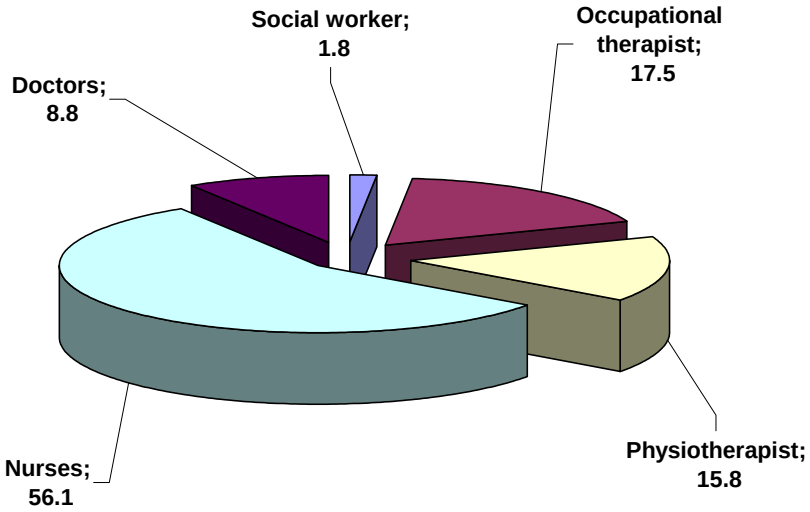
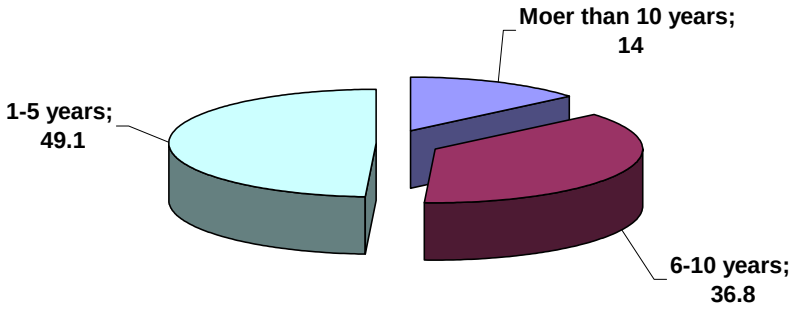


Figure (5.17) distribution of the study sample by profession

Figure (5.17) shows that 8.8% from the sample were doctors, 56.1% from the sample were nurses, 15.8% from the sample were physiotherapists, 17.5% from the sample were occupational therapists and 1.8% from the sample were social workers.

The majority of employees were nurses. This is attributed to the fact that the hospital depends mostly on nursing. However, nursing is the most changing in the hospital because of the increasing demand on them in governmental hospitals. This explains the higest rate of turnover in nursing at WMRH.

Years of experience in your field :

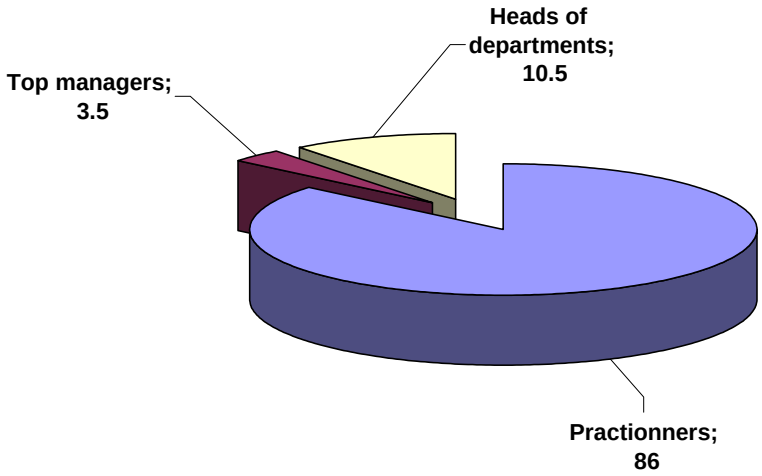


Figure(5.18) distribution of the study sample by years of experience in your field

As show in figure (5-18) the majority of participant service providers in the study (49.1%) has short experience (1-5 years), 36.8% from the sample has 6-10 years experience and 14.0% from the sample more than 10 years experience .

The study result showed that about 85.9% of employees work for less than 10 years in the hospital and 50% work for less than 6 years. An employee who works more than 10 years in the hospital is considered of pioneers.

5.4.9 Title of current position:

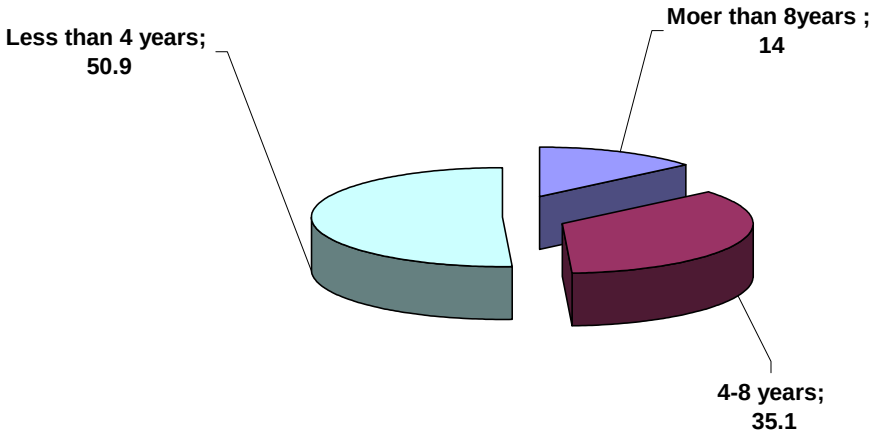


Figure(5.19) distribution of the study sample by title of current position

According to figure(5-19), the highest percentage with title of current position showed that 86.0% from were practitioners, 3.5% from the sample were top manager and 10.5% from the sample were heads of departments.

There is directional frame in the hospital whereas there is a number of directors, leaders, and the large number from employee who do the plains that put before. The hope in developing management as the hospital frame is few and fare because of directional employments existing.

5.4.10 Years in current position:



Figure(5.20) distribution of the study sample by years in current position

Figure (5-20) shows that 50.9% from the sample has less than four year in their current position. 35.1% from the sample has 4-8 years in their position. 14% from the sample has more than eight years in their position .

This elaborates the idea that the hope in developing the position of employee is narrow and far. This fact contributes in reducing the average experience at WMRH.

5.4.12 Average monthly income:

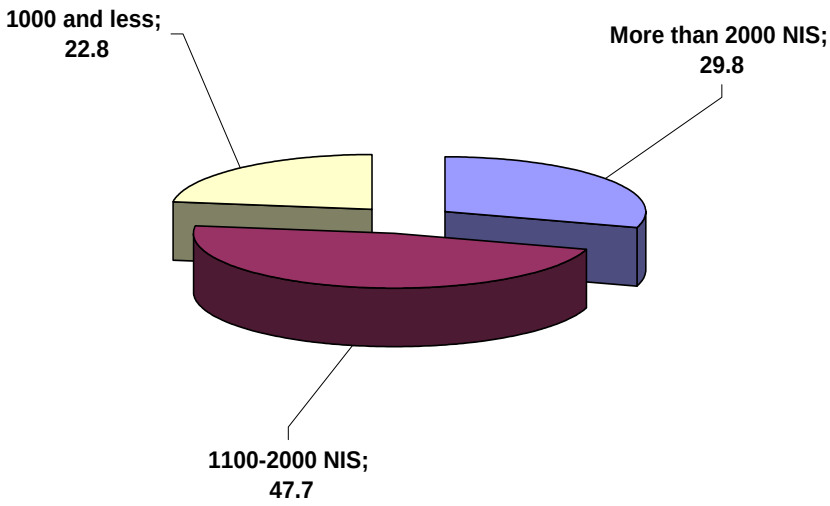


Figure (5.21) distribution of the study sample by average monthly income

Figure(5-21) show that 22.8% from the sample has average monthly income less than 1000 NIS, 47.4% from the sample has average monthly income 1001 NIS to 2000NIS and 29.8% from the sample has average monthly income more than 2000NIS.

Nearly 70.2% of employee have a salary less than 2000 new Shekels. Satisfaction about salary is high. This is attributed to the fact that most of employees are new employees and 30%of employee are from the high management categories who have high salaries.

5.5 RESULTS AND DISSCUTION:

5.5.1 The result of the research question related to providers:

Fourth question: What is the level of job satisfaction for health care providers in El-Wafa Medical Rehabilitation Hospital? To answer this question, the researcher studied some domains such as organization culture, supervisor relation, team work,_work schedules, continuous education, general satisfaction and salary from providers opinions and used descriptive statistic to analysis data.

Discussion the result of the first question:

First domain : organization culture

- **Discussion of the result of organization culture:**

Table No.(5-24)

Result of the provider opinions toward organization culture

Items	Mean	Standard deviation	Weight mean
I have job security	3.86	1.043	77.19
The organization appreciates my efforts	3.49	1.071	69.82
I have a clear job description	3.12	1.166	62.46
I understand the organization roles	3.05	1.076	61.05
The organizational culture encourages me to improve my performance	3.04	1.085	60.70
I understand the organization's vision	2.67	0.970	53.33
Total	**3.20**	**0.704**	**64.09**

This domain was measured by 6 items as shown in table (5.24). Results showed that the weight mean for all items of the field equals 64.09%. This means employees understand the rule of an organization .

Organization culture is a general concept which is difficult to define or explain precisely. It includes traditions, values, policies, mission, philosophy, plan, beliefs and

attitudes that constitute a pervasive context for every thing we do and think in a facility of health (Diab, 2002).

The researcher believes that the employees are satisfied with the behavior of the organization in general; however, most of them are not oriented to the vision or mission of organization. That is congruous with the study results of Gooley, (2001) who found that the primary reasons cited for job satisfaction were employee discomfort with or misunderstanding of the culture and general lack of sense of belonging.

Green, (1997) encouraged the same idea by state deferent people enjoy working in different types of organizational culture and they are more likely to be happy and satisfied at work if their attributes and personalities are consistent with the cultures of that part of the facility in which they are employed.

At the same filed , another study of Koustelions et al. (2003) explored relation between job satisfaction and job security in a sample of 97 Greek fitness instructors, 18-42 years of age, showed that there was a positive relationship between job security and job satisfaction. Particularly, job security was correlated with promotion, job itself, and the organization as a whole.

Other study of Hammad, (1997) showed that half of nurses were satisfied about decision making in their organization

❖ **Second field : Supervisors relation :**

Table No.(5-25)

Result of the provider opinions toward supervisors

Items	Mean	Standard deviation	Weight mean
There is no discrimination between employee in my organization	3.84	1.031	76.84
The manager pays attention to employees' suggestions about development of work	3.61	1.013	72.28
My supervisor appreciate my performance	2.88	1.135	57.54
Superiors give contradicting orders	2.81	0.990	56.14
The supervisor are interested only by achieving work	2.61	1.192	52.28
My immediate supervisor just	2.58	1.267	51.58
My managers influence positively in my attitudes towards my work	2.53	1.020	50.53
Total	**2.98**	**0.622**	**59.60**

This domain was measured by 7 items as shown in table (5-25). The results showed that the weight mean for all items of the field equals 59.6%. This means that the supervisor are interested only by achieving work.

The researcher believes that human being always don't like the one who control them. The results prove that the rules in the organization are sterile and not allow the supervisor to achieve their goals easily and the employees don't understand that their supervisors are under pressure from administration to achieve only the work with high quality.

Consistent with study findings were Bore et al, (2002) who stated that unfairness at work is a predictor of absenteeism and may lead to temporarily withdrawal from the organization as employees do not want to be at work. Bore et al. (2002) found also that

different stressor may lead to stress symptoms which make employees unable to come to their work and that there was direct relationship between unfairness at work and absenteeism.

These results is disagree with the findings of John and Politis, (2006) who tested the relationship between the dimensions of self-leadership behavioral-focused strategies, job satisfaction and team performance. Result showed that the relationship between self-leadership behavioral-focused strategies and job satisfaction is direct, positive and significant

Consistent with John and Politis study, there was another study De vries et al. (1998) that found a positive relationship with supervisors who may influence positively the performance of employees and increase their motivation to do work.

Other study of Darwish, (2000) who used a sample of 474 employees from 30 facilities in United Arab Emirates and found that affective commitment mediates the influences of satisfaction with working conditions, payment, supervision and security on both affective and behavioral tendency attitudes toward change.

❖ **Third field : Team work:**

Table No.(5-26)

Result of the provider opinions toward team work

Items	Mean	Standard deviation	Weight mean
My work impacts positively other associates' work	2.37	0.858	47.37
My coworkers appreciate my performance	2.12	0.825	42.46
I am providing a vital function in the organization	1.72	0.675	34.39
Teamwork is an essential requirement in my job performance	1.65	0.855	32.98
Total	1.96	0.529	39.30

With regards to the effectiveness of team work results showed that the weight mean for all items of the field equals 39.3%. The means that teamwork is not effective in a job performance.

The researcher disagrees with the study result because the team works in the hospital is very effective and the results of clients perspective about team work were positive and effective. Work is running in the organization with team working, the concept of rehabilitation supports teamwork and the outcome of the team are supported from the result that most of study sample (49.1%) have less than 5 years experience. The effect of turnover is clear.

Relevant to the result with team work the study of Hammad, (1997) explored the level of job satisfaction among Gaza nurses educators. Hammad, (1997)used a sample of 44 who represented the total educators in Gaza colleges of nursing. The researcher used self-administered questionnaires and in-depth semistructured interviews. He found that the level of job satisfaction was 65.9%. He ranked the satisfying factors as the highest in descending order of preference as poor communication and work environment.

On other hand Aries and Ritter,(1999) in their study compared satisfaction of nurse with and without burnout. The result showed that nurses with low scores on burnout had a job with the following characteristics good relationships within the team and between doctors and nursing staff. The study of Nylenna et al. (2005) is consistent with Aries and Ritter, (1999) in that they found that the reported level of satisfaction was highest for cooperation with colleagues and fellow workers.

Other study related to the results is Harriet, (2000) who stated that the failure of the collaboration between health professionals could be attributed to failure to use communication styles that facilitate collaboration.

❖ **Forth field : Work schedules:**

Table No.(5-27)
Result of the provider opinions toward work schedules

Items	Mean	Standard deviation	Weight mean
Work schedule is convenient	2.11	1.080	42.11
I have flexibility in scheduling	2.12	0.600	42.46
Total	2.11	0.668	42.28

The weight mean for all items of the field equal 42.28 %. This means that the work schedule is not convenient.

The researcher disagrees with the results because employees work 35 hour per week and many of them can change the schedules of any time, but sometime the nurses can't take the vacation because of work stress and lack of nurses due to increase demand on nurses in governmental hospitals this leads to absenteeism of staff. Extra-time work is accounted as overtime.

The study result agree with the study results of Diab, (2002) who mentioned that employees are dissatisfied with work schedule.

The study of Ozyurt et al. (2006) investigated the levels of job satisfaction and burnout among Istanbul physicians. Results showed that job satisfaction was inversely correlated with number of shifts per month. There were also significant predictors of burnout dimensions. Job satisfaction was related to the number of vacations for each individual level. This result is consistent with results of current research.

Another study which was congruous with the present study results was DeLisa et al. (1997) who evaluated physiatrist career satisfaction and current practice patterns. They emphasized that the workload which is greater than 50 hours per week causes dissatisfaction.

❖ **Fifth field : Continuous education:**

Table No.(5-28)
Result of the provider opinions toward continuous education.

Items	Mean	Standard deviation	Weight mean
Development programs occurred in my organization	3.26	1.061	65.26
I have a good chance of promotion	2.95	1.109	58.95
Total	3.11	0.895	62.11

This domain measured continuous education. The weight mean for all items of the field equal 62.11 %. this means that the development of education of program is not fulfilled at WMRH.

The researcher believes that this is a very strong point in the organization of scale. It motivates employees to go forward to improve their knowledge. But unfortunately the residual number of team is very little because of the continuous turnover toward governmental hospital. As seen, the turnover affects providers. Providers lose their knowledge as they practice work as a routine. This makes them do boring work. This result might encourage the managers to spend time and efforts in preparing education training programs.

Through literature review this result was consisted with the result of Sambrook et al. (2001) who determined the level of continuing education activity in dentistry. They used postal questionnaires and sent them to all fellows of royal Australasian college of dental surgeons in 1998. The results showed that approximately 25% of college fellows reported little or no continuing education activity.

On other hand the study results of Diab, (2002) mentioned that about 90% of employed dentists did not enroll in training program .

The findings of this study regarding the relationship between education and job satisfaction were contradictory. Some researchers stated that education has little impact on job satisfaction. Some studies showed that people with higher education are more satisfied

Agho et al. (1993). Whereas other studies suggested that people with higher education are less satisfied Burris, (1983). Professional development is an important aspect of career perspective that plays a significant role in job satisfaction Wilson et al (1998).

❖ **Sixth field : commitment to organization:**

Table No.(5-29)
Result of the provider opinions toward commitment to organization

items	Mean	Standard deviation	Weight mean
I am free to take work related decisions	3.65	1.172	72.98
I am satisfied with rules provision in my organization	3.61	1.065	72.28
My unit is well-equipped	3.30	1.017	65.96
I am satisfied by the organization role	3.02	1.232	60.35
There is no difference between my personal values and work-laws applied in my organization	2.56	1.053	51.23
I am proud of my organization	2.56	1.053	51.23
My unit is appropriately staffed	2.46	1.070	49.12
Number of employees is enough related to number of patients	2.46	1.181	49.12
My work performance is steadily improving	2.18	0.928	43.51
At the end of the work day, I feel satisfied with my work performance	2.11	0.772	42.11
Total	**2.79**	**0.583**	**55.79**

The study results in general showed that the weight mean for all items of the field equals 55.79%. This means that providers are not committed to organization. Because of the differences in values between people, the employees are dissatisfied from certain organization values. The study results support the idea of employees who work in WMRH to develop their economic status.

Relevant to agreement with the first and second items in commitment to organization of Nylenna et al. (2005) explored the level of job satisfaction among general practitioners and compared it with that of hospital doctors. Results showed that Norwegian general practitioners had high level of job satisfaction. The reported level of satisfaction was highest for their opportunities to use their abilities, cooperation with colleagues and fellow workers, variation in work, and freedom to choose own method of working.

Recognition must be offered to employee with good performance to encourage him/her keep good performance. In addition to that , to encourage others to improve their performance to obtain good quality of work Schein, (1992).

On the other hand, the results of John and Politis, (2005) disagreed with the research results . these researches examined the relationship between the dimensions of dispersed, self-management, leadership and a number of work environment dimensions conducive to creativity and productivity. A total of 104 useable questionnaires were received from employees who are engaged in self-managing activities. Findings showed that there were" obstacle" dimensions of the work environment for creativity is negative and significant. The findings have clearly shown that the "stimulant" dimensions of the work environment for creativity have a positive and significant impact on both creativity and productivity.

Other study of Lopopolo, (2002) examined relationship of role- related variables to job satisfaction and organizational commitment. Through a survey of 273 hospital-based physical therapists. The result showed the positive influence of occupational commitment and the role behaviors.

❖ **Seven field : salary**

Table No.(5-30)
Result of the provider opinions toward salary

items	Mean	Standard deviation	Weight mean
I am satisfied by my benefits	4.05	0.934	81.05
I am satisfied by my salary	4.05	1.202	81.05
My salary suits my qualifications	3.98	1.077	79.65
Total group	**4.03**	**0.889**	**80.58**

Table (5-30) presents the highest percentage related to all study result regard to salary. The result showed for general the weight mean for all items of the field equal 80.58% . This means that the organization offers high salaries.

The researcher attributes there results to the motivation given by the organization. But if we look back to the result we find about 49.1% of them are newly employed ,most of them young and have no responsibility. Therefore they are satisfied with their salaries.

Through the literature review the researcher found that the salary is are the main domain for satisfaction. The most significant relationships were found within the pay per salary. In the Maslows Hierarchy of needs the salary was ranked with the basic physiological needs.

Congruous with the results of the study, Sager et al. (1989) state that the pay has been often mentioned as a motivator for performance and a determinant of job satisfaction. The study of DeConinck and stilwell, (2004) agreed with Sgare et al. (1989) advertising managers in United States were the manager who perceived that they had been fairly reward and procedural justice were more satisfied with their pay.

Other study consist with Sager et al. (1989) Lambret et al . (2001) in which American workers found that financial reward were positively related to job satisfaction.

Relevant to these study findings was as study of logan et al. (1997) where its result were consisted with prediction of may studies in western countries which state that the income was the second factor of job dissatisfaction.

5.5.2 RESULT OF THE FIVE QUESTION:

Five question: Are there statistical significant differences in the levels of provider's satisfaction taking into account selected demographic variables? To answer this question the researcher studies some variables such as(gender ,age ,marital stats ,level of qualification, years of experience and monthly income)related to providers opinions.

Table No.(5-31)
Independent t test for respondent of the sample on Evaluation of Services Provided at El-Wafa Medical Rehabilitation Hospital in Gaza strip: Provider Perspectives related to gender

domain	Gender	N	Mean	Std. Deviation	T	P-value
organization	**Male**	30	3.233	0.758	0.321	0.749
	Female	27	3.173	0.653		
Supervisors	**Male**	30	3.010	0.659	0.375	0.709
	Female	27	2.947	0.589		
Team work	**Male**	30	1.958	0.602	-0.098	0.922
	Female	27	1.972	0.446		
Work schedules	**Male**	30	2.300	0.750	2.298	0.025
	Female	27	1.907	0.501		
Cont. education	**Male**	30	3.100	0.986	-0.046	0.963
	Female	27	3.111	0.801		
Salary	**Male**	30	2.863	0.598	1.009	0.317
	Female	27	2.707	0.565		
commitment to organization	**Male**	30	4.167	0.993	1.236	0.222
	Female	27	3.877	0.746		
TOTAL	**Male**	30	2.948	0.502	0.915	0.364
	Female	27	2.832	0.448		

Table (5.31) shows that as general the value of t value for all domain equal 0.915 which is less than the critical value 2.0 and the p-value equal 0.364 which is greater than 0.05 that there is no difference between males and females perspectives in satisfaction related to organization, supervisors, salary and commitment to organization. However, there were

differences in team work, work schedules and continuing education. In general, there is no significant difference in satisfaction between males and females in this study .

These study findings are congruous with Eker, (2004) who investigated the level of job satisfaction among physiotherapists and identified the best predictors of job satisfaction. The result showed there were no significant satisfaction differences between two genders.

Other relevant study of Gamal, (2008) found that the gender was not significant for degree of job satisfaction

On other hand the study of Maghrabi and Hayajneh, (1993) that was conducted using two groups of managers with sample size of 120 to determine whether there are significant difference in job motivation, job satisfaction and life satisfaction among both male and female Saudi managers. They found that male groups have job motivation and job satisfaction than female groups. This difference could be attributed to cultural differences between different communities.

Table No.(5-32)
One way ANOVA test for respondent of the sample on Evaluation of Services Provided at El-Wafa Medical Rehabilitation Hospital in Gaza strip: Provider Perspectives related to age

department	Source	Sum of Squares	df	Mean Square	F	Sig.
organization	Between Groups	2.2904	3	0.7635	1.588	0.203
	Within Groups	25.4884	53	0.4809		
	Total	27.7788	56			
Supervisors	Between Groups	0.4220	3	0.1407	0.351	0.789
	Within Groups	21.2693	53	0.4013		
	Total	21.6914	56			
Team work	Between Groups	0.2291	3	0.0764	0.262	0.852
	Within Groups	15.4507	53	0.2915		
	Total	15.6798	56			
Work schedules	Between Groups	0.6120	3	0.2040	0.443	0.723
	Within Groups	24.3967	53	0.4603		
	Total	25.0088	56			
Cont. education	Between Groups	0.6163	3	0.2054	0.246	0.864
	Within Groups	44.2521	53	0.8349		
	Total	44.8684	56			
Salary	Between Groups	1.9989	3	0.6663	2.075	0.114
	Within Groups	17.0148	53	0.3210		
	Total	19.0137	56			
commitment to organization	Between Groups	2.6249	3	0.8750	1.113	0.352
	Within Groups	41.6597	53	0.7860		
	Total	44.2846	56			
total	Between Groups	0.4688	3	0.1563	0.676	0.571
	Within Groups	12.2520	53	0.2312		
	Total	12.7208	56			

The critical value F at degrees of freedom "3,53" and significant level 0.05 equals 2.78

In many studies minor difference between the age and opinion toward work services had been found. The researcher found as shown in table (5-32) as general the value of F value for all domains equals 0.676 which is less than the critical value (2.78) and the p-value equal 0.571 which is greater than 0.05. This means that there is no difference of the

respondent about each domain (organization, supervisors, teamwork, work schedules, continuing education, salary and general satisfaction) related to age.

Relevant to the study result of Bernal et al. (1998) which included large national probability sample of 1,095 workers, used questionnaires and found that there was a significant, but weak positive linear age / job satisfaction relationship. That is age failed to explain a substantial proportion of linear variance in job satisfaction measure. This indicates that age, as a chronological variable, is not a viable predictor of job satisfaction.

Consist with the Bernal et al. (1998) study was Eker, (2004) who investigated the level of satisfaction among physiotherapists, and identify the best predictors of job satisfaction. The results showed that there was no significant satisfaction difference between age groups .

Moreover, Gamal, (2008) found that the age is not significantly associated with degree of job satisfaction.

Table No.(5-33)
One way ANOVA test for respondent of the sample on Evaluation of Services Provided at El-Wafa Medical Rehabilitation Hospital in Gaza strip: Provider Perspectives related to marital status

department	Source	Sum of Squares	df	Mean Square	F	Sig.
organization	Between Groups	1.1182	2	0.5591	1.132	0.330
	Within Groups	26.6605	54	0.4937		
	Total	27.7788	56			
Supervisors	Between Groups	1.7753	2	0.8876	2.407	0.100
	Within Groups	19.9161	54	0.3688		
	Total	21.6914	56			
Team work	Between Groups	0.3955	2	0.1978	0.699	0.502
	Within Groups	15.2843	54	0.2830		
	Total	15.6798	56			
Work schedules	Between Groups	0.9658	2	0.4829	1.085	0.345
	Within Groups	24.0430	54	0.4452		
	Total	25.0088	56			
Cont. education	Between Groups	2.5117	2	1.2559	1.601	0.211
	Within Groups	42.3567	54	0.7844		
	Total	44.8684	56			
Salary	Between Groups	1.3272	2	0.6636	2.026	0.142
	Within Groups	17.6865	54	0.3275		
	Total	19.0137	56			
commitment to organization	Between Groups	0.1468	2	0.0734	0.090	0.914
	Within Groups	44.1378	54	0.8174		
	Total	44.2846	56			
Total	Between Groups	0.5948	2	0.2974	1.324	0.274
	Within Groups	12.1260	54	0.2246		
	Total	12.7208	56			

The critical value F at degrees of freedom "2,54" and significant level 0.05 equal 3.17

Results shown in table (5-33) as general the value of F value for all domain equal 1.324 which is less than the critical value 3.17 and the p-value equal 0.274 which is greater than 0.05. That means there is no difference between respondents about each domain (organization, supervisors, teamwork, work schedules, continuing education, salary and general satisfaction) related to marital status.

Encourage the study result of Gamal, (2008) reported that the job satisfaction among physicians is an important concern from the perspective of physician and patients. The researcher used randomly selected physician from the Egyptian ministry of health and population hospital all participants fill a self administered questioners which include socio-demographic characteristic data . Results showed that the material statues didn't influence job satisfaction.

Congruous with the study results is Thabet, (2004) who examined job satisfaction among managers working in Gaza's hospitals Tabet, (2004) founded that there were no significant difference between material status and job satisfaction factors.

On other hand the study of Liu et al. (2003) examined the environmental and socio-demographic factors that influence job satisfaction and job-related communication among physician assistant in Taiwan. The study found that the marital status was important demographic factor influencing job satisfaction.

Table No.(5-34)
One way ANOVA test for respondent of the sample on Evaluation of Services Provided at El-Wafa Medical Rehabilitation Hospital in Gaza strip: Provider Perspectives related to level of qualification

department	Source	Sum of Squares	df	Mean Square	F	Sig.
organization	Between Groups	1.4030	4	0.3508	0.692	0.601
	Within Groups	26.3758	52	0.5072		
	Total	27.7788	56			
Supervisors	Between Groups	0.6540	4	0.1635	0.404	0.805
	Within Groups	21.0374	52	0.4046		
	Total	21.6914	56			
Team work	Between Groups	2.1121	4	0.5280	2.024	0.105
	Within Groups	13.5677	52	0.2609		
	Total	15.6798	56			
Work schedules	Between Groups	2.1103	4	0.5276	1.198	0.323
	Within Groups	22.8984	52	0.4404		
	Total	25.0088	56			
Cont. education	Between Groups	1.8851	4	0.4713	0.570	0.685
	Within Groups	42.9833	52	0.8266		
	Total	44.8684	56			
Salary	Between Groups	0.5506	4	0.1377	0.388	0.816
	Within Groups	18.4631	52	0.3551		
	Total	19.0137	56			
commitment to organization	Between Groups	11.1566	4	2.7891	4.378	0.004
	Within Groups	33.1280	52	0.6371		
	Total	44.2846	56			
total	Between Groups	0.6836	4	0.1709	0.738	0.570
	Within Groups	12.0373	52	0.2315		
	Total	12.7208	56			

The critical value F at degrees of freedom "2,54" and significant level 0.05 equal 3.17

Results shown in table (5-34) as general the value of F value for all domain equals 0.738 which is less than the critical value 3.17 and the p-value equal 0.570 which is greater than 0.05 . That means there is no difference between the respondents about each domain (organization, supervisors, teamwork, work schedules, continuing education and salary)

related to level of qualification. However, F- value (statistical) for "commitment to organization" was calculated at 4.37 (p=0.004) which is more than F-critical (3.17, p=0.05). Therefore, there is a difference between respondents a bout " commitment to organization" as a domain of satisfaction in relation to qualifications.

Gamal, (2008) found that the educational level doesn't influencing job satisfaction however, it was significantly associated with specialty.

On the other hand, the study of Thabet, (2004) state that there was significant differences between level of education and satisfaction factors like supervisor, absenteeism and general satisfaction. She added that managers with master degrees were more generally satisfied more than those with diploma degree. There was no significant difference between hospital managers level of education and work environment, relationships with colleges and ability to work. On the other hand, Thabet , (2004) proved that there were no significant differences between job satisfaction factors and type of work ,the comparison revealed profession of managers.

Table No.(5-35)
One way ANOVA test for respondent of the sample on Evaluation of Services Provided at El-Wafa Medical Rehabilitation Hospital in Gaza strip: Provider Perspectives related to years of experience

department	Source	Sum of Squares	df	Mean Square	F	Sig.
organization	Between Groups	4.2096	2	2.1048	4.822	0.012
	Within Groups	23.5691	54	0.4365		
	Total	27.7788	56			
Supervisors	Between Groups	0.1574	2	0.0787	0.197	0.822
	Within Groups	21.5340	54	0.3988		
	Total	21.6914	56			
Team work	Between Groups	0.1605	2	0.0802	0.279	0.757
	Within Groups	15.5193	54	0.2874		
	Total	15.6798	56			
Work schedules	Between Groups	0.0251	2	0.0126	0.027	0.973
	Within Groups	24.9836	54	0.4627		
	Total	25.0088	56			
Cont. education	Between Groups	0.2687	2	0.1344	0.163	0.850
	Within Groups	44.5997	54	0.8259		
	Total	44.8684	56			
Salary	Between Groups	0.3263	2	0.1632	0.471	0.627
	Within Groups	18.6874	54	0.3461		
	Total	19.0137	56			
commitment to organization	Between Groups	0.3693	2	0.1846	0.227	0.798
	Within Groups	43.9153	54	0.8132		
	Total	44.2846	56			
total	Between Groups	0.3918	2	0.1959	0.858	0.430
	Within Groups	12.3290	54	0.2283		
	Total	12.7208	56			

The critical value F at degrees of freedom "2,54" and significant level 0.05 equal 3.1

Table No.(5-36)
Multiple Comparisons L S D test for years of experience

Domains	Mean Difference	Less than 4 years	4-8 years	More than 8 years
organization	Less than 4 years		-0.581*	-0.399
	4-8 years	0.581*		0.183
	More than 8 years	0.399	-0.183	

To test the hypothesis the researcher used one way ANOVA test and the result shown in table (5-35) say that the value of F test for each domain except (organization) is less than the critical vale which is 3.17. and the p-values for each domain except (organization) are greater than 0.05 that mean there is no difference between the respondents about each domain supervisors, teamwork, work schedules, continuing education, salary and general satisfaction) due to years of experience. Table (5-36) shows the L S D Multiple Comparisons test which compares between each tow categories of the years of experience variable. The different group is that with 4-3 years experience.

Liu et al. (2003) examined the environmental and socio-demographic factors that influence job satisfaction and job-related communication among physician assistant in Taiwan. A self-administered mail survey was used. The response rate to the survey was high 71.01%. The results showed the number of working years are important demographic factors influencing job satisfaction.

Abu Ghali, (2006) in his study, the working experience of participants varied between 9-34 years. He found no significant differences between years of experience and all sub-scale dimensions in here study.

Table No.(5-37)
One way ANOVA test for respondent of the sample on Evaluation of Services Provided at El-Wafa Medical Rehabilitation Hospital in Gaza strip: Provider Perspectives related to average of monthly income

	Source	Sum of Squares	df	Mean Square	F	Sig.
organization	Between Groups	4.5274	2	2.2637	5.257	0.008
	Within Groups	23.2513	54	0.4306		
	Total	27.7788	56			
Supervisors	Between Groups	0.9214	2	0.4607	1.198	0.310
	Within Groups	20.7700	54	0.3846		
	Total	21.6914	56			
Team work	Between Groups	0.0106	2	0.0053	0.018	0.982
	Within Groups	15.6692	54	0.2902		
	Total	15.6798	56			
Work schedules	Between Groups	0.4694	2	0.2347	0.516	0.600
	Within Groups	24.5394	54	0.4544		
	Total	25.0088	56			
Cont. education	Between Groups	2.1108	2	1.0554	1.333	0.272
	Within Groups	42.7576	54	0.7918		
	Total	44.8684	56			
Salary	Between Groups	2.2612	2	1.1306	3.644	0.033
	Within Groups	16.7525	54	0.3102		
	Total	19.0137	56			
commitment to organization	Between Groups	4.5231	2	2.2615	3.071	0.055
	Within Groups	39.7615	54	0.7363		
	Total	44.2846	56			
total	Between Groups	1.5895	2	0.7948	3.856	0.027
	Within Groups	11.1313	54	0.2061		
	Total	12.7208	56			

The critical value F at degrees of freedom "2,54" and significant level 0.05 equal 3.17

Table No.(5-38)
Multiple Comparisons L S D test for Average of monthly income

Domains	Mean Difference	0 NIS - 1000 NIS	1001 NIS – 2000 NIS	More than 2000 NIS
organization	0 NIS -1000 NIS		-0.703*	-0.602
	1001 NIS – 2000 NIS	0.703*		0.101
	More than 2000 NIS	0.602	-0.101	
Salary	0 NIS -1000 NIS		-0.477*	-0.471*
	1001 NIS – 2000 NIS	0.477*		0.006
	More than 2000 NIS	0.471*	-0.006	
Total	0 NIS -1000 NIS		-0.399*	-0.397*
	1001 NIS – 2000 NIS	0.399*		0.002
	More than 2000 NIS	0.397*	-0.002	

To test the hypothesis the researcher used one way ANOVA test . The results shown in table (5-37) say that the value of F test for each domain except organization and salary is less than the critical vale which is 3.17 and the p-value for each domain except for organization and salary are greater than 0.05.This means that there is no difference between the respondents about each domain supervisors, teamwork, work schedules, continuing education, salary and general satisfaction) due to years of experience. Table (5-38) shows that the L S D Multiple Comparisons test which compare between each tow categories of the years of experience variable and the deference between the categories labeled by "*".

Abu Ghali, (2006) assessed the level of quality improvement project if met its objectives and the quality assurance concepts and activities have been institutionalized into the ministry of health units. He found that there was no significant statistical difference between the average monthly income and the dimensions of the study (policy, leadership, core value, structure, information, communication and rewarding).

Thabet, (2004) found in her study that there was differences between income and attitudes toward work these results revealed that the source of differences was in those managers who had very high salaries.

5.5.3 RESULT OF THE SIXTH QUESTION:

Sixth question: what are health providers perspectives with regarded to continuing education program and work in general?

Table No.(5-39)
Continuing education program

My organization have continuous education program	Frequency	percentages
Yes	18	31.6
No	39	68.4
I am enrolled in continuing education program	**Frequency**	**percentages**
Yes	3	5.3
No	54	94.7
I am joined in continuous education program before	**Frequency**	**percentages**
Yes	14	24.6
No	43	75.4
Continuous education affects positively my work performance	**Frequency**	**percentages**
Yes	34	59.6
No	23	40.4

Table (5-39) shows that 31.6% from the sample agreed that organization has continuing education program but 68.4% disagree. The researcher agrees with this result despite of the satisfaction gained from continuing education. In the organization there is no clear education program running. 5.3% from the sample were to enrolled in continuing education program, but 94.7% were not enrolled. This supports idea mentioned before that their is no continuing education program running in the organization. 24.6% from the sample joined the continuing education program before, but 75.4 didn't. This also supports the opinion that there is no continuing education program running in the organization. 59.6% from the sample mentioned that continuing education affects positively their work performance, but 40.4% from the sample disagree. These study results illustrate that employees highly evaluate and understand the importance of continuing education as in-services or out-services program.

Reasons for low participation in continuing education program in WMRH from providers perspectives

Don't know about continuing education program.

There are no programs in the area of specialization

The failures of previous training programs

Lack of opportunities as being busy in work

lack of opportunities for girls in education out side.

Providers opinions for benefits of continuing education program

keep us up-date in rehabilitation.

encourage concepts and culture of teamwork.

exchanges experience and knowledge.

improve performance level.

What is the most important three needed for future training?

Neuro - psychological measurement

Courses in computer, Internet, initial first aid

Courses in all disciplines in your organization

Participation in scientific conferences

Hydro therapy

How to deal with spinal cord injury

Brain injury

Courses in the use of modern equipment

Table No.(5-40)
Have enough time to finish work

I have enough time to finish my work	Frequency	percentages
Yes	9	15.8
No	48	84.2
Total	57	100.0

Table (5-40) show that 15.8% from the sample reported that they have enough time to finish work but 84.2% from the sample didn't, The type and load of work puts pressure on all the team. Moreover, the staff is required to deliver good service quality which is competent and satisfactory from clients and third party payers perspectives, in addition to management.

Table No.(5-41)
Worry about termination

I am worry about termination my job at any time	Frequency	percentages
Yes	36	63.2
No	21	36.8
Total	57	100.0

Table (5-41) shows that 63.2% from the sample reported that they are worry about termination of their at any time but, 36.8% from the sample didn't .The type of contracts doesn't support employees. Employees always worry about sustainability of the organization.

Causes of worry about termination of job at any time

There is no sense of security .

My rights are insufficient and not clear

Management cares about work more than employees

There is no incentive

The policy of Board of Directors

Insufficient salary

The type of the contracts

Lack of appreciation of any efforts

Discrimination in dealing with employees

Mood of the Board of Directors

The main three problem you face in the work field?

Lack of experts in some staff in the hospital

lack of suitable working hours

lack of interest in the quality of work

The absence of suitable place for the work of psychological counseling.

The gap between employees and the Board of Directors

The type of work

Increase the number of patients related to staff

Lack of specialists

Lack of appreciation efforts

Turnover of employees

Bad management

Inappropriate allocation of staff.

Poor understanding of employee to their rights

Difficult communications

No development while working

No feed back about work from supervisors

The absence of a clear vision of the hospital

Table No.(5-42)

General providers perspective toward all dimensions in study

items	Mean	Standard deviation	Weight mean
organization	3.20	0.704	64.09
Supervisors	2.98	0.622	59.60
Team work	1.96	0.529	39.30
Work schedules	2.11	0.668	42.28
Cont. education	3.11	0.895	62.11
Salary	4.03	0.889	80.58
commitment to organization	2.79	0.583	55.79
	2.88	0.476	57.68

The result showed that the weight mean for all domains of the field is 57.68% this means that the providers are dissatisfied with services introduced for them in WMRH.

The results showed big deference between clients and providers satisfaction as shown in table (5-42) The clients are more satisfied than providers toward services delivered to them from WMRH. Clients are the service consumer and they are the main element to effectively conduct this study. The client who receives the service is able to

assess the effectiveness. In this study the clients received high quality of services that clarified the provider give the client all the care by high quality however, service providers don't have equal right in an organization that reflects Islamic culture.

These study findings are congruous with the study of Dearmin, (1995) who stated that the client satisfaction is one measure used to assess the performance of health care programs .

Other study of Massoud, (1994) analyzed the quality of health care system in Palestine and highlighted the quality defect which is reflected in the inefficiency of health care system to deliver quality care. He reported that there is general dissatisfaction among public and professionals regarding quality of health care in Palestine. Also he indicated that one of the major problems in Palestine health care system is lack of consideration of client's satisfaction. The researcher pointed out that once clients had admitted in any Palestinian health care setting, they had to follow the system utilized there blindly and did not possess any right to ask, discuss or refuse treatment. He added that there is discomfort among public, politicians and health professionals in Palestine regarding the quality of health care. This discomfort has been demonstrated on recurrent clashes between public and health professionals, miss trust and bad communications among providers and clients.

In addition, Goldstein et al. (1999) state that the importance to the clinician of a patient's level of satisfaction with care as part of the patient-therapist relationship, maintaining a high level of patient satisfaction may also have an economic impact on the clinician. Patients who are satisfied with the services they have received are more likely to remain loyal to the provider such as therapist .

5.6 Commentary on the research study results:

The participants in the focus group were requested to comment on the study results. Their comments were very important. They stated that this study is considered the first evaluation study about the field of rehabilitation in Gaza strip. Therefore, it is important to inform the decision makers with the result of the study in order to make required corrective actions. In the focus group the following information were provided to participants in addition main result in tables were handed in to each one.

1. Clients perspective with regard to the services provided was significant. This shown to all services except social worker and psychologist services.
2. The client's satisfaction with provided service provided in WMRH was high (71.73 %).
3. Result showed that there is no statistical significance relationship between client's satisfaction with selected socio- demographic variables.
4. Provider perspective regarded to services provided in WMRH was low (57.68%).
5. Result showed that there is no statistical significance relationships between provider satisfaction with the selected socio- demographic variables.
6. Result showed that there is effective interaction between team members and client's has been associated with greater efficiency .
7. Result showed that there is no statistical relationships between client's satisfactions and provider satisfaction. This result associated with our Palestinian values which is Islamic in nature.

CHAPTER SIXTH
RECOMMENDATION AND SUGGESTIONS

CHAPTER SIXTH
RECOMMENDATION AND SUGGESTIONS

6.1 Introduction:

In this chapter, the researcher recommended and suggests some recommendations that could help the WMRH. Administration to improve services for clients and providers to reach to high quality level.

6.2 Focus group:

Is a method of learning and data collection in which a group of interested or experts take part in certain activity. Participants usually take on active role. The focus group has leader(s).

Aims:

1. Employing study findings into practice
2. Evidence based practice

Target group:

Rehabilitation team (Dr. Maher shamia: MD, Dr. Fadel Naneem: MD, Dr. Khamis Elessi: MD, Mr. Ali Abou Rialla: NsG, Mr. Moussa AbuMostafa: OT, Miss Efaf AbuGazala: OT, Mr. Saber AbuMoussa: OT, Mr. Fadel Mussoud: PT, Mr. Fouad Luzen: OT, Dr. Ayman Amber: MD, Dr. Omar Sukar: MD, Mr. Mohamed Krezem: PT, Mr. Sameer Badah: Psychologist and Miss Huda Abu Rouss: OT)

Place: EL-Wafa Medical Rehabilitation Hospital

Time :Thursday 19-5-2009 at 11am-12:30 pm.

Ethical approval: see annex()

Session:

Introduction:

Orientation about the study: the researcher made participants in focus group oriented to study objectives, methodology, main relevant findings and recommendations. A copy of results was handed in to each participant.

In the focus group, the following information were provided to participants, in addition to a copy of the main results in tables were handed in to each one.

Working individually: Each participant was requested to comment on the study results and how to implement the study findings in practice. Their comments were important. They stated that this study is considered the first evaluation study of rehabilitation in EWMRH. Therefore, it is important to inform the decision makers with the results of the study in order to make required applicable corrective actions.

First recommendation from providers

Suggestions to improved work quality and performance

Expert staff and talent retention

The work of the lectures and courses and workshops

Replacement of external expertise

Give feed on positive action

Fixed work contracts

Entertainment of staff

Follow-up to the officials to work seriously and continuous

equality

Give salaries on time

Change management in hospital

Improve behavior management with staff

A clear financial system

Provide an appropriate atmosphere for work

Summary of focus group and final recommendations:

For clients:

- ☒ Development of services with defects, low performance or low consumers satisfaction such as social worker and psychologist
- ☒ Improving and developing of clinical practice by Evidence Based Practice and quality assurance. Resources and equipment a crucial elements of this process.
- ☒ Activation of home visit and adaptation before clients being discharged home.

- ☒ CBR following-up and feedback for WMRH.

For providers:

- ☒ Job description that distinguishes between various disciplines and professions.
- ☒ Establishing a sustainable and effective continuing education program that serves the facility and staff needs with participation of staff as individuals and departments.
- ☒ Linking remuneration with performance
- ☒ Improving communication both vertical and horizontal
- ☒ Improving the performance of all management levels; top, middle and line
- ☒ Improving the performance of rehabilitation team

6.3 Recommendations:

After analyzing the result of this study, the researcher should be inform the decisions maker with the study result and recommended some point to manager to improve provider services and for providers to improve services introduce to the clients.

- According to the study result, most of clients there are not satisfied with social and psychological workers role in WMRH so, try to motivate social worker and psychologist services by increase number of social worker and psychologist.
- To increased awareness of organization mission and vision to providers by explain it for providers by written paper or orally when engaged to the organization.
- Clarifying the job description of the employees to identify the tasks, duties and responsibilities of the employees to improve their job performance.
- Development of a management process that allows proper supervision ways and equal opportunities to all employees.
- Encourage continuous educational training program related to the rehabilitation subjects to increase quality level.
- Developing the financial and reward system to suit level of qualifications and improve economic status.
- Encourage group meeting different level of employee to improve relationship between employee and increasing attitude toward team work.

- The need to train employees to how communicate with clients by make workshops to increased the awareness of important of client satisfaction that express high quality of care.
- Improving and developing of clinical practice by Evidence Based Practice and quality assurance. Resources and equipment a crucial elements of this process.
- Activation of home visit and adaptation before clients being discharged home.
- CBR following-up and feedback for WMRH.
- Job description that distinguishes between various disciplines and professions.
- Improving the performance of all management levels; top, middle and line

6.4 Suggestions for future research :

1. A comprehensive study which involves all departments of WMRH.
2. A comparison study for the same departments after one years or more.
3. Using different study design such as longitudinal and qualitative studies.
4. Conducting further studies that investigate team work, comparison within WMRH and between different facilities of rehabilitation.

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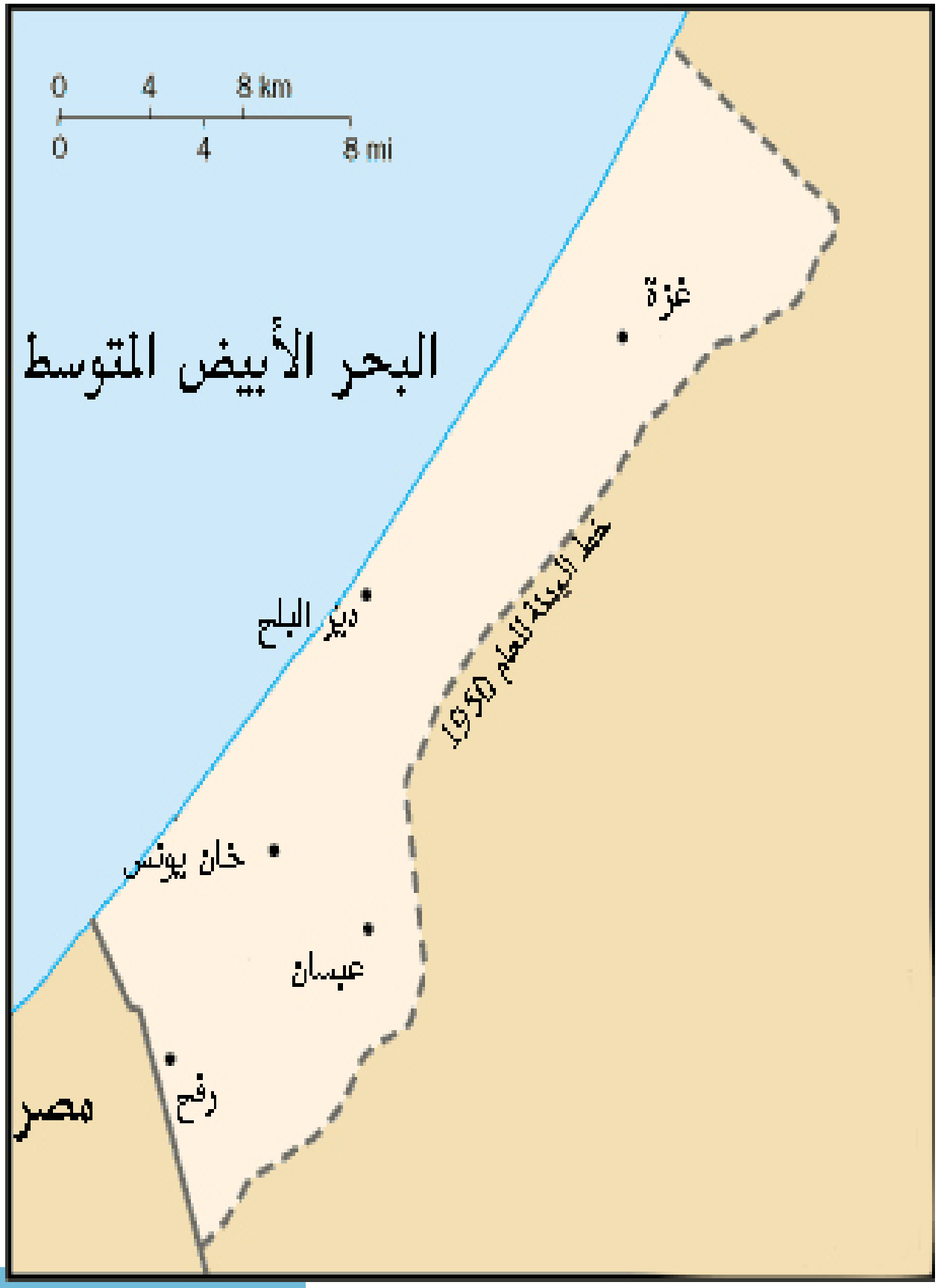
Annexes

Annex (1)

Annex(2)



Annex (3)

بسم الله الرحمن الرحيم

Date: 15/05/2009

السيـــد / د. ماهر محمود شامية **المدير الطبي لمستشفى الوفاء** حفظه الله ،،،

السلام عليكم ورحمة الله وبركاته وبعد،،،

الموضوع : طلب عمل focus group

حيث أنني كما تعلمون في الإجراءات النهائية لبحث التخرج للحصول على درجة الماجستير في علوم التأهيل من الجامعة الإسلامية ولان جميع نتائج البحث قد انتهيت من مخرجاتها نود من سيادتكم الموافقة على عمل مجموعة (**focus group**) مكونة من جميع محاور فريق التأهيل في المستشفى وذلك يوم الثلاثاء الموافق 2009/5/19م الساعة الثانية عشر في قاعة المكتبة وذلك بهدف عرض نتائج البحث على الفريق ومناقشة توصيات البحث مع الفريق.

ولكم خالص الشكر

مقدم الطلب الباحثه

ميرفت عسفه

Annex (4)

فقرات استبانه تقييم خدمات التأهيل المقدمة بواسطة مستشفى الوفاء للتأهيل الطبي والجراحات التخصصية من وجه نظر مستلم الخدمة في صورتها الأولية قبل التحكيم.

التاريخ: / /2008 الرقم التسلسل.....

معلومات شخصية:

من فضلك أجب عن الأسئلة التالية:

1-العمر.....

2-الجنس: ذكر ☐ انثى ☐

3-العنوان:

محافظة الشمال ☐ محافظة غزة ☐ محافظة الوسطى ☐

محافظة رفح ☐ محافظة خانيونس ☐

4-الحالة الاجتماعية:

أعزب ☐ متزوج ☐ مطلق ☐ أرمل ☐

5-عدد أفراد العائلة بما فيهم أنت:.....

6-معدل الدخل الشهري:.....

7-المستوى التعليمي:

ثانوية عامة ☐ دبلوم ☐ بكالوريوس ☐ ماجستير ☐ دكتوراه ☐ غير ذلك ☐

8-تاريخ الدخول...../...../.....

9-عدد مرات الدخول .....

10-سبب الدخول

جلطة دماغية ☐ تقرحات فراش ☐ شلل نصفي ☐ إصابة في الدماغ ☐

شلل رباعي ☐ بتر ☐ عظام ☐

11-طريقة التغطية المالية للخدمات

مجانًا ☐ وزارة الصحة ☐ وزارة الشئون الاجتماعية ☐ تأمين السيارات ☐

شخصي ☐ أخرى ☐

ضع/ي إشارة (√) مقابل كل خانة حسب ما تراه منسبا لرأيك:

قسم الأطباء

الرقم	العبارة	موافق بشدة	موافق	متردد	غير موافق	غير موافق بشدة
12	أرى الطبيب كل يوم					
13	يقضي الطبيب معي وقت كافي					
14	يفهم الطبيب ما أقول					
15	يشرح الطبيب لي عن حالتي					
16	الطبيب مهتم بحالتي					
17	الطبيب يقدم لي المساعدة					
18	الطبيب يناقش معي الخطة العلاجية					
19	الطبيب يناقش معي بدائل للعلاج					
20	الطبيب يوضح لي الإجراءات قبل عملها					
21	الطبيب أخبرني عن تشخيصي					
22	الطبيب أخبرني نفس التشخيص الذي أعرف					
23	الطبيب أفادني بمعلومات عن فوائد العلاج					
24	الطبيب أفادني بمضار العلاج					
25	الطبيب يشاركني في اتخاذ القرار المناسب لحالتي					
26	الطبيب لديه مهارة في العمل					

قسم التمريض

الرقم	العبارة	موافق بشدة	موافق	متردد	غير موافق	غير موافق بشدة
27	التمريض يجيب على طلبي قدر المستطاع					
28	التمريض لديهم مهارة في العمل					
29	التمريض يوضح لي تأثير العلاج قبل إعطاءه					
30	التمريض يعطوني العناية اليومية الكاملة					
31	يتعامل معي الممرضون حسب الخطة العلاجية					
32	عمل التمريض في الفترة الصباحية يعيق باقي الفريق عن العمل					
33	التمريض يحترم خصوصيتي					
34	التمريض متعاون مع باقي فريق التأهيل					
35	ينظم الممرضون العمل مع باقي الفريق					
36	التمريض دربني للتعامل مع إعاقتي					
37	يضع التمريض المرضى مع بعضهم في الغرف حسب حالاتهم					

قسم العلاج الطبيعي

الرقم	العبارة	موافق بشدة	موافق	متردد	غير موافق	غير موافق بشدة
38	أحصل على جلسة علاج طبيعي					
39	أخصائي العلاج الطبيعي ينظم وقت الجلسات مع باقي الفريق					
40	أخصائي العلاج الطبيعي يشرح لي عن منافع جلسة العلاج الطبيعي					
41	أخصائي العلاج الطبيعي يشرح لي عن مضار جلسة العلاج الطبيعي					
42	أخصائي العلاج الطبيعي يشاركني في اتخاذ القرارات المناسبة للعلاج					
43	أخصائي العلاج الطبيعي يقضي معي وقت كافي					
44	أحصل على أكثر من جلسة في اليوم					
45	أحصل على جلسة العلاج الطبيعي في السرير					
46	أحصل على جلسة العلاج الطبيعي في صالة التمارين					
47	يستخدم الأخصائي الأدوات الكهربائية في جلسات العلاج الطبيعي					

48	الأجهزة المستخدمة في جلسات العلاج الطبيعي موجودة باستمرار					
49	أخصائي العلاج يتعاون مع بافي أعضاء الفريق					
50	أخصائي العلاج الطبيعي يتعامل معي بلطف					
51	أخصائي العلاج الطبيعي يحترم خصوصيتي					

قسم العلاج الوظيفي

الرقم	العبارة	موافق بشدة	موافق	متردد	غير موافق	غير موافق بشدة
52	أحصل على جلسة علاج وظيفي					
53	أخصائي العلاج الوظيفي ينظم وقت الجلسات مع باقي الفريق					
54	أخصائي العلاج الوظيفي يشرح لي عن منافع جلسة العلاج الوظيفي					
55	أخصائي العلاج الوظيفي يشرح لي عن مضار جلسة العلاج الوظيفي					
56	أخصائي العلاج الوظيفي يشاركني في اتخاذ القرارات المناسبة للعلاج					
57	أخصائي العلاج الوظيفي يقضي معي وقت كافي					
58	أحصل على أكثر من جلسة في اليوم					
59	أحصل على جلسة العلاج الوظيفي في السرير					
60	أحصل على جلسة العلاج الوظيفي في صالة التمارين					
61	يستخدم الأخصائي الأدوات الكهربائية في جلسات العلاج الوظيفي					
62	الأجهزة المستخدمة في جلسات العلاج الوظيفي موجودة باستمرار					
63	أخصائي العلاج يتعاون مع بافي أعضاء الفريق					
64	أخصائي العلاج الوظيفي يتعامل معي بلطف					
65	أخصائي العلاج الوظيفي يحترم خصوصيتي					

قسم الخدمة الاجتماعية

الرقم	العبارة	موافق بشدة	موافق	متردد	غير موافق	غير موافق بشدة
66	لقد سبق وزرت قسم الخدمة الاجتماعية					
67	تعرفت على الاخصائى الاجتماعي					
68	زارني الأخصائي الاجتماعي وأنا في غرفتي					

69	طلبت مساعدة معنية من الخدمة الاجتماعية					
70	تلقيت خدمة معنية من قسم الخدمة الاجتماعية					
71	الأخصائي الاجتماعي يحفظ لي خصوصيتي					

قسم الصحة النفسية

الرقم	العبارة	موافق بشدة	موافق	متردد	غير موافق	غير موافق بشدة
72	لقد سبق وزرت قسم الخدمة النفسية					
73	تعرفت على الاخصائى النفسي					
74	زارني الأخصائي النفسي وأنا في غرفتك					
75	طلبت مساعدة معنية من الأخصائي النفسي					
76	تلقيت خدمة معنية من قسم الأخصائي النفسي					
77	الأخصائي النفسي يحفظ لي خصوصيتي					

الأقسام الأخرى

الرقم	العبارة	موافق بشدة	موافق	متردد	غير موافق	غير موافق بشدة
78	فريق التاهيل متواجد في أي وقت					
79	يتواصل معي الفريق بطريقة مناسبة					
80	لدي الحق في السؤال عن حالتي في أي وقت					
81	يجيب الطاقم عن سؤالي بطريقة مناسبة					
82	الطاقم يفهمني					
83	الطاقم يحترمني					
84	أشعر بأن الطاقم يتعامل مع بعضه كالفريق					

الرجاء أجب بنعم أو لا

85- هل أنت مستعد للزيارة المنزلية؟

نعم ☐ لا ☐

86- من يتخذ قرار الزيارة المنزلية عن طريق؟

فريق التأهيل ☐ المريض نفسه ☐ مع بعض ☐

87- هل تم تدريب عائلتك عن طريق الفريق؟

نعم ☐ لا ☐

88-هل واجهت أي مشكلة خلال الزيارة المنزلية؟

نعم ☐ لا ☐

89هل ناقشت هذه المشكلة مع الفريق؟

نعم ☐ لا ☐

90-هل ساعدك الفريق في وضع حلول لمشكلتك؟

نعم ☐ لا ☐

91-هل أسرتك تزورك

نعم ☐ لا ☐

92-إذا نعم هل يأتوا كل:

يوم ☐ أكثر من مرتين في الأسبوع ☐ كل أسبوع ☐

93-إذا لا هل السبب

الطريق لا يوجد وقت ☐ مكان المستشفى ☐ الحالة المادية ☐ غير ذلك ☐

<u>المريض المستعد للخروج</u>

94-هل أنت معتمد الآن على نفسك في أنشطة الحياة اليومية

نعم ☐ لا ☐

95-هل تم زيارة منزلك من قبل طاقم التأهيل لتقييم مدى ملائمة المنزل لحالتك

نعم ☐ لا ☐

96-هل الفريق الطبي ساعدك في التعرف على برامج تأهيل بعد خروجك من المستشفى

نعم ☐ لا ☐

97-هل تنوي الاستمرار في العلاج بعد الخروج من المستشفى

نعم ☐ لا ☐

98-الرجاء اكتب أي اقتراحات يمكنها تحسين مستوى الخدمة في المستشفى:

99-الرجاء أكتب أي تعليق لم يتم التطرق إليه في هذه الاستبانة:

الباحثة / ميرفت عسفة

Annex(5)

فقرات استبانه تقييم خدمات التأهيل المقدمة بواسطة مستشفى الوفاء للتأهيل الطبي والجراحات التخصصية من وجه نظر مقدم الخدمة في صورتها الأولية قبل التحكيم.

التاريخ: / / 200 **الرقم----------**
(خاص بالباحث)

البيانات الشخصية

من فضلك أجب عن جميع الأسئلة التالية.
ضع/ي إشارة (√) مقابل كل خانة حسب ما يناسبك

1-العمر:---------- سنة

2-الجنس: ذكر ☐ أنثى ☐

3-العنوان:

محافظة الشمال ☐ محافظة غزة ☐ محافظة الوسطى ☐

محافظة خان يونس ☐ محافظة رفح ☐

4-الحالة الاجتماعية:

أعزب/ آنسة ☐ متزوج/ة ☐

أرمل/ة ☐ مطلق/ة ☐

5-عدد أفراد الأسرة التي تعيلها بما فيها أنت:----------

6-متوسط الدخل الشهري(من كل مصادر الدخل):---------- شيكل

7-المؤهل العلمي:

ثانوية عامة ☐ دبلوم ☐ بكالوريوس ☐

ماجستير ☐ دكتوراة ☐

8-المهنة الأساسية----------

9-تاريخ التعيين سنة ----------

10-الخبرة الكلية في مجال مهنتك:---------- سنة

11-الوظيفة الحالية " المسمى الوظيفي"----------

12-عدد سنوات العمل في الوظيفة الحالية---------- سنة

ضع/ي إشارة (√) مقابل كل خانة حسب ما تراه منسبا لرأيك

الرقم	العبارة	موافق بشدة	موافق	متردد	غير موافق	غير موافق بشدة
.1	لدي معرفة كاملة عن رؤية مؤسستي					
.2	لدي معرفة كاملة عن رسالة مؤسستي					
.3	لدي معرفة كاملة عن قيم مؤسستي					
.4	مؤسستي تشجعني على تحسين أدائي					
.5	مؤسستي تقدر جهودي					
.6	مؤسستي تقدر التزامي					
.7	أنا راضي عن دور مؤسستي					
.8	أنوي تغيير عملي إذا أتيحت لي الفرصة					
.9	عملي يؤثر على عمل الآخرين					
.10	عملي يؤثر على نجاح مؤسستي					
.11	أدائي في العمل يتقدم باستمرار					
.12	أنا راضي عن عملي					
.13	أؤدي دور حيوي في مؤسستي					
.14	العمل كفريق مهم جداً في مؤسستي					
.15	لدي علاقات جيدة مع زملائي					
.16	أشعر بالرضا عن عملي في نهاية اليوم					
.17	قسمي مجهز بطاقم مناسب					
.18	جدول الخاص بالعمل مناسب					
.19	جدول العمل قابل للتغيير					
.20	قسمي مجهز بالمعدات اللازمة					
.21	قسمي مجهز بالأدوات اللازمة					
.22	بإمكاني أخذ إجازتي في أي وقت					
.23	لدي مرونة في جدول العمل					
.24	توزيع العمل عادل					
.25	توزيع العمل مناسب					
.26	يوجد تطوير في مؤسستي					
.27	لدي وصف وضيفي واضح					
.28	لدي أمان وضيفي					

.29	أنا راضي عن الحوافز المقدمة لي					
.30	أنا راضي عن راتبي					

الرقم	العبارة	موافق بشدة	موافق	متردد	غير موافق	غير موافق بشدة
.31	راتبي يناسب مؤهلاتي العلمية					
.32	راتبي يناسب خبراتي في العمل					
.33	رئيسي في العمل يؤثر على اتجاهي في أداء عملي					
.34	رئيسي المباشر عادل					
.35	يوجد لدي فرصة للتطوير الوظيفي					
.36	أتمنى أن يكون لدي رئيس جديد					
.37	رؤسائي في العمل يقدروا جهودي					
.38	زملائي في العمل يقدروا جهودي					
.39	يوجد نظام اتصال فعال في مؤسستي					
.40	رئيسي في العمل يعطيني تغذية إيجابية عن عملي					
.41	يهتم المدراء فقط بإنجاز العمل					
.42	المسئولين في العمل يعطون أوامر متناقضة					
.43	لدي علاقات جيدة مع المرضى					
.44	عدد العاملين في قسمي مناسب لعدد المرضى					
.45	يوجد مساواة بين الموظفين من قبل الإدارة					
.46	أنا راضي عن قوانين المؤسسة					
.47	لا يوجد اختلاف بين قيمي الشخصية والقوانين المعمول بها في المؤسسة					
.48	أنا فخور في مؤسستي التي أعمل بها					
.49	يهتم المدراء بالاقتراحات المقدمة من العاملين					
.50	لدي الحرية في اتخاذ قرارات صعبة فيما يتعلق بالعمل					
.51	راتبي يناسب مؤهلاتي العلمية					

الرجاء أجب/اي بنعم أو لا

64-هل أنت ملتحق في برنامج للتعليم المستمر؟

نعم ☐ لا ☐

65-هل برنامج التعليم المستمر في نفس مجال عملك؟

نعم ☐ لا ☐

66-هل سبق لك أن التحقت في برنامج التعليم المستم؟ر

نعم ☐ لا ☐

67-هل برنامج التعليم المستمر يؤثر على ادائك في العمل؟

نعم ☐ لا ☐

68-هل لديك الوقت الكافي لإنهاء عملك؟

نعم ☐ لا ☐

69-هل تقبل أن تعمل وقتا إضافيا دون مقابل؟

نعم ☐ لا ☐

70هل أنت قلقا من احتمال إنهاء خدمتك؟

نعم ☐ لا ☐

71-من فضلك اكتب أي اقتراحات يمكن أن يحسن مستوى العمل حسب وجهة نظرك

72-من فضلك اكتب أي تعليقات أخرى

شكرا لكم

الباحثة ميرفت عسفة

Annex(6)

فقرات استبانتا تقييم خدمات مستشفى الوفاء للتأهيل الطبي من وجهة نظر مستلم الخدمة ومقدمها في صورتهما الأولية

بسم الله الرحمن الرحيم

السيد الدكتور/ة_____ يحفظه/ ـا الله

السلام عليكم ورحمة الله وبركاته،،،،

الموضوع/ استبانه تقييم خدمات التأهيل المقدمة بواسطة مستشفى الوفاء للتأهيل من وجه نظر مستلم الخدمة.

أرجو الله أن تكونوا بخير وعافية وبعد،،،،
الإشارة إلى الموضوع أعلاه، فاننى أتشرف أن أضع بين أيديكم استبانتين بعنوان:

" **تقييم خدمات التأهيل المقدمة بواسطة مستشفى الوفاء للتأهيل من وجه نظر مستلم الخدمة ومقدمها**"
الاستبانة المذكورة- والمرفقة مع هذه الرسالة- هي الأداة التي ستستخدمها الباحثة في إعداد بحث لنيل درجة الماجستير في (علوم التأهيل) من قسم الصحة النفسية المجتمعية في كلية التربية بالجامعة الإسلامية والذي يحمل عنوان" **تقييم خدمات التأهيل المقدمة بواسطة مستشفى الوفاء للتأهيل من وجه نظر مستلم الخدمة ومقدمها"،** تحت إشراف الأستاذ المشارك في قسم علم النفس بالجامعة الإسلامية/د.سناء أبو دقة.
أرجو تكرمكم بإبداء رأيكم وتوجيهاتكم في الاستبانة المرفقة من حيث ملائمة العبارات والفقرات،وسلامتها اللغوية في تقييم خدمات المقدمة بواسطة مستشفى الوفاء للتأهيل الطبي والقيام بالتعديل أو حذف بعض العبارات أو الفقرات التي ترون أنها بحاجة إلى تعديل أو حذف.
أثمن لكم عاليا حسن اهتمامكم، وكلى أمل أن أتلقى ردكم في اقرب وقت، سائلة المولى عز وجل أن يجعل ذلك في موازين حسناتكم، وجزآكم الله خيرا.

تقبلوا بقبول فائق الاحترام والتقدير

الباحثة/ميرفت عسفة

Annex (7)

First: Clients' questionnaire

Correlation coefficient between items of doctors' domain & total score of domain

Items	R	Significant level
Doctor spend enough time with me	0.47	not significant
Doctor understand what I say	0.73	significant at the 0.01 (**)
Doctor explain to me my condition	0.79	significant at the 0.01 (**)
Doctor careful	0.25	not significant
Doctor helpful	0.78	significant at the 0.01 (**)
Doctor discus my treatment plan with	0.79	significant at the 0.01 (**)
Doctor explain treatment alternative with me	0.83	significant at the 0.01 (**)
Doctor describing procedures to me prior to do them	0.72	significant at the 0.01 (**)
Doctor inform me clearly about my diagnosis	0.43	not significant
Doctors till me the same diagnosis I know	0.19	not significant
Doctor give me information about the possible benefits about treatment	0.63	significant at the 0.05(*)
Doctor give me information about the possible side effect of treatment	0.78	significant at the 0.01 (**)
Doctor participate me in the decisions taken for my case	0.51	not significant
Doctor is skilful	0.6	significant at the 0.05(*)

Correlation coefficient between items of nursing domain and total score of domain

Items	R	Significant level
nurses answer my requests as soon as they can	0.48	not significant
Nurses are skilful	0.50	not significant
Nurses explain treatment side effect to me	0.74	significant at the 0.01 (**)
Nurses give me complete daily care	0.56	significant at the 0.05(*)
Nurses deal with me according my treatment plan	0.59	significant at the 0.05(*)
The nursing morning care badly affects the work of other teams	0.56	significant at the 0.05(*)
Nurses respect my privacy	0.52	significant at the 0.05(*)
Nurses cooperative well with other teams	0.50	not significant
Nurses organize their work with other team members	0.58	significant at the 0.05(*)
Nurses train me well to deal with me disability	0.33	not significant
Nurses put patients according to their diagnosis	0.36	not significant

Correlation coefficient between item of PT domain and total score of domain

Items	R	Significant level
I receive PT sessions daily	0.75	significant at the 0.01 (**)
Physiotherapists coordinate sessions time with other team	0.53	significant at the 0.05(*)
physiotherapists inform me about the befits of physiotherapy exercises	0.42	not significant
physiotherapists inform me about the side effect of physiotherapy exercises	0.42	not significant
physiotherapists share me in the decisions taken for me	0.49	not significant
physiotherapist spend enough time with me	0.65	significant at the 0.01 (**)
I have more than one session per day	0.75	significant at the 0.01 (**)
I take my session done in the bed	0.49	not significant
My session don in the Gym	0.67	significant at the 0.01 (**)
Physiotherapists use electric equipment during sessions	0.73	significant at the 0.01 (**)
The equipment used in PT sessions are available	0.61	significant at the 0.05(*)
Physiotherapists cooperative with other team	0.52	significant at the 0.05(*)
Physiotherapists deals kindly with me	0.68	significant at the 0.01 (**)
Physiotherapists respect of my privacy	0.70	significant at the 0.01 (**)

Correlation coefficient between each item of OT domain and total score of domain

Items of appointments registration domain	R	Significant level
I receive occupational therapists (OT) sessions	0.62	significant at the 0.05(*)
Occupational therapists coordinate sessions time with other team	0.57	significant at the 0.05(*)
Occupational therapists inform me about the befits of occupational therapy	0.40	not significant
Occupational therapists inform me about the side effect of occupational therapy	0.45	not significant
Occupational therapists share me in the decisions taken for me	0.53	significant at the 0.05(*)
Occupational therapists spend enough time with me	0.91	significant at the 0.01 (**)
I take my session done in the bed	0.17	not significant
My session don in the occupational therapy department.	0.66	significant at the 0.01 (**)
Occupational therapists use assisted equipment during sessions	0.53	significant at the 0.05(*)
The equipment used in OT sessions are available	0.65	significant at the 0.05(*)
Occupational therapists cooperative with other team	0.70	significant at the 0.01 (**)
Occupational therapists deals kindly with me	0.80	significant at the 0.01 (**)
Occupational therapists respect of my privacy	0.91	significant at the 0.01 (**)

Correlation coefficient between each item of social domain and total score of domain

Items	R	Significant level
social worker follow my case with other team	0.90	significant at the 0.01 (**)
I know the social worker	0.97	significant at the 0.01 (**)

Social worker visited me in my bed	0.97	significant at the 0.01 (**)
Social worker	0.96	significant at the 0.01 (**)
I have received a certain service from the social worker	0.96	significant at the 0.01 (**)
Social worker respect of my privacy	0.89	significant at the 0.01 (**)

Correlation coefficient between items of psychological domain and total score of domain

Items	R	Significant level
psychologist follow my case with other team	0.93	significant at the 0.01 (**)
I know the psychologist	0.96	significant at the 0.01 (**)
The psychologist visited me in my bed	0.95	significant at the 0.01 (**)
I request a certain help from the psychologist	0.73	significant at the 0.01 (**)
I have received a certain service from the psychologist	0.81	significant at the 0.01 (**)
psychologist respect of my privacy	0.93	significant at the 0.01 (**)

Correlation coefficient between each evaluation domains and total score of instrument

Evaluation domains	r	Significant level
Physician	0.55	significant at the 0.01(**)
Nurses	0.83	significant at the 0.01(**)
Physiotherapy	0.89	significant at the 0.01(**)
Occupational therapy	0.73	significant at the 0.01(**)
Social worker	0.76	significant at the 0.01(**)
Psychologist	0.65	significant at the 0.01(**)

Service providers' questionnaire

Correlation coefficient between items of organization domain & total score of domain

Items	r	Significant level
I understand the organization's vision	0.60	significant at the 0.05(*)
The organizational culture encourages me to improve my performance	0.85	significant at the 0.01(**)
The organization appreciates my efforts	0.78	significant at the 0.01(**)
I understand the organization roles	0.91	significant at the 0.01(**)
I have a clear job description	0.47	not significant
I have job security	0.77	significant at the 0.01(**)

Correlation coefficient between each item of supervisor domain and total score of domain

Items of appointments registration domain	R	Significant level
My managers influence positively in my attitudes towards my work	0.79	significant at the 0.01(**)
My immediate supervisor just	0.81	significant at the 0.01(**)

My supervisor appreciate my performance	0.53	significant at the 0.05(*)
My supervisor provide me positive feedback	0.62	significant at the 0.05(*)
The supervisor are interested only by achieving work	0.23	not significant
Superiors give contradicting orders	0.24	not significant
There is no discrimination between employee in my organization	0.50	not significant
The manager pays attention to employees' suggestions about development of work	0.65	significant at the 0.05(*)

Correlation coefficient between each item of team work domain and total score of domain

Items of appointments registration domain	R	Significant level
My work impacts positively other associates' work	0.57	significant at the 0.05(*)
My work impacts the organization's success	0.21	not significant
Teamwork is an essential requirement in my job performance	0.61	significant at the 0.05(*)
I have good work relationships with my coworkers in different words	0.50	not significant
I am providing a vital function in the organization	0.16	not significant
My coworkers appreciate my performance	0.72	significant at the 0.01(**)
effective Communication in place	0.60	significant at the 0.05(*)
I have a good rapports with my patient	0.12	not significant

Correlation coefficient between each item of work schedule domain and score of domain

Items of appointments registration domain	R	Significant level
Work schedule is convenient	0.80	significant at the 0.01(**)
The week schedule is flexible	0.33	not significant
My vacation time is appropriate	0.91	significant at the 0.01(**)
I have flexibility in scheduling	0.73	significant at the 0.01(**)

Correlation coefficient between each item of education domain and total score of domain

Items of appointments registration domain	R	Significant level
Development programs occurred in my organization	0.89	significant at the 0.01(**)
I have a good chance of promotion	0.88	significant at the 0.01(**)

Correlation coefficient between each item of salary domain and total score of domain

Items	R	Significant level
I am satisfied by my benefits	0.83	significant at the 0.01(**)

I am satisfied by my salary	0.97	significant at the 0.01(**)
My salary suits my qualifications	0.93	significant at the 0.01(**)

Correlation coefficient between items of general satisfaction domain and total score of domain

Items of appointments registration domain	r	Significant level
I am satisfied by the organization role	0.55	significant at the 0.05(*)
I am willing to change my job if opportunity arrives	0.37	not significant
My work performance is steadily improving	0.76	significant at the 0.01(**)
At the end of the work day, I feel satisfied with my work performance	0.71	significant at the 0.01(**)
My unit is appropriately staffed	0.28	not significant
Number of employees is enough related to number of patients	0.46	not significant
There is no difference between my personal values and work-laws applied in my organization	0.29	not significant
I am proud of my organization	0.73	significant at the 0.01(**)
I am free to take work related decisions	0.65	significant at the 0.05(*)
My unit is well-equipped	0.39	not significant
I am satisfied with rules provision in my organization	0.75	significant at the 0.01(**)

Correlation coefficient between each domain and total score

Evaluation domains	r	Significant level
Organization	0.61	significant at the 0.05(*)
Supervisors	0.67	significant at the 0.01(**)
Team work	0.33	not significant
Work schedules	0.12	not significant
Cont. education	0.36	not significant
Salary	0.77	significant at the 0.01(**)
General satisfaction	0.80	significant at the 0.01(**)

Evidence collected showed that questionnaires were valid and suitable enough to measure the concept of interest.

ANNEX (8)

Helsinki committee approval

Palestinian National Authority
Ministry of Health
Helsinki Committee

السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

التاريخ2009/6/3

Name:

الاسم: ميرفت محمود محمد عسفة

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

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

Evaluation of services Provided at El Wafa medical Rehabilitation Hospital in Gaza Strip: Clients and Provider perspectives

In its meeting on June 2009

و ذلك في جلستها المنعقدة لشهر 6 2009

and decided the Following:-

و قد قررت ما يلي:-

To approve the above mention research study.

الموافقة على البحث المذكور عاليه.

Signature
توقيع

Member
عضو

Member
عضو

Chairperson

Conditions:-

- Valid for 2 years from the date of approval to start.
- It is necessary to notify the committee in any change in the admitted study protocol.
- The committee appreciate receiving one copy of your final research when it is completed.

ANNEX (9)

بسم الله الرحمن الرحيم

الجامعة الإسلامية – غزة
The Islamic University - Gaza
الشئون الأكاديمية – وحدة الجودة
Academic Affairs–Quality Unit

الرقم..... الاربعاء 05 جمادى الثانية 1428 Ref
التاريخ..... Date 2007/06/20

الأخ الأستاذ/ تيسير البلتاجي حفظه الله

مدير عام جمعية الوفاء الخيرية

السلام عليكم ورحمة الله وبركاته،،،

الموضوع: تسهيل مهمة طالب ماجستير

يهديكم المجلس الأكاديمي لبرنامج ماجستير الصحة النفسية والمجتمعية بالجامعة الإسلامية أطيب التحيات، ونرجو من سيادتكم التكرم بتسهيل مهمة الطالبة/ **ميرفت عسفة**، والتي تحمل رقم جامعي 2004/5736، المسجلة في برنامج الماجستير بكلية التربية تخصص صحة نفسية ومجتمعية/ علوم التأهيل، وذلك بهدف الحصول على إحصائيات لغاية البحث العلمي.

وتفضلوا بقبول فائق التقدير والاحترام

رئيس المجلس الأكاديمي للبرنامج

د. عليان عبد الله الحولي

P.O. Box 108, Rimal, Gaza, Palestine fax: +970 (8) 286 0800 فاكس tel: +970 (8) 286 0700 تلفون ص.ب 108 الرمال غزة فلسطين
public@iugaza.edu.ps www.iugaza.edu.ps

Annex (10)

استمارة وصف الاستبانة للمرضى المشاركين في الدراسة

استبيانه حول

تقييم خدمات التأهيل المقدمة بواسطة مستشفى الوفاء للتأهيل الطبي والجراحات التخصصية من وجه نظر مستلم الخدمة ومقدمها

عزيزي مقدم/ة الخدمة

نود أن نعلمكم أننا بصد إجراء دراسة بحثية مقدمة لكلية التربية- قسم الصحة النفسية و المجتمعية /علوم التأهيل في الجامعة الإسلامية ، والهدف منها تقييم خدمات التأهيل المقدمة في مستشفى الوفاء للتأهيل الطبي والجراحات التخصصية من وجه نظر مقدم الخدمة والمستفيد منها.

ونشكر لكم مشاركتكم في هذه الدراسة، ونعلمكم بأنه سيكون لها دور ايجابي في تحسين وتطوير نوعية الخدمات، و بأن تمنحونا بعضاً من وقتكم الثمين للإجابة على أسئلة الاستبانه.علما بان الإجابة على الأسئلة الواردة تستغرق من 20 إلى 25 دقيقة.

نرجو منكم عدم كتابة الاسم ونؤكد لكم بأن إجاباتكم على الأسئلة الواردة في الاستبيان ستكون سرية وستستخدم لغرض الدراسة فقط وستكون محل اهتمام وتقدير.

علماً بأنكم تحتفظون بحقكم في رفض الإجابة على أي سؤال أو جميع الأسئلة الواردة في الاستبيان.

شكرا" لكم على المشاركة

Annex (11)

بسم الله الرحمن الرحيم

الأخ/ات الفاضل/ة

السلام عليكم ورحمة الله

نود أن نعلمكم أننا بصدد إجراء دراسة بحثية مقدمة لكلية التربية- قسم الصحة النفسية و المجتمعية /علوم التأهيل في الجامعة الإسلامية ، والهدف منها تقييم خدمات التأهيل المقدمة في مستشفى الوفاء للتأهيل الطبي والجراحات التخصصية من وجه نظر مقدم الخدمة والمستفيد منها.

ونشكر لكم مشاركتكم في هذه الدراسة، ونعلمكم بأنه سيكون لها دور ايجابي في تحسين وتطوير نوعية الخدمات، علما بأن المشاركة اختيارية والبيانات سوف تستخدم لإغراض البحث العلمي .

نرجو منكم عدم كتابة الاسم ونؤكد لكم بأن إجاباتكم على الأسئلة الواردة في الاستبيان ستكون سرية وستستخدم لغرض الدراسة فقط وستكون محل اهتمام وتقدير.

علماً بأنكم تحتفظون بحقكم في رفض الإجابة على أي سؤال أو جميع الأسئلة الواردة في الاستبيان.

التاريخ:2008/7/20
الباحثة/ ميرفت عسفة

Annex (12)

Dear Dr./----------
May god's peace and mercy be upon you,,,,

Subject: The questionnaire of the evaluation of services provided at El-Wafa Medical rehabilitation hospital In Gaza strip: clients and provider perspectives.

Referring to the above subject, I am glad to up in your hands the questionnaires entitled: "Evaluation of services provided at El-Wafa Medical rehabilitation hospital In Gaza strip: clients and provider perspectives"

The mentioned questionnaires, which are attached to this letter, are the tool used by the researcher in the preparation for the Master degree research in (the Rehabilitation Science) of the Department of Community Mental Health in the Islamic University/ Collage of Education, which are entitled: "Evaluation of services provided at El-Wafa Medical rehabilitation hospital In Gaza strip: clients and provider perspectives", under the supervision of Associate Professor in the Department of Psychology in the Islamic University ,Dr. Sana,a Abu Dakka.

Thus, I ask you kindly to give opinion and guidance about this questionnaires regarding: the phrases and paragraphs, language, and making all the suitable amendments, or deleting cretin words or paragraphs, which you believe need to be modified or deleted.

I highly appreciate your cooperation, and hope to hear from you soon.

With my best regards.

Yours sincerely,

Researcher: Mirvat Asfa

Annex(13)

Dear client,

May god's peace and mercy be upon you,,,,

I highly appreciate your sincere and honest participation in filling this questionnaire, which is part of the study for obtaining a Master degree in Rehabilitation Science from Islamic University –Gaza.

The objective of this study is to evaluate the services provided at El-Wafa rehabilitation hospital in Gaza strip, from clients and provider perspectives. you participation in this study will have a valuable role to improve and develop type of services introduce in future plans of this hospital, noting that the participation in filling this questionnaire is optional.

It is noteworthy that the information in this questionnaire is confidential and will not affect the services you receive from the hospital.

Researcher / Mirvat Asfa

Annex(14)

Dear provider,

May god's peace and mercy be upon you,,,,

I highly appreciate your sincere and honest participation in filling this questionnaire, which is part of the study for obtaining a Master degree in Rehabilitation Science from Islamic University –Gaza.

The objective of this study is to evaluate the services provided at El-Wafa rehabilitation hospital in Gaza strip, from clients and provider perspectives. you participation in this study will have a valuable role to improve and develop type of services introduce in future plans of this hospital, noting that the participation in filling this questionnaire is optional.

It is noteworthy that the information in this questionnaire is confidential and will use for research only.

Researcher / Mirvat Asfa

Annex (15)

Final Version of Questionnaire in English

Questionnaires for providers

Questionnaire about: evaluation of services provided at El-Wafa Medical rehabilitation hospital In Gaza strip: clients and provider perspectives.

Date: \ \ 2008 **Number---------**

Personal data:

Please answer all the followed questions.

1- Age ----------years

2- Gender: Male ☐ Female ☐

3- Address:

Northern district ☐ Gaza district ☐ Middle district ☐

Khan-Younes district ☐ Rafah district ☐

4- Marital status:

Single ☐ Married ☐

Widow ☐ Divorce ☐

5-Level of qualification.

Secondary school ☐ diploma ☐ bachelor degree ☐

Master degree ☐ doctorate ☐

6- Number of your family members including yourself ----------

7-Main Profession ----------

8-Date of employment ----------

9-Years of experience in your field ----------

10- Title of current position ----------

11- Years in current position ----------years.

12- Average of monthly income ----------NIS

No.	Items	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
1.	I understand the organization's vision					
2.	The organizational culture encourages me to improve my performance					
3.	The organization appreciates my efforts					
4.	I understand the organization roles					
5.	I have a clear job description					
6.	I have job security					
7.	My managers influence positively in my attitudes towards my work					
8.	My immediate supervisor just					
9.	My supervisor appreciate my performance					
10.	My supervisor provides me positive feedback					
11.	The supervisor are interested only by achieving work					
12.	Superiors give contradicting orders					
13.	There is no discrimination between employee in my organization					
14.	The manager pays attention to employees' suggestions about development of work					
15.	My work impacts positively other associates' work					
16.	My work impacts the organization's success.					
17.	Teamwork is an essential requirement in my job performance					
18.	I have good work relationships with my coworkers					

No.	Items	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
19.	I am providing a vital function in the organization					
20.	My coworkers appreciate my performance					
21.	Effective Communication in place					
22.	I have a good rapports with my patient					
23.	Work schedule is convenient					
24.	I have flexibility in scheduling					
25.	My vacation time is appropriate					
26.	I have flexibility in scheduling					
27.	Development programs occurred in my organization					
28.	I have a good chance of promotion					
29.	I am satisfied by the organization role					
30.	I am willing to change my job if opportunity arrives					
31.	My work performance is steadily improving					

No.	items	Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
32.	At the end of the work day, I feel satisfied with my work performance					
33.	My unit is appropriately staffed					
34.	Number of employees is enough related to number of patients					
35.	There is no difference between my personal values and work-laws applied in my organization					
36.	I am proud of my organization					
37.	I am free to take work related decisions					
38.	I am satisfied by my benefits					
39.	I am satisfied by my salary					
40.	My salary suits my qualifications					
41.	My unit is well-equipped					
42.	I am satisfied with rules provision in my organization					

43. My organization have continuous education program

☐ **Yes** ☐ **No**

44. I am enrolled in continuous education program

☐ **Yes** ☐ **No**

if yes ,what the program joint in now?

1----------

2----------

3----------

if no, what the cause?

---

45. I am joined in continuous education program before

☐ **Yes** ☐ **No**

46- When the last time?

47-continuous education affects my work performance

☐ **Yes** ☐ **No**

if yes explain, how?

---

if no explain, why?

48-What the three important needed for future training?

---

49. I have enough time to finish my work

☐ **Yes** ☐ **No**

if no , why?

50-I accept to work overtime without pay

☐ **Yes** ☐ **No**

if no why?

51-I am worry about termination my job in any time ?

☐ **Yes** ☐ **No**

If yes ,explain why?

---

52. What the main three problem you face in the work field?

53.Please write your suggestions to improved the work level

54.Please write any other relevant comments

Thank for your cooperation.

Mirvat Assfa

Questionnaires for client

Questionnaire about: evaluation of services provided at El-Wafa Medical rehabilitation hospital In Gaza strip: clients and provider perspectives.

Date: \ \ 2008 **Number---------**

Personal data:

Please answer all the followed questions.

1- Age ----------years

2- Gender: Male ☐ Female ☐

3- Address:

Northern district ☐ Gaza district ☐ Middle district ☐

Khan-Younes district ☐ Rafah district ☐

4- Marital status:

Single ☐ Married ☐

Widow ☐ Divorce ☐

5- Number of your family members including yourself ----------6-

Average of monthly income ----------NIS

7- Level of qualification.

Secondary school ☐ Diploma ☐ Bachelor Degree ☐

Master degree ☐ Doctorate ☐ Others specify ----------

8- Date of admission ----------\----------\----------.

9- Times of admission ----------.

10- Cause of admission

CVA ☐ Bed Sores ☐ Paraplegia ☐ Traumatic brain injury ☐

Quadriplegia ☐ Amputation ☐ Orthopedic ☐

11-Type of payment

MOH ☐ **Insurance Company** ☐ **Private** ☐ **Don't Know** ☐

Doctor Department

No	Item	Strongly agree	Disagree	Uncertain	Agree	Strongly disagree
12	Doctor understand what I say					
13	Doctor explain to me my condition					
14	Doctor helpful					
15	Doctor discus my treatment plan with					
16	Doctor explain treatment alternative with me					
17	Doctor describing procedures to me prior to do them					
18	Doctor give me information about the possible benefits about treatment					
19	Doctor give me information about the possible side effect of treatment					
20	Doctor is skillful					

21-Please. Mention three important problems that you faced with doctors?

22-What yours suggestion to improve doctor works?

Nursing Department

No	Item	Strongly agree	Disagree	Uncertain	Agree	Strongly disagree
23	Nurses explain treatment side effect to me					
24	Nurses give me complete daily care					
25	Nurses deal with me according my treatment plan					
26	The nursing morning care badly affects the work of other teams					
27	Nurses respect my privacy					
28	Nurses organize their work with other team members					

29-Please. Mention three important problems that you faced with nursing?

30-What yours suggestion to improve nursing works?

Physiotherapy department

No	Item	Strongly agree	Disagree	Uncertain	Agree	Strongly disagree
31	I receive PT sessions daily					
32	Physiotherapists coordinate sessions time with other team					
34	physiotherapist spend enough time with me					
35	I have more than one session per day					
36	My session don in the Gym.					
37	Physiotherapists use electric equipment during sessions					
38	The equipment used in PT sessions are available					
39	Physiotherapists cooperative with other team					
40	Physiotherapists deals kindly with me					
41	Physiotherapists respect of my privacy					

42- Please. Mention three important problems that you faced with physiotherapy?

43-What yours suggestion to improve physiotherapy works?

Occupational therapy

No	Item	Strongly agree	Disagree	Uncertain	Agree	Strongly disagree
45	I receive occupational therapists (OT) sessions					
46	Occupational therapists coordinate sessions time with other team					
47	Occupational therapists share me in the decisions taken for me					
48	Occupational therapists spend enough time with me					
49	My session don in the occupational therapy department.					
50	Occupational therapists use assisted equipment during sessions					
51	The equipment used in OT sessions are available					
52	Occupational therapists cooperative with other team					
53	Occupational therapists deals kindly with me					
54	Occupational therapists respect of my privacy					

55- Please. Mention three important problems that you faced with occupational therapy?

56-What yours suggestion to improve occupational therapy works?

Social worker

No	Item	Strongly agree	Disagree	Uncertain	Agree	Strongly disagree
57	Social worker follow my case with other team					
58	I know the social worker					
59	The Social worker visited me in my bed					
60	Social worker					
61	I have received a certain service from the Social worker					
62	The social worker keep my privacy					

63-Please. Mention three important problems that you faced with social worker?

64-What yours suggestion to improve social worker works?

Psychologist

No	Item	Strongly agree	Disagree	Uncertain	Agree	Strongly disagree
65	psychologist follow my case with other team					
67	I know the psychologist					
68	The psychologist visited me in my bed					
69	I request a certain help from the psychol					
70	I have received a certain service from th psychologist					
71	The psychologist keep out my privacy					

72-Please. Mention three important problems that you faced with psychologist?

73-What yours suggestion to improve psychologist works?

Please answer "Yes" or "No"

74-Are you ready to go for home visit?

strongly agree	disagree	uncertain	agree	strongly disagree

75-The decision to go for home visit was taken by

Yourself ☐ **Hospital team** ☐ **Together** ☐

76-Did the hospital team train your family to deal with you?

Yes ☐ **No** ☐

77-Did you face any problem while you were on home visit?

Yes ☐ **No** ☐

78-Did you speak with the hospital team about the problems?

Yes ☐ **No** ☐

79-If yes the hospital team help you in finding solutions?

Yes ☐ **No** ☐

80-Your family is visiting you

Yes ☐ **No** ☐

81-if yes they visit you every

Day ☐ **two days weekly** ☐ **once weekly** ☐

82-if no the cause is

Difficult transportation to the hospital ☐ **No time** ☐ **The location of the hospital** ☐

Economic status ☐ **Others** ☐

Patient ready to go home visit:

83-are you dependant on your self on daily living activity?

Yes ☐ **No** ☐

84-if yes explain the percent?

Yes 100% ☐
Yes 70% ☐
Yes 50% ☐
Yes 25% ☐

85-Are the rehabilitation team visit your home to evaluate if the home suitable for your case or not?

Yes ☐ **No** ☐

86-Are the rehabilitation team assist you to defend social rehabilitation program after discharge?

Yes ☐ **No** ☐

87-Did you want continuo in treatment after discharge?

Yes ☐ **No** ☐

88-Please write any general suggestion to improve the level of work in EL- Wafa hospital?

89-Please write any other relevant comments

Thank for your cooperation.

Mirvat Assfa