Primary Health Care Training

An Assessment of Needs in the West Bank and Gaza Strip

Department of Community Health
Birzeit University
1995

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INTRODUCTION

This study attempts to contribute to the improvement and development of the Palestinian health care system by studying the work of a broad sample of clinics, with a special focus on human resources working in primary health care. It comes at a time when Palestinians are gradually taking charge of some of their own affairs, including the health sector. At this time, much attention is being placed on immediate needs arising from system distortions and dependence inflicted by years of military rule. So far, reformation plans have focused on providing resources to restore the physical infrastructure without paying sufficient attention to structural problems that afflict the medical/health care system itself. Such structural problems affect aspects of the system including policy formulation and planning, financial resource availability, supervision and management, and networking or coordination between different parts of the system. The problems manifest themselves in the absence of standards and protocols, and in insufficient or inappropriate training of human resources, particularly those working in the primary health care sector.

Previous work on the development of health systems in countries emerging from conflict has documented the risks associated with strategies focusing on infrastructural development without considering long-term development objectives. It has been shown that such strategies can exacerbate a more fundamental structural crisis, leading to even more serious crises[1].

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[1] See, for instance, Macrae J. and A. Zwi, *A Healthy Peace? Rehabilitation and Development of the Health Sector in "Post-Conflict Situations"* (a draft framework prepared for a comparative research project), Health Policy Unit, London School of Hygiene and Tropical Medicine, London, January 1994; Macrae, J., A. Zwi, and V. Forsythe, *Post-Conflict Rehabilitation: Preliminary Issues for Consideration by the Health Sector*, Health Policy Unit, London School of Hygiene and Tropical Medicine, London, 1995; Macrae, J., A. Zwi, and H. Birungi, *A Healthy Peace? Rehabilitation and Development of the Health Sector in a 'Post'-Conflict Situation: The Case of Uganda*, Health Policy Unit, London School of Hygiene and Tropical Medicine, London, 1995. See also, Alubo, S.O., "Debt Crisis, Health and Health Services in Africa," *Social Science and Medicine*, Vol. 31(6) (1990), pp.639-48; McDermott, K., "Community Health and Reform in Hong Kong," *Social Science and Medicine*, Vol. 23(2) (1986), pp.191-9.

This study and the recommendations emerging from it intend to address two specific problem areas: the training needs of human resources working in primary health care and the development of sound management, coordination, and supervision mechanisms and processes that can identify, intercept, and monitor crisis points in the system on an ongoing basis.

THE MAKINGS OF THE CURRENT HEALTH SYSTEM

A Historical Perspective: Modern medicine takes root in the country

As in other developing countries[2], Western scientific medicine took root in its institutional form in Palestine in the early twentieth century with the advent of British colonialism and with the incorporation of Palestine into the world economic system[3]. Since then the indigenous medical system[4] has undergone a variety of modifications as a result of changes in economic and social relations accompanying British rule. The increasing use of money, markets, and exchange, forced an evolution in the response of the population to health and disease; health and medical care underwent a gradual process of commoditization. As was noted in North Yemen[5], social and economic transformations over approximately 50 years manifested themselves in attitudinal change. Attitudes shifted away from the health-promoting behavior that formed one of the foundations of indigenous thinking about medicine to an attitude based primarily, but not entirely, on the purchase of a cure.

The principles underlying health care practices in the two systems were and continue to be different from each other. Within the modern biomedical framework, health is conceived as a biological phenomenon divorced from political,

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[2] See, for example, Paul, J., "Medicine and Imperialism," in *Monthly Review*, New York, 1978, pp. 271-81; and Macdonald, J., *Primary Health Care, Medicine in its Place*, (London: Earthscan Publications, 1993).

[3] Owen, R. (ed.), *Studies in the Economic and Social History of Palestine in the Nineteenth and Twentieth Century*, (London: Macmillan, 1982), p. 2.

[4] The indigenous medical system has its roots in Arab medicine, as is the case with most indigenous medical systems in the Middle East. For further information see Morsey, S., "Towards a Political Economy of Health: A Critical Note on the Medical Anthropology of the Middle East," *Social Science and Medicine*, Vol 15B (1981), pp.159-63.

[5] Pridham, B.R.(ed.), *Economy, Society and Culture in Contemporary Yemen* (Kent: Croom Helm, 1985), p.170.

economic, social, and cultural realities. The solutions of health problems are defined in terms of activities and procedures taking place within the clinic. The assumptions and approach to health care found in the indigenous medical system, however, are strikingly similar to those of the modern primary health care conception in terms of the holistic orientation. For example, both acknowledge social, economic, and psychological/mental factors as important components of the making of health and disease, and focus attention on the concept of health promotion[6].

Gradually, modern medicine with its biomedical orientation began to take over the indigenous system. Ironically, by the time the World Health Organization began to identify the principles and practice of primary health care as key components in addressing the health problems of developing societies biomedical medicine had invaded not only medical practice but also the consciousness of the population. These changes led to the contemporary problem wherein a highly biomedical conception of health and health services is imbued not only in the consciousness of health professionals, but also in the concrete demands of the population.

Post-1948

In 1948, the West Bank became part of the Hashemite Kingdom of Jordan while the Gaza Strip fell under Egyptian administration. Modern medical services, as provided through Jordanian and Egyptian infrastructures, appear to have reached refugees and rural areas in the 1950's. These services were restricted to rudimentary biomedical care[7]. By 1967, prior to Israeli occupation, the Palestinian health care system was composed of a network of regional hospitals and clinics that provided rudimentary services. It seems that these services often failed to reach those who needed them most. On the eve of Israeli occupation, three sponsors provided health care in each area: the Jordanian or Egyptian government, the United Nations Relief and Works Agency (UNRWA) (for refugees only), and the private sector. The private sector at this time included minimal services provided by charitable societies and ordinary private practice.

[6]See Morsey, S., op. cit.

[7]Based on information gathered by the authors through interviews conducted with health professionals who worked in the system in the 1950's and 1960's.

The majority of the people sought and received health care from the governments. This sector was affected most negatively by the onset of Israeli military rule. Health budgets were slashed. Hospitals and other health facilities were closed or deprived of critical personnel. In 1967, the physician-to-population ratio reached the low of 8 per 10,000 in the West Bank and Gaza Strip. In the same year Israel's physician-to-population ratio was 28 per 10,000 and Jordan's 22 per 10,000[8].

By the middle of the 1980's, serious inequalities in the distribution of governmental health services became apparent. The government system neglected primary health care and health in the rural areas where the majority of people lived. More importantly, it became evident that the military authority's agenda for the first 15 years of occupation-a policy aimed at breaking down the existing basic health infrastructure and developing dependency on Israeli services-had succeeded[9]. It should be noted that infrastructural breakdown and the consequent dependence on Israeli structures in all aspects of life were hallmarks characterizing military rule. In this sense the deterioration in the health services was not an exception[10].

In the middle and late 1980's, a new Israeli policy evolved that encouraged the creation of health services especially for the Arabs. From the Palestinian point of view, these new measures served to reinforce fears concerning the role of health care provision in the political sphere. People began to recognize that the dependency of the West Bank and Gaza on Israel presupposed the dependence of the health services sector as well. Fears "that it is appropriate to develop a second-rate health sector for Palestinian Arabs in order to exclude them from the first-rate services which are reserved for Israelis" and awareness that "this even lets the Israelis win the reputation of having developed health conditions in the occupied territories" were also reinforced.

[8] Katbeh, S., *The Status of Health Services in the West Bank* (Jerusalem: Jordan Medical Council, 1979) (in Arabic).

[9] Giacaman, R., *"Disturbing Distortions: Health Conditions in the West Bank", Revue d'Etudes Palestiniennes*, No. 12 (Summer 1984), pp. 23-36 (in French).

[10] See, for example, Aruri, N. (ed.), *Occupation: Israel over Palestine* (London: Zed Press, 1984), and Benvenisti, M., *The West Bank and Gaza Data Base Project, Pilot Study Report*, (Jerusalem: Jerusalem Post, 1982).

Palestinian Responses to Israeli Military Rule: The rise of Palestinian primary health care

Palestinians working in health services turned towards the non-governmental sector as the only space within which to mount a response to the events taking place in the public sector. The understanding and development of resistance through the improvement of health conditions and services fell within the context of a wider trend in the occupied territories. This trend aimed to preserve whatever could be preserved and to build independent Palestinian institutions capable of supporting current needs while providing the infrastructure for the future Palestinian state.

Over the years, the response of Palestinian health care professionals to Israeli military rule moved through three prototypic responses. Arising in the early years of occupation, the first called for the adjustment to Israeli administration and hegemony, and advocated the acceptance of the new status quo. The second appeared in the 1970's and promoted the idea of developing medical and health facilities independent from the military authorities but within the boundaries of military rule and regulations. This response advocated mostly urban-based curative medical care. The third emerged in the late 1970's from the collective experience of resistance and reflected the increasing desire to disengage from destructive policies and regulations. Here the emphasis was on defying military rules and regulations and on reaching people in rural and disadvantaged ares with basic health services.

With practice and experience this third response developed into a primary health care movement rooted in the local non-governmental organizations (NGO's). This movement moved away from the biomedical care model and reintroduced principles of primary care into medical and health care practice. It is in this non-governmental sector that much of the conceptual and practical developments in Palestinian primary care provision took place[11].

[11] For a more comprehensive discussion on building a Palestinian infrastructure of resistance in relation to health care provision see Barghouthi, M. and Giacaman, R.,*"The Emergence of an Infrastructure of Resistance"*, in Nassar, J. and Heacock, R. (eds.), Intifada, Palestine at The Crossroads (New York: Praguer Press, 1990), pp.73-87.

Current Health Services Structure

Today, health services continue to be provided by the ailing governmental sector recently handed over to the Palestinian Authority, UNRWA (for refugees only), and the non-governmental and private sectors. The latter sector is divided into several sub-sectors. Charitable societies operate major hospitals and diagnostic centers, as well as primary health care centers. Palestinian NGO's, in particular a number of health committees, provide mostly primary care services and focus on rural and disadvantaged areas and preventive health care. Finally, an active and chaotic private medical and health care sector is also in place. It is impossible to estimate its share of health services provision at this time.

Primary health care services in the West Bank and Gaza Strip comprise of curative/preventive clinics, maternal and child health care centers, rudimentary elements of a dental services program, and diagnostic aids including laboratories and x-ray facilities. As of 1992, there were 439 centers operating in the West Bank and 75 operating in the Gaza Strip. Of those, approximately 60%[12] were operated by the Palestinian health care sector-popular committees and charitable societies. Since 1992 a serious financial crisis, primarily affecting NGOs i the West Bank, has led to the closure of approximately 150 health care centers. Closures continue and this crisis threatens to destroy the Palestinian infrastructure of resistance that was built during the years of occupation and that continues to be needed in the interim and longer term.

[12] Barghouthi, M. and Daibes, I., *Infrastructure and Health Services in the West Bank: Guidelines for Health Care Planning*, (Ramallah, West Bank: Health Development Information Project, 1993). Information on Gaza was obtained from the project's unpublished database.

Health Human Resources

In 1993, it was estimated that there were about 1,550 practicing physicians in the West Bank and Gaza Strip, with about 75% working in the West Bank and 25% working in the Gaza Strip. Of those, 89% were male[13]. The same study estimated that there were 2,542 nurses, of those 44% were male. The majority of the male nurses worked in the Gaza Strip. The study approximated 44 health management personnel (probably working primarily in secondary and tertiary care institutions) and 1528 paramedics and technicians, with 68% of the latter being males. Of a total of 7,310 health human resources estimated to be working in the West Bank and Gaza Strip in 1993, 21% were physicians, 35% nurses, and 21% paramedical technicians -77% of the working human resources were estimated to work in these three fields. Thus the medical and health professions continue to be dominated by physicians, nurses and paramedics. It is also clear that a gender based division of labor dominates the Palestinian health care system.

In the same study quoted above, substantial regional variations in estimated ratios of physicians, nurses and technicians per 1,000 population were noted. The central region (Jerusalem, Bethlehem, Ramallah and Nablus) fared better than peripheral areas. Jerusalem had an estimated high of 1.22 physicians and 2.97 nurses per 1,000 in contrast to Jenin (in the northern West Bank) which had only 0.53 physicians and 0.52 nurses per 1,000[14]. These results confirm that health human resources are unevenly distributed in the West Bank with the central part absorbing the bulk of resources and services to the disadvantage of the north and the south.

[13] Abu Libdeh, H., *The Human Resources Survey in Health: Interim Report No. 2-A, Summary of Main Findings* (Jerusalem: Planning and Research Center, 1993) pp.29-35.

[14] Ibid, p.39

The same study also indicated that 64% of the health human resources in the West Bank and Gaza Strip worked in the non-governmental/private sector. The study did not indicate the distribution of these resources between NGOs and the private sector. A 1991 study listing of working physicians in the West Bank, however, indicated that 52% of the physicians worked in the Palestinian NGO sector, 22 % in the private sector, 22% in the government system, and 4% with UNRWA[15].

The distribution of health human resources by type of health facility demonstrates a second distribution problem favoring the hospital setting to the disadvantage of primary health care. In a 1991 survey of 782 physicians[16], 48% were employed in governmental or Palestinian hospitals, 22% in private practice, 21% in NGO-sponsored primary health care services, 5% in the government public health system, and 4% in the UNRWA primary health care system[17]. Only 30% of the physicians were employed within the primary health care system during that year. Since 1991, difficulties encountered by the Palestinian NGO primary care system has led and continues to lead to the closure of clinics, thereby further reducing the level of staffing within the primary health care sector.

In summary, previous research indicates an unequal distribution of human resources, in favor of the center and of curative services, at the expense of the periphery and of primary, preventive and promotive health.

[15] Giacaman, R., *Health Conditions and Services in the West Bank and Gaza Strip* (Geneva: UNCTAD/ECDC/SEU/3, 1994), p.84.

[16] This represented about 65% of the physicians listed in the survey as working in the West Bank at that time.

[17] Ibid, p.84.

STUDY OVERVIEW AND METHODOLOGY

Background

Upgrading health care delivery systems often requires a special focus on human resources development and training[18]. To appropriately train health human resources, it is necessary to identify and select key service providers engaged in particular areas of health care service delivery, to understand their function within the overall health care team, to assess their tasks and duties, and to determine further training needs[19]. Training needs analysis is an essential step in the development of programs for upgrading and continuing education. Furthermore, such studies need to take into consideration both the demands of practitioners and national strategic long-term training objectives.

This study investigates the training needs and demands of physicians and nurses working in the primary health care sector in the West Bank and Gaza Strip. The primary health care sector was identified as a priority sector in health care delivery and, consequently, as a focus for human resource development schemes[20]. Upgrading and developing primary health care structures is generally well accepted

[18] See, for instance, Mosley, W.H., "Population Change, Health Planning and Human Resource Development in the Health Sector," World Health Statistical Quarterly, Vol.47 (1) (1994), pp.26-30.

[19] See, for example, Oyediran, M., "The Importance of Training and Supervision in Quality of Care", *Advances in Contraception*, Vol 9 (2) (1993), pp. 175-180; Sheperd, J., " Analysis of Training Needs of Qualified Nurse Practitioners", *British Journal of Nursing*, Vol. 1(6) (July 9-22, 1992) pp.310-3; and Weitzel, S. et al, " A Research and Training Needs Assessment of Florida's Mental Health System", *Journal of Mental Health* Administration, Vol.. 16(2) (1989), pp.111-116.

[20] For a well-argued analysis of why primary health care is a priority in health care delivery, especially in the developing world, see Macdonald, J., *Primary Health Care, Medicine in Its Place*, (London: Earthscan Publications, 1993).

as a priority area in rebuilding health systems not only because it is cost effective, but also because increased accessibility to effective primary care service and the rationale behind it can reduce the incidence of some problems of secondary and tertiary care.

The study has chosen to focus only on the training of physicians and nurses because of the difficulty of training health human resources with different skill levels and tasks within the same training scheme. Moreover, successful models for training other types of health human resources, such as community health and rehabilitation workers, have been developed by other local institutions. The involvement of additional institutions in examining and fulfilling training needs is unnecessary at this moment[21]. Physicians and nurses were identified as a priority group for training because they often form the key personnel influencing the activities and focus of primary health care services.

There is a general lack of training schemes specific to primary health care provision within its holistic - non-vertical - context. At the same time, it was thought possible and important that these two types of human resources be trained together. Despite the differences in responsibilities and tasks of physicians and nurses, they have generally similar educational backgrounds and skill levels. Additionally, the joint training scheme illustrates how primary health care ought to be practiced, as a team, in contrast to the more classical approach of segmented and individualized care[22].

Structure

The study was designed to include two parts. The first part comprised of the administration of a specifically designed questionnaire aimed at obtaining responses from physicians and nurses to questions related to four areas:

[21] In the West Bank and to a lesser extend Gaza Strip, community health and rehabilitation workers are currently important human resources engaged in the provision of primary health and rehabilitation care. It is estimated that there are 250-300 such workers operating in the country, some within the context of very successful schemes.

[22] For further information on the need to develop new and innovative approaches to medical and health sciences training, and on the importance of training physicians and nurses together for primary health care, see Kantrowiz, I. et al, *Innovative Tracks at Established Institutions for the Education of Health Personnel*, (Geneva: The World Health Organization, 1987).

1. **Primary health care centers**. Information pertaining to primary health care centers where they work, such as their activities, programs, services, staffing, task distribution, management, and administration.

2. **Health human resources**. Information pertaining to the individual respondents, delineating personal information such as age, sex, educational status, and training history.

3. **Concept of primary care**. Questions designed to uncover the concepts of primary care utilized and shaping practice, especially in relation to principles that form the core of the primary health care concept such as curative and preventive medical and health care, team work, and community mobilization and participation. This section was intended to assess the respondents understanding of primary care and his/her role within it.

4. **Training needs**. Information aimed at assessing future training needs, as expressed by practitioners themselves. This section is based on statements made by respondents in relation to present health problems they encounter in their practices, including specific conceptual and practical skills in which they desire further training in order to improve their working abilities.

The questionnaire was developed after a period of consultation with local health experts and was piloted and revised based on a small sample of clinics. Many of the questions were deliberately left open-ended, in order to allow for a maximal utilization of the data obtained during the period of analysis.

The second part of this study comprised of open-ended interviews with 22 health care experts, researchers, and trainers from the West Bank and Gaza Strip. Care was taken to include professionals working within the governmental, non-governmental/private, and UNRWA sectors. Interviews focused on the main problems encountered in upgrading and managing the existing primary health care network. This included specific recommendations for the further development of the system as a whole and for human resources in particular. This sector also included an assessment of future national training needs in the context of the transitional nature of the current socio-economic, epidemiological, and political context.

Survey Sample

The sample for the survey was designed from a listing of all the clinics operating in the West Bank and Gaza Strip in 1992[23]. The listing reported the distribution presented in Tables 1 and 2. Initially, a 50% sample of the clinics listed as operating in the area was selected with attention to maintaining accurate geographic distribution by region, setting, and by operational institution to the greatest extent possible. Both the West Bank and Gaza were divided into northern, central, and southern regions. In total, the original sample included 220 clinics in the West Bank and 35 in the Gaza Strip.

Once fieldwork began, however, it was discovered that a large number of West Bank non-governmental clinics had closed down in 1993. Thirty-eight clinics in the survey sample had closed down in one year[24]. An additional five clinics were not reached because of settler violence in the north of the country, and one clinic in Hebron was not surveyed because of an extended curfew. In addition, fieldworkers found that 18 clinics shared personnel who worked part-time in several clinics. This further reduced the number of clinics visited. The final sample included 193 clinics - 161 in the West Bank and 32 in the Gaza Strip - out of the original 255. Tables 3 and 4 illustrate the distribution of clinics surveyed in this project by operating institution, setting and regional location.

[23] This listing was obtained from the Health Development Information Project, Ramallah, West Bank.

[24] For a listing of the closed clinics, see Appendix 2.

TABLE 1
Distribution of Clinics in the West Bank in 1992
by Institution Operating Clinic and Location

Characteristics	Number	Percentage
Total Clinics	439	100
Operating Institution		
Government	172	39
Popular Committees	127	29
Charitable Societies	117	27
UNRWA	23	5
Setting		
Urban	85	19
Rural	354	81
Regional Location		
Central West Bank	170	39
Northern West Bank	203	46
Southern West Bank	66	15

TABLE 2
Distribution of Clinics in the Gaza Strip
by Institution Operating Clinic and Location

Characteristics	Number	Percentage
Total Clinics	70	100
Operating Institution		
Government	28	40
Charitable Societies	17	24
Popular Committees	15	22
UNRWA	10	14
Regional Location		
Northern Gaza	15	21
Central Gaza	30	43
Southern Gaza	25	36

During 1994, fieldworkers visited 50% of the clinics that existed in 1993 and found 38 closed in the West Bank and none in Gaza. Extrapolating from this it was reasonable to estimate that about 80 clinics had closed down during 1993 in the West Bank. Based on this, it is estimated that not more than 400 clinics were operating in the West Bank and Gaza Strip in the first part of 1994. Fieldworkers reached 193, or at least 48% of the total number of clinics operating in the early part of 1994. This is considered a conservative estimate for the number of clinics, as other local experts have estimated that well over 100 clinics have closed down during 1994[25].

[25] The Health Development Information Project estimates that the total number of closures by March 1994 exceeded 100 clinics, and, on surveying the clinics, found out that by the end of 1994, closures had reached about 150.

TABLE 3
Survey Sample (West Bank)

Characteristics	Number	Percentage
Total Clinics	161	100
Operating Institution		
Government	76	47
Popular Committees	32	20
Charitable Societies	41	26
UNRWA	12	8
Setting		
Urban	46	24
Rural	147	76
Regional Location		
Central West Bank	60	37
Northern West Bank	75	47
Southern West Bank	26	16

TABLE 4
Survey Sample (Gaza)

Characteristics	Number	Percentage
Total Clinics	32	100
Operating Institution		
Government	15	47
Charitable Societies	6	19
Popular Committees	6	19
UNRWA	5	15
Regional Location[26]		
Northern Gaza	4	13
Central Gaza	17	53
Southern Gaza	11	34

Survey Technique

Four fieldworkers administered the questionnaire. Fieldworkers were selected based on previous experience in conducting fieldwork as well as knowledge of the areas they would serve. The team underwent an intensive three-day training seminar in questionnaire administration. Training included role playing as well as field visits, followed by comments and discussions.

[26] Because of logistical problems, fieldworkers reached for of a total of seven selected clinics in the northern region of the Gaza Strip.

Fieldworkers began with the piloting of the questionnaire. Each of the fieldworkers completed five questionnaires, reaching each of the four regions of the country. During the period of fieldwork, weekly meetings allowed for the discussion of impressions, results, and problems. This information consistently enlightened the analysis of the statistical information obtained through the interviews. Care was taken to ensure that fieldworkers documented in writing their impressions and comments during the course of the fieldwork, as well as their assessments of the results.

Clinic visits entailed interviewing only physicians and nurses, not other members of the health staff. Not all clinics, however, were staffed by physicians and nurses. Some were staffed by physicians, and others by physicians and community health workers. A substantial proportion of clinics were visited by physicians only part of the week, one physician often covered two-four clinics. For example, in the Ramallah government clinics, 25 clinics were served by eight physicians in 1994. This means that although fieldworkers surveyed about 48% of the clinics in the West Bank and Gaza Strip they did not cover the same percentage of physicians and nurses, but probably a higher percentage in the West Bank and a lower percentage in the Gaza Strip (in the Gaza Strip, clinics were often staffed by a much larger number of personnel than in the West Bank).

Data obtained from the survey questionnaire was coded and entered into the computer. Utilizing SPSS software, the data was analyzed and cross-tabulated. Comments obtained from the fieldworkers were also analyzed.

Interviews with Experts

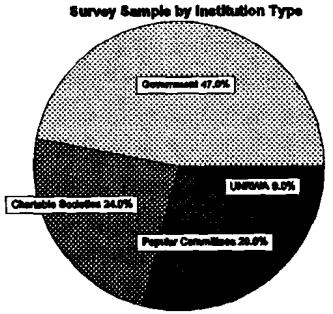
Interviews with experts were carried out by two researchers from the Community Health Department. Interviews followed a written questionnaire. The questionnaire was, however, prepared in a deliberately open-ended manner with the intention of encouraging a semi-structured interview. The results of the interviews were then codified and collated for analysis.

SURVEY RESULTS—THEME 1
Primary Health Care Centers

Overview

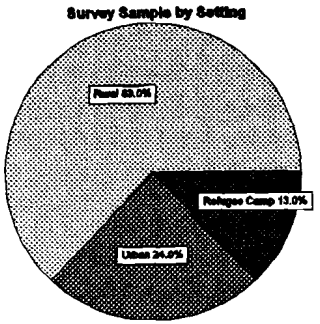
- Of the 193 clinics visited, 47 percent were operated by government authorities, 24 percent by charitable societies, 20 percent by popular committees, and 9 percent by UNRWA.

Illustration 1



- Looking at the setting of the clinics, 63 percent were rural clinics, 24 percent urban ones, and 13 percent in refugee camps.

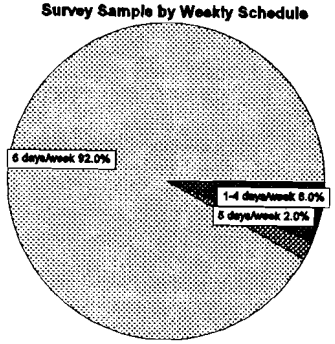
Illustration 2



- On the whole, 92 percent of the clinics surveyed reported to operate 6 days per week, 2 percent 5 days per week, and the rest 1-4 days per week. The average number of days when the clinics were operational was 5.9 days.

Illustration 3

Survey Sample by Weekly Schedule



- Only five percent of the clinics reported working five or fewer hours per day. The rest operated between 6 and 24 hour per day. The mean number of working hours daily was 7.1 hours. The majority of the clinics operated during morning and early afternoon hours, with the exception of emergency clinics. The majority of the clinics operating more than 8 hours per day were located in the Gaza Strip, where the average number working hours per clinic was found to be 10.1 hours. This is believed to be the impact of UNRWA emergency clinics, established in the late 1980's during the uprising.

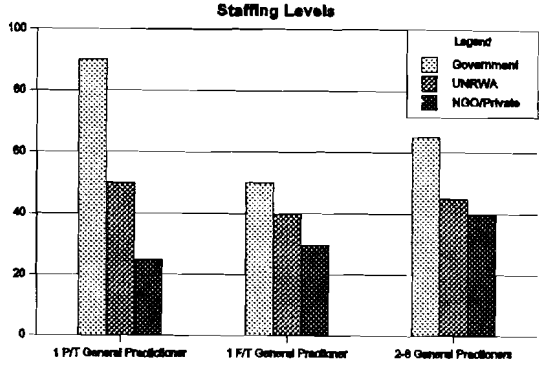
Staffing

The largest percentage of clinics surveyed (44 percent) were staffed by only one part-time general practitioner. Thirty-nine percent were staffed by one full-time general practitioner, and 17 percent by 2-8 general practitioners. The larger clinics are found almost exclusively in Gaza. Of those operating with only a part-time physician, 75 percent were government clinics. An average of one practitioner per clinic was found.

A total of 599 physician posts were attached to the clinics surveyed. This included both general practitioners and specialists, and full-time and part-time posts. The survey found an average of 3.1 physician posts per clinic overall[27]. The difference in staffing levels between the West Bank and Gaza Strip were substantial, with an average of 6.3 physicians and 6.6 nurses per clinic in Gaza, in contrast to an average of 2.4 physicians and 1.4 nurses per clinic in the West Bank. These results are illustrated in Table 5.

Illustration 4

Staffing Levels



Twelve clinics (6 percent) were staffed by only one doctor and no other supporting staff. All of those were located in the West Bank, six were sponsored by popular committees, five by charitable societies, and one by the Israeli military government. Twenty-four clinics (12 percent) were staffed by doctors and community health workers, without nurses, and 117 clinics (60 percent) were staffed by doctors and nurses without community health workers. The rest of the clinics (22 percent) employed all three types of health staff. Eighty-two percent of the government clinics visited were staffed exclusively by doctors and nurses, while many of the NGO clinics employed community health workers instead of nurses.

Table 5 illustrates a low utilization of other types of health staff: 67 percent of the clinics did not employ laboratory technicians, 89 percent did not employ pharmacists, 75 percent did not employ pharmacy assistants, 92 percent did not employ rehabilitation workers, 67 percent did not employ administrators, 97 percent did not employ dental technicians, and 95 percent did not employ health educators.

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[27] This tabulation counts posts and not physicians, as some of the physicians, especially governmental ones, were found to be working part-time in several clinics.

This may indicate the relatively poorly developed programmatic component of clinic operations. The type of staff employed indicates that different components of primary care are either absent or taking place with minimal special programs components because of staff shortages. The emphasis in these clinics appears to rest on the curative side of primary care. The average overall number of staff, including cleaners, was 9 per clinic, the mode was 2 per clinic, and the median 5 per clinic.

Illustration 5

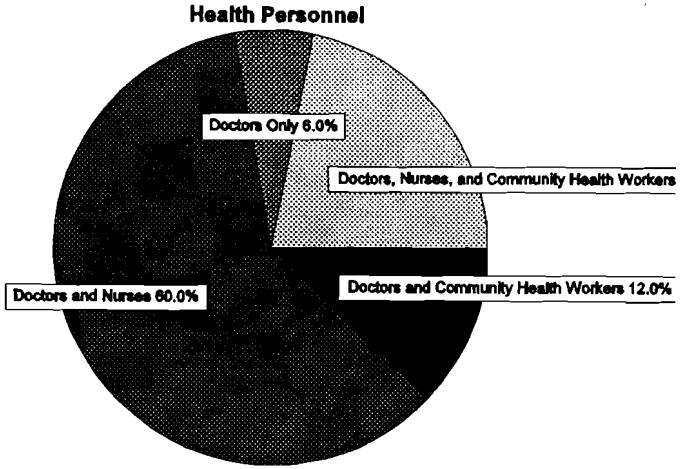


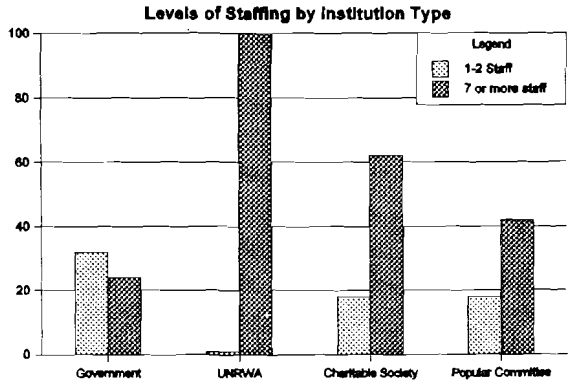
TABLE 5
Number of Health Personnel in Clinics
(percentage of total clinics)

HEALTH PERSONNEL	NONE	ONE	TWO OR MORE
Full-time general practitioner	44	39	17
Part-time general practitioner	51	37	12
Full-time specialists	80	14	6
Part-time specialists	54	19	27
Full-time nurses	23	43	34
Part-time nurses	83	15	3
Health workers	67	17	17
Laboratory technicians	67	22	11
Pharmacists	89	8	4
Pharmacy assistants	75	19	6
Rehabilitation workers	92	4	4
Administrators	67	15	18
X-ray technicians	97	2	1
Dental technicians	97	3	0
Health educators	95	2	3
Other specialists	85	7	9
Cleaners	58	28	15

Again, the differences between West Bank and Gaza clinics were substantial; the average number of staff per clinic in Gaza was 23.2 in contrast to 6.7 in the West Bank. Clearly, any further analysis of staff data must be linked to the average patient load in these clinics, data that was impossible to obtain accurately in this survey.

In terms of the levels of staffing, the governmental clinics fared least well when compared to the other clinics, with 32 percent of governmental clinics staffed by 1-2 persons. In contrast, none of the UNRWA clinics were staffed by only 1-2 persons, and only 11 percent and 18 percent of the charitable society and popular committee clinics, respectively. Only 24 percent of the governmental clinics had 7 or more persons staffing them, in contrast to 100 percent of the UNRWA clinics, 62 percent of the charitable societies clinics, and 42 percent of the popular committee clinics. Judging from the level of staffing in these clinics, it appears that the best staffed clinics are those of UNRWA, followed by the non-governmental sector and the governmental one. This may reflect better service availability at UNRWA clinics. On the other hand, it may also be a reflection of the higher patient loads of these UNRWA clinics.

Illustration 6



Although UNRWA's staffing levels are highest among the primary health care providers, it should be noted that a significant increase took place in the late 1980's at the beginning of the Palestinian uprising, in response to emergency conditions. Staff employed under the emergency program were employed on a temporary basis. Recently, this emergency program began to be minimized. As for the governmental sector, it is well established that since 1967 this sector has suffered a serious lack of funds, reflected not only in the staffing of clinics but in most other aspects of the operation as well.

Table 6 illustrates the impact of setting on the levels of clinic staffing. The table indicates a significant difference in the number of staff in clinics of rural areas, refugee camps, and urban areas. Note that 55 percent of rural clinics are staffed by only 1-3 persons, in contrast to 8 percent of refugee camp clinics, and 9 percent of urban clinics. Likewise, only 13 percent of rural clinics are staffed by 9 or more people, in contrast to 88 percent of refugee camp clinics, and 63 percent of urban clinics[28]. Clearly, health staff is concentrated in the urban areas and refugee camps—this is reflected in the survey results even though 63 percent of the clinics visited were village based.

Illustration 7

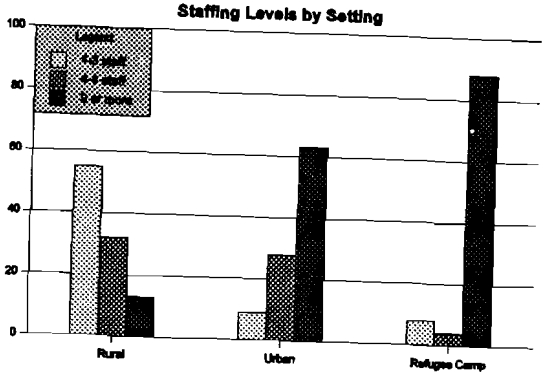


TABLE 6
Staffing of Clinics by Setting
(percentage of total in setting)

TOTAL STAFF	RURAL	REFUGEE CAMP	URBAN
1-3	55	8	9
4-8	32	4	28
9 or more	13	88	63

Chi Square = 79.02420, p=0.00000

[28] All of the rural clinics staffed by 9 or more persons were found in central villages in the West Bank and were providing services to several communities in the vicinity.

In a sense, these results are expected due to the concentration of people in refugee camps and towns; the need for staff must correspond to the number of visitors. In addition, town clinics in general serve as referral centers for rural clinics. In towns a wider range of programs and services are available. Urban clinics, although catering primarily to the needs of urban dwellers, also serve some of the referral needs of rural areas.

An interesting finding is that the popular committees appear to have concentrated their efforts in reaching rural areas. The study found that 84 percent of committee clinics were located in rural areas, in contrast to 75 percent of the government clinics, and 47 percent of charitable society clinics[29]. In contrast, only 3 percent of popular committee clinics were located towns. Twenty-one percent of governmental clinics and 49 percent of charitable society clinics were located in towns (qui square 108.60527, p=0.00000). The states intention of the local nongovernmental movement to address the problem of unavailability of services in rural areas appears in these results to have been at least partially successful.

TABLE 7
Staffing by West Bank Regions and Gaza
(percentage of region category)

STAFFING	CENTER	NORTH	SOUTH	GAZA
1-3	26	65	35	6
4-8	36	19	38	19
9 or more	38	16	27	75

Chi square =53.14610, p=0.00000

[29] UNRWA's is mandated to serve refugees and refugees live mostly in refugee camps or urban areas.

Table 7 summarizes the situation for staffing by region and demonstrates that the north of the West Bank has the smallest number of staff operating its clinics. In the northern region, 65 percent of the clinics are staffed by 1-3 people, in contrast to 35 percent in the south, 26 percent in the center, and only 6 percent in Gaza. Only 16 percent of northern clinics are staffed by 9 or more persons, in contrast to 27 percent in the south, 38 percent in the center and 75 percent in Gaza.

The difference in the level of staffing can be explained partially by the presence of clinics in urban versus rural areas. Urban areas are expected to have a higher concentration of beneficiaries than rural areas, and, therefore, higher staff concentrations than rural areas. This is particularly true when the West Bank regions are compared to Gaza.

This is not, however, the only explanation. By studying only the responses from rural clinics and comparing the average number of staff per clinic by region, the northern West Bank still had the lowest rate of staffing. Eighty-three percent of the clinics in the northern region were staffed by only 1-3 persons, followed by 40 percent of the southern clinics, 37 percent of central clinics, and a low of 11 percent of Gaza clinics. (chi square = 34.64882, p=0.00001) When the set was restricted to urban clinics, the relationship between the level of staffing and region disappeared. These results demonstrate that the problem of regional inequalities is specific to rural communities, with northern rural clinics showing particular needs.

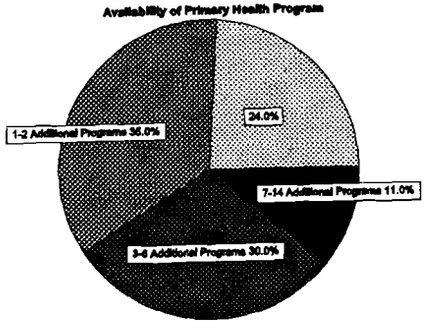
Regional variation and regional/rural disadvantage has already been shown to be a serious public health and health policy/planning problem by other studies[30]. The northern and southern regions in general and rural areas of the north and the south in particular are consistently shown to lag behind the central region of the West Bank in relation to health care infrastructure development. The results of this study then potentiate the disadvantage argument and point to rural clinics in the north of the country as a priority for future action.

[30] Barghouthi, M. and I. Daibes., *Infrastructure and Health Services in the West Bank: Guidelines for Health Care Planning* (Ramallah, West Bank: Health Development Information Project, 1993).

Programs Operated in The Clinics

The data found in Table 8 results from questions about the types of programs offered in the clinics surveyed. Combining results about programs in the different clinics the survey shows that 47 clinics (24 percent) did not operate any programs clinics the survey shows that 67 clinics (35 percent) operated 1-2 additional outside of a basic curative clinic, 67 clinics (35 percent) operated 1-2 additional programs, 58 clinics (30 percent) operated 3-6 additional programs, and 21 clinics (11 percent) 7-14 additional programs[31]. Table 9 illustrates summary information on total programs operated in addition to a basic curative clinic, organized by organization operating the clinic.

Illustration 8



[31] The results obtained in this 1994 survey were almost identical to the results obtained in the Health Development Information Project 1992 survey on rural primary health care. It appears that the type and level of programs were stable during a time when the number of clinics in the region was unstable. *Ibid.*, pp. 121-39.

TABLE 8
Availability of Special Programs
by Institution Type and Total
(percentage of clinics)

PROGRAM	TYPE OF INSTITUTION				
	GOVERNMENT	UNRWA	COMMITTEES	CHARITABLE	TOTAL
Cardiology clinic	2	29	16	22	12
Dental clinic	7	24	28	41	24
Dermatology clinic	17	12	32	20	20
Diabetes clinic	8	65	16	20	17
Health education	15	65	40	17	25
Hypertension clinic	9	47	16	13	15
Internal medicine	8	24	24	26	17
Mother & child health	43	53	29	30	38
Ophthalmic clinic	4	18	24	9	10
Pediatric clinic	24	53	29	41	32
Rehabilitation	1	12	3	7	4
Sanitation	0	6	0	2	1
School health	6	53	26	17	17
Women's health	32	59	66	61	48

TABLE 9
Number of Additional Programs Offered
by Institution Type and Total
(percentage of clinics)

PROGRAM	TYPE OF INSTITUTION				
	GOVERNMENT	UNRWA	COMMITTEES	CHARITABLE	TOTAL
None	35	6	18	15	24
1-2	40	24	29	34	35
3-6	22	41	34	36	30
7-14	3	29	18	15	11

Chi square 26.37280, p=0.00177

Table 9 demonstrates a significant difference among the four types of institutions operating clinics in terms of the number of programs offered. UNRWA, once again, did better than others and the governmental sector fared least well. Notice for instance that 35 percent of the governmental clinics offer no programs other than basic curative services, in contrast to only 6 percent of UNRWA clinics, 15 percent of charitable society clinics, and 18 percent of popular committee clinics. Inversely, only 3 percent of governmental clinics operate 7 or more programs, in contrast to 29 percent of UNRWA clinics, 18 percent of popular committee clinics, and 11 percent of charitable society clinics.

Of 193 clinics, 32 of the clinics that did not offer any programs other than strict curative care were governmental clinics—27 in rural areas and 5 in urban areas. This represented 68 percent of clinics with no services other than curative. In addition, one UNRWA clinic, seven charitable society clinics, and seven popular committee clinics offered only curative care.

These results raise questions pertaining to the type and quality of services offered in general and by the governmental health services in particular, and suggest a need to upgrade existing services so that they can become true primary level care instead of exclusively curative operations.

TABLE 10
Number of Additional Programs
Offered by Region
(percentage of area)

PROGRAMS	REGION			
	CENTER	NORTH	SOUTH	GAZA
None	6	54	15	6
1-2	35	37	39	25
3-6	42	9	42	38
7-14	17	0	4	31

Chi square =77.47702, p=0.00000

Table 10 records the number of programs offered in clinics divided by region. The central region clinics offer a wider variety of services relative to the rest of the West Bank and comparable only to Gaza. Note that only 6 percent of both central region and Gaza clinics offer only a basic curative service, in contrast to 15 percent of clinics in the southern West Bank and 54 percent in the north. A high of 31 percent of Gaza clinics and 17 percent of central West Bank clinics offer 7 or more programs, in contrast to 4 percent in the south and none of the clinics in the north of the West Bank.

This picture is comparable to the picture obtained from examining staffing levels in the clinics by region and further demonstrates that both Gaza and the central part of the West Bank have relatively more developed clinic services. Again, the northern part of the West Bank appears the most underdeveloped in the area, followed by the southern region of the West Bank.

Examining the relationship between the number of programs offered by the clinics and the locale of the clinic, we find once again that urban areas and refugee camp clinics have a wider range of services than those found in rural areas. This is documented in Table 11.

TABLE 11
Number of Additional Programs Offered
by Clinic Setting
(percentage of clinics)

NUMBER OF PROGRAMS	RURAL	REFUGEE CAMP	URBAN
None	30	4	22
1-2	37	36	26
3-6	27	32	35
7-12	6	28	17

Chi Square= 18.68472, p 0.00473

Table 11 shows that 30 percent of rural clinics were found to offer no health programs other than strict curative care, in contrast to 22 percent for urban area clinics and 4 percent of refugee camp clinics. Only 6 percent of rural area clinics offer 7 or more additional health programs, in contrast to 28 percent of refugee camp clinics, and 17 percent of urban clinics. Once again, rural areas appear to be the most deprived, with urban areas coming second, and refugee camps faring better than the other two locales.

It is important to stress that the above analysis does not include any assessment of the quality of the programs operated at the primary care level. It is well known that quality varies greatly not only between one provider and another, but also among different clinics operated by one provider. A lack of standardization and adequate supervision of activities has meant that different institutions, even different staff working within the same institution, have interpreted the content and nature of similar programs in different ways. There are very few institutions that do not suffer from this problem. The above data does at least demonstrate, however, the availability of selected services, allowing for a general assessment of the level of development of these health services and pointing to possible areas for future training and/or upgrading.

Summary

Based on the results of the survey aspect of this study, the following conclusions can be drawn.

- The least developed clinics are governmental clinics, with the highest number of clinics with strictly curative services, minimal staffing, and the least variety of health human resources.

- Rural areas are the most disadvantaged in terms of the types and range of programs available. Towns are the second most disadvantaged. UNRWA clinics were found to have more extensive services than clinics of the other sectors.

- Regional differences are evident. Central West Bank and Gaza clinics appear to be better developed than clinics located in the north and the south of the West Bank. The north appearing to be the least advantaged region of all, especially the rural areas of the north.

SURVEY RESULTS—THEME 2
Health Human Resources

Overview

In total, fieldworkers interviewed 270 health professionals—140 nurses and 130 physicians—who were found working in the clinics at the time of interview. Of those 46 percent worked in the government sector, 42 percent in the non-governmental/private sector (10 percent with popular committees and 32 percent with charitable societies), and 12 percent with UNRWA. Fifty-eight percent of those interviewed were working in village clinics, 26 percent in urban clinics, and 16 percent in refugee camps.

Selected Characteristics of Nurses and Physicians

Table 12 summarized the survey results with respect to selected characteristics of nurses and physicians. The age range of interviewees was quite wide, ranging from 23 to 73 years of age. The mean age of the interviewees was 37.3 years. Thirty-six percent of the sample was found to be 40 years of age or older, 44 percent 30-39 years, and 20 percent under 30. Most of those working at the primary care level fell within the age range of 30 to 50 years. The survey reveals that many working in primary care are of an appropriate age and experience range to be upgraded.

The average nurse interviewed had 12.8 years of clinical experience and the average physician had 10.6 years of experience. Length of experience in primary health care was found to be slightly shorter than in general health care, with an average of 9.6 years for nurses and 7.2 years for physicians. These results are interesting in that there seems to be enough continuity and sufficient experience for these human resources to identify major problems within the system.

TABLE 12
Characteristics of Nurses and Physicians
(percentage of human resource category and total)

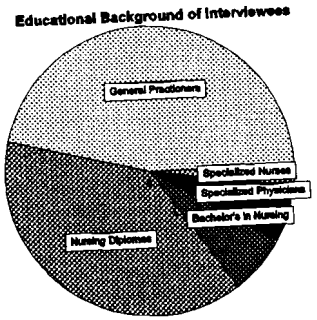
CHARACTERISTICS	NURSES	PHYSICIANS	TOTAL
Age			
23-29	32	7	20
30-39	33	56	44
40-73	35	37	36
Sex			
Male	27	88	56
Female	73	12	44
Country of Study			
Western Europe	3	19	11
Eastern Europe	0	57	27
Arab World	11	22	17
Local Universities	86	0	44
Asia and Latin America	0	2	1
Average years of practical experience	12.8	10.6	11.8
Average years of primary health care experience	9.6	7.2	8.5

Of the total sample 56 percent were males and 44 percent females. As anticipated, the majority of physicians were male with 88 percent of the physicians being males. The majority of nurses were females with 73 percent of the nurses being female. In total 16 women physicians were employed in the clinics interviewed. Twenty-nine of the thirty-eight male nurses were employed in the governmental sector. Most of these, 15, worked in the north of the West Bank; 14 worked in the Gaza Strip. This data reinforces the anticipated division of labor within the medical professions and demonstrates that it is also present at the primary care level.

Of the total sample, 43 percent were general practitioners, 36 percent held diplomas in nursing, 9 percent were nurse's aides with long experience[32], 6 percent held bachelors degrees in nursing[33], 6 percent were specialized physicians, and 2 percent specialized nurses.

Illustration 9

Educational Background of Interviewees



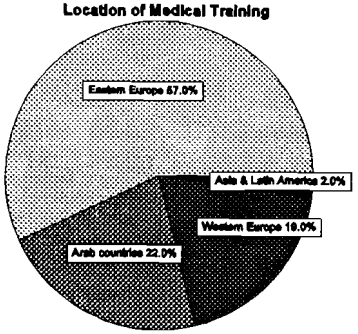
Of the 23 nurses aides, 15 were employed by the governmental sector, 1 by UNRWA, 5 by charitable societies and 2 by the committees.

[33] Generally speaking, nurses holding bachelor's degrees prefer to work in a hospital setting. Hospital salaries and benefits tend to be superior to those of primary health care work. In addition, there is a prevailing attitude that hospital work is more valued than primary health care work, an attitude that is part and parcel of the medical and health care hierarchy and the sophisticated equipment-oriented ideology of medical and health care that continues to exist in this country. In any case, it is reasonable to suggest that building a cost effective and continuous primary health care structure for the country should entail the employment of nurses with higher degrees only in selected posts. Properly trained village health care workers could very adequately be utilized instead. As they often come from the communities that they serve, they often offer an advantage over nurses.

As expected the large majority of physicians were trained abroad: 57 percent in Eastern Europe, 22 percent in Arab countries, 19 percent in Western Europe, and 2 percent in Asia and Latin America. In contrast, the large majority of nurses were trained locally (86 percent). This is a testimony to the development of nursing training institutions in the area and to the benefits accrued to primary health care as a result of the availability of this training during the past 20 years or so.

Illustration 10

Location of Medical Training



In summary, the sample of human resources revealed an expected division of labor in health care, with males working as physicians and females as nurses. All physicians had been trained outside the country because of the absence of a medical school in the country. Most nurses were trained locally and their training needs were also absorbed locally. This represents a trend that should be encouraged for cost effectiveness reasons and because local trainers can respond to the country's needs, as long as quality is upgraded and/or maintained.

Tasks Performed

Table 13 demonstrates the division of labor between physicians and nurses, and illustrates that, in general terms, physicians tend to concentrate on curative care, while nurses engage more actively in preventive care. Four nurses (3 percent) said frankly that they diagnose and treat patients. Two worked in the charitable society sector, one with the committees, and one in a government clinic. As many as 43 percent of physicians reported engaging in health education. The large majority, however, described health education as talking to the patient about matters such as how to take medications or other minor instructions relevant to the treatment of disease.

TABLE 13
Division of Labor between Physicians and Nurses
(percentage of human resource category)

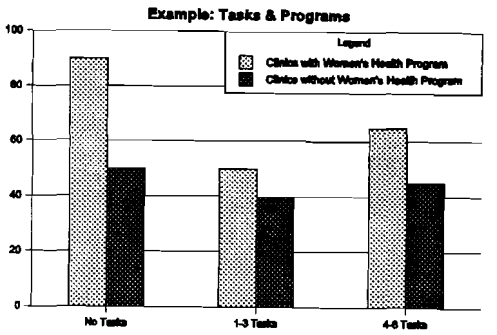
TASKS PERFORMED	PHYSICIANS	NURSES	EITHER/ BOTH
Administrative/supervisory tasks	36	50	44
Diagnosis and treatment	98	3	49
Family planning	10	16	13
First aid/emergency	88	86	87
Health education	43	70	57
Home visiting	22	52	38
Immunization/infant weighing	11	72	43
Prenatal care	39	71	56
Referral	96	15	54
School health education	0	1	1

Eleven percent of the physicians reported engaging in immunization while leaving the rest of the well-baby clinic to nurses. Twenty-two percent of the physicians reported visiting homes, almost exclusively for curative calls. In contrast, 52 percent of the nurses visited homes and listed different reasons, many falling under preventive care. Nurses tended to be more preoccupied with supervisory tasks, with 50 percent of the nurses reporting time spent in such tasks in contrast to 36 percent of the physicians. It should be noted, however, that for the large majority, administrative/supervisory tasks centered on report writing, and medication and supply orders. Minimal activities were reported in other kinds of administrative or supervisory work, especially the areas of team building and team work, monitoring, education and upgrading, assessment and evaluation, and formulation of recommendations for future action.

For the purpose of this survey, the following tasks were defined as ``primary health care related tasks'': family planning, health education, home visiting, immunization, prenatal care, and school health education. These six tasks were used to measure involvement in an approach to health care that expanded beyond curative care. In a similar manner, for purposes of evaluation, special attention was paid to the availability of primary health care programs in clinics. Such programs were defined as those geared toward one of the aspects of primary care, such as hypertension and diabetes clinics, pediatric clinics, family planning, maternal and child health, women's health, and school health education.

It was interesting to observe that the availability of primary health care programs in a clinic did not determine who performed primary health care related tasks and who did not. For example, look at the responses to questions concerning primary health tasks when cross-tabulated with clinics offering or not offering a women's health program. Eight percent of the nurses whose clinics did not offer women's health programs reported not to engage in any primary health care tasks, in contrast to six percent of nurses working in clinics offering the program. The trend continues: 52 percent of the nurses with no program reported conducting 1-3 primary health care tasks, in contrast to 54 percent of nurses working in clinics offering a program; and 53 percent of those with no program reporting engaging in 4-6 primary health care activities, in contrast to 48 percent of those whose clinics offered a program. The results were similar for other activities in relation to programs. This suggests that tasks and activities might occur independently of the presence or absence of a concrete program geared toward the alleviation of a particular health problem. This points to the insufficiency or absence of systematic, supervised, and evaluated activities, and suggests that personal initiative is a strong component determining tasks. It also raises questions as to the quality and impact in both the short- and longer-term of the tasks performed.

Illustration 11



Examining primary health care related tasks reported by physicians and nurses in relation to setting, the survey showed a significant difference by locale. Sixteen percent of those working in a rural clinic reported no involvement in primary health care related tasks, in contrast to 29 percent working in refugee camps, and 34 percent in towns (Chi square =15.93821, p=0.00310). These results should be interpreted with caution due to several additional factors. Firstly, UNRWA clinics tend to have a relatively larger number of health personnel, with a more differentiated division of labor than the other sectors. Specialization might account for an apparent lack of primary health care activities. Indeed, the school health program UNRWA operates in Gaza takes place outside the clinic system and takes the form of an independent system operating on its own. Although UNRWA had a school health program, it does not appear within the context of the programs and activities of clinics.

Secondly, government urban clinics not only have a relatively larger staff than village clinics, but also often pose as referral centers for rural clinics (as mentioned above). This means that town centers are engaged in specialty service more often than primary care. Governmental urban maternal and child health care centers operate under a separate structure from urban clinics. The rationale and utility for this separation is questionable, especially if one emphasizes the importance of the availability of comprehensive primary care to women and children within one location. As it stands, governmental maternal and child health care centers only offer immunization, well-baby clinic activities, and health education. If a child reaches these centers ill, the child must be referred to a curative care clinic for treatment and follow up.

Thirdly, tasks are often determined by the daily patient load at a particular clinic. If the patient load is quite high, as is the case with UNRWA clinics and in clinics located in congested areas, even if a primary health care program exists the high curative patient load can interfere with program implementation. In fact, many UNRWA staff reported their willingness to engage in preventive care and health education activities and noted their inability to do so because of the consistently high patient load. UNRWA clinics are estimated to have an average of four minutes per patient.

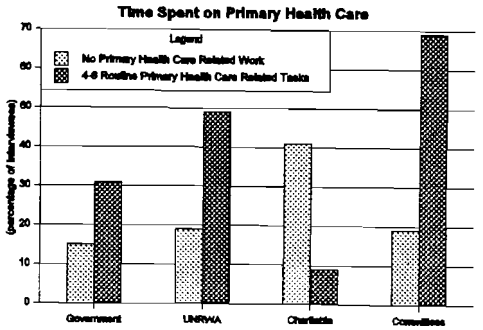
TABLE 14
Number of Primary Health Care Related Tasks Offered
by Organization Type Operating Clinic
(percentage of type of organization)

	TYPE OF INSTITUTION			
TASKS	GOVERNMENT	UNRWA	CHARITABLE	COMMITTEES
None	15	19	41	19
1-3	54	32	50	68
4-6	31	49	9	13

Chi square=38.42173, p=0.00000

Table 14 indicates that a high of 41 percent of charitable society human resources do not engage in any primary health care related tasks as a routine part of their assigned tasks, at all, in contrast to 19 percent of both UNRWA and popular committee staff, and 15 percent of government clinic employees. Committee staff reported to conduct 1-3 primary health care related activities more often than others, with 68 percent of the staff responding positively. In contrast, 54 percent of governmental sector employees, 50 percent of the charitable society employees, and 32 percent of UNRWA staff responded positively to this inquiry. UNRWA staff reported the highest rate of primary health care activities, 49 percent of UNRWA staff reported engaging in 4-6 primary health care activities, followed by governmental employees with 31 percent, 13 percent of popular committee employees, and 9 percent of the charitable

Illustration 12



societies staff. These results are particularly striking in view of the fact that 35 percent of government clinics reported not to offer any programs at all other than strict curative care. This suggests that governmental care is highly variable and uneven, and cannot be judged as a system with internal coherence.

TABLE 15
Division of Individual Labor Hours
(average percentage of total work time)

TASKS	NURSES	PHYSICIANS	TOTAL
Curative care	39	82	59
Preventive care	41	10	26
Training others	2	2	2
Administrative work	17	3	10
Other	1	3	3

The statistics in Table 15 indicate that 59 percent of the total time spent by those interviewed was spent on curative care, 82 percent of physicians' time and 39 percent of nurses' time. Fifty-five of the physicians (43 percent) reported that they spent 100 percent of their time on curative care. The 55 physicians were evenly distributed among the different health care providers with equal frequency between urban and rural areas. [A noteworthy exception to this stands with UNRWA employees, only two UNRWA physicians reported working in curative care all of the time.] Twenty-five of those physicians (46 percent) were located in northern clinics, reinforcing the argument that the northern network of clinics is one of the least developed in the country.

Nurses fared better than physicians in terms of engagement in preventive care, with 41 percent of nursing time on average going toward preventive care in contrast to only 10 percent of physician time. This illustrates the continued influence of the biomedical care model over physicians' practice at the primary care level, even in the context of a primary care clinic requiring active involvement in tasks other than curative care. In addition, a substantial proportion of nursing time appears to continue to be absorbed by the curative component of clinic activities.

Nurses appear to carry the administrative burden of the operation as well with 17 percent of their time on the average being spent on administrative tasks, in contrast to 3 percent average for physicians. As noted above, administrative duties concentrated on report writing and follow up of orders for medications and materials.

The training of others was found to be an almost nonexistent task across the board, with only 2 percent of the work time for both physicians and nurses reported used for this task.

Clearly, the main emphasis in these clinics continues to be curative care, with preventive activities and administrative work being relegated to nurses and with apparently very little activity in the area of training others. The latter should constitute an important component of community action, mobilization, and primary health care.

When respondents were asked whether the time allotment for different tasks was suitable for work needs, 47 percent responded positively and the remainder negatively. Of the 53 percent noting dissatisfaction, 48 percent blamed high patient loads, and unavailability of staff and/or funds for distracting them from preventive work. A strong awareness of the need to engage in preventive care was noted, especially among physicians. (See below). Yet structural, financial, and/or personnel reasons appeared to the respondents to interfere with such work.

These findings reinforce the need to link training courses to structural and institutional changes in order for such courses to have an impact; it is not sufficient to raise the technical level and awareness of health staff. It is equally important to assist staff and their institutions in making necessary changes to allow them to practice what they have learned. Such an approach to training might yield better results than other approaches. Additionally, training cannot take place in a vacuum, the principal impediment to structural institutional change is often the lack of

available funds. Given the present economic conditions and the downward spiral that has gripped the country during the past two years, comprehensive solutions to upgrading problems are far from clear.

While no differences in responses to these questions were noted in relation to age or region, physicians tended to be more unsatisfied with their time allotments than nurses. Seventy percent of physicians reporting insufficient time allotment in relation to work responsibilities, in contrast to 39 percent among the nurses (chi square =26.26610, p=0.00000). Differences were noted among organizations as well, with the highest level of dissatisfaction coming from UNRWA employees of whom 71 percent responded that time allotments were inadequate. Sixty-three percent of popular committees staff reported dissatisfaction, 52 percent of the charitable society staff, and 46 percent of governmental employees.

This may be explained in view of certain aspects of the UNRWA system. The system is rather well differentiated with different types of programs and probably better in-service training and continuing education than the other sectors. At the same time the patient load in UNRWA clinics is often high enough to preclude staff from paying adequate attention to different elements of the primary health care scheme. The popular committees tend to have adopted more of the principles of primary care than the other sectors. This measure of awareness of the need to improve may explain the dissatisfaction.

On the whole, tasks of physicians tend to concentrate in the curative area and nurses appear to carry the burden of preventive and program activities whenever offered. Preventive activities often take place even in the absence of clearly defined programs that are well monitored, supervised, and assessed. Personal initiative appears to play an important role in determining tasks performed.

This perception is reinforced by the finding that older health workers are less likely to be engaged in primary health care tasks. The survey results show that 13 percent of workers between the ages of 23-29, 22 percent of those ages 30-39, and 29 percent of those 40-73 did not participate in any primary health care task. From the opposite angle, 40 percent of those 23-29, 23 percent of those 30-39, and 18 percent of those 40-73 reported engaging in 4-6 primary health care related tasks (chi square =11.05560, p=0.02595). When the responses for nurses and physicians are studied separately, the relationship between age and tasks performed disappears for physicians but remains strong for nurses. These results probably reflect the primarily curative engagement of physicians remaining constant with age. The

results further suggest that nurses' younger age may be a factor in encouraging nursing personnel to engage in preventive and primary health care related activities. This may reflect not only energy levels, but also educational levels and state of consciousness.

Patient loads are also important. If the curative patient load is not supported by an adequate number of staff, then most of the clinic staff are drawn into curative activities. This leaves preventive activities undone altogether, or, done in a unsystematic and discontinuous manner, and raises questions as to the ultimate impact of the tasks of these health human resources on health.

SURVEY RESULTS—THEME 3
Concepts of Primary Health Care

Staff Meetings as Indicators of Team Work

Forty-seven percent of the clinics surveyed reported not to have any staff meetings at all, whether internal or central, 18 percent reported having them ``as needed", and 35 percent reported having them regularly. These results raise questions as to the quality control, supervisory, and managerial aspects of clinic operations, as well as internal clinic dynamics and team work. The latter represents an important component of primary health care. Table 16 records results on frequency of staff meetings by type of organization.

TABLE 16
Frequency of Staff Meetings by Type of Organization
(percentage of clinics)

	TYPE OF INSTITUTION			
FREQUENCY	GOVERNMENT	UNRWA	COMMITTEES	CHARITABLE
Never	56	29	34	48
As needed	13	12	21	26
Regularly	31	59	45	26

Chi square =12.75576, p=0.04708

The government clinics appear to have incorporated staff meetings least frequently into the work schedule. Fifty-six percent of government clinics reported as never having meetings, in contrast to 48 percent of charitable society clinics, 34 percent of popular committees clinics, and 29 percent of UNRWA clinics. Regular meetings tended to take place more often among UNRWA and popular committee clinics, 59 percent of the time in UNRWA clinics and 45 percent in popular

committees clinics, in contrast to 31 percent in government clinics and 26 percent in charitable societies clinics. Clearly, much work can be done in the area of instituting and maintaining regular meetings. This would be constructive not only from a managerial perspective but also from a technical primary health care point of view. Potential success in this area of work is indicated by staff recognition of the importance of team meetings. Ninety-two percent of the physicians and nurses interviewed, reported that regular team meetings are important to improving work conditions, as well as work quality.

Community Participation

Although community participation is one of the tenets of primary health care, the majority of the staff interviewed (physicians and nurses) did not involve the community in their activities. Of the total, 61 percent of the staff reported not to engage with the community on any level. Nurses appeared to work more with the community than physicians, with 46 percent of the nurses reporting involving communities in activities, in contrast to 31 percent of the physicians (chi square =6.95519, p=0.0083). Popular committee staff appeared most involved in the community. Fifty percent of popular committee staff reported engaging communities in their action, in contrast to 48 percent of UNRWA staff, 38 percent of government staff, and 29 percent of charitable society workers. Regional differences were minimal in this area. Explanations as to the lack of community participation were varied and included the problem of time constraints and the ``lack of responsiveness of the population". Some did not think of such involvement as important. Others said the institution did not allowed staff to engage in cooperative relationships with the local communities.

Looking more closely at respondents' understanding of community participation, fieldworkers found firstly that the large majority considered community participation an important component of their work. When asked if such work was important, 98 percent responded positively and 2 percent negatively. When asked why, however, the range of answers denoted a clear need to formulate a definition of community participation suitable for national purposes. For instance, 21 percent thought that community participation equaled health education. These respondents did not see the need for active participation of the community in decision making, problem solving, and project operation. Fifteen percent thought participation is needed so people can understand disease, 6 percent thought it important in order to increase communication between the clinic and the community. The exact goals of this were not defined. Only 12 percent thought that a campaign for real

improvement in health conditions must entail active community participation and were able to define the concept in relatively clear terms. Some physicians thought that this was not their role but the role of the nurse. Others thought that community participation involved only talking to people, rather than engaging them gradually in problem solving, planning, and other aspects of the health scheme in their community. Clearly, much works needs to and can be done in this area, not only from the perspective of improving the quality of services, but also to improve cost effectiveness and to increase the ultimate impact of health services on the health of the population.

Of all of the respondents, only 21 percent reported having been trained in methods of community participation. Those responding positively had participated in either on-the-job training or short training courses offered locally, or in specialized primary health care training abroad. The rest had no formal training at all, although 39 percent reported informal training. Informal training could derive from their "belonging" to the country as Palestinians and their interest in people. The survey showed no appreciable differences in response by age, profession, region or organization operating the projects. Differences in responses were noted, however, between the West Bank and Gaza. Of the total, 28 percent of those working in the southern West Bank reported having participated in training, likewise, 27 percent of those working in the central region of the West Bank responded positively, 17 percent of those from the north, and only 12 percent from Gaza (chi square = 30.15238, p=0.00004). Given available information, it is not possible to explain why Gaza and the northern West Bank staff reports differed from results from those working in the south and central part of the West Bank. A consciousness or accessibility explanation is not sufficient, especially as the highest percentage of trained staff came from the south (28 percent) at the same time when the south continues to be rather underdeveloped and to have poor access to training courses.

When asked about the main problems encountered in executing community participation schemes, fieldworkers found that 37 percent of respondents focused on the lack of funds and trained human resources as a main problem, and 29 percent blamed problems in the community, including lack of responsiveness, lack of awareness, and community factionalism. The rest of the answers were rather varied and diffuse, ranging from lack of initiative to the absence of coordination among different community oriented health services.

These responses touch an important aspect of the problem of the current health care system. On the one hand, there seems to be a clear need for upgrading the services, so that they can have a better impact on health, and ultimately, improve the quality of life of people. On the other hand, the current economic crisis makes it difficult to employ new staff that can implement projects and to absorb added costs that come with training of old staff. Extra operating budgets are required for staff to implement their training. The real dilemma today is precisely that upgrading *is* needed and training courses *can* be launched successfully, yet at the same time, the health care infrastructure is in the process of shrinking because of the diminishing level of financial support.

A resolution for this dilemma is not clear. One must, however, work for maximal cost effectiveness when launching new and needed programs. In this sense, it would be reasonable to suggest increased focus on village health workers, rather than only on nurses and physicians. Physicians' and nurses' training could be conducted with the aim of creating a supervisory, monitoring, and training structure for primary health care clinics. At the level of practice and given the present salary scales of physicians, it would be too costly to relegate much of the preventive care to them. In any case, physicians tend to be men who come from outside the immediate community, in contrast to village health workers who tend to be women from the communities themselves. Because of their own backgrounds, village health workers would probably be much better fit to conduct preventive and community mobilization activities as a main portion of their tasks. Village health workers, however, require upgrading and the establishment of a managerial and supervisory system within each clinic, linking their work and activities to the curative components, and rationalizing the services as a whole.

The Role of the Community Health Worker

When physicians and nurses were asked about their understanding of the role of the community health worker an expected high of 35 percent reported that her role is providing assistance to the physician and nurse in whatever is being done, 57 percent listed different primary health care activities as part of her role—especially those involving home visiting and health education, 3 percent reported that her role

is assisting the professionals and doing home visiting and health education, and 5 percent either did not know what a community health worker was or thought that she had no role at all in primary health care provision. Overall, 40 percent defined the role as assistant or negated the role altogether, and 60 percent appeared to have some idea about a separate role, independent from or in addition to general assistance.

Curiously, nurses appeared to be substantially less informed about the role of the community health worker, with a high of 51 percent of the nurses describing community health workers as assistants or with no separate role, in contrast to 28 percent of the physicians (chi square = 13.87353, p=0.00020). The finding that only 34 percent of the males (whether physicians or nurses) thought that the role of the community health worker is one of assistance in contrast to 48 percent of the females reinforces this observation (chi square = 5.06409, p=0.0146). This is an important finding in that it indicates the need to focus on nurses perceptions and attitudes in relation to the development of the team approach to primary health care. These results appear to vindicate physicians, who are often blamed for degrading community health workers and their role. Even though most community health workers are female, it is the nurses who appear to negate their role to a larger extent than physicians.

Perhaps this results from a feeling of competition with the community health workers who could be perceived as replacements for nurses in primary health care positions. It could also result from inadequate training of nurses and the lack of opportunities for upgrading and continuing education for nurses, especially in comparison to physicians (as observed earlier in this study). Regardless of the reason, this finding suggests that future training needs to focus on perceptions and attitudes of nurses even to a larger extent than physicians in order to foster a cooperative and effective primary health care team.

Physicians and nurses between 30-39 years of age reported the most accurate understanding of the role of the community health worker. Forty-four percent of those aged 23-29 reported health workers as assistants, in contrast to 34 percent of those aged 30-39, and 45 percent of those 40 years or over.

Regionally, northern West Bank physicians and nurses again appeared less well informed than the others with 66 percent of those reporting health workers as assistants, in contrast to 30 percent for Gaza, 29 percent for the central region of the West Bank, and a curious and unexplained 14 percent for the southern West Bank (chi square = 42.83990, p=0.00000).

Organizational differences also appeared, with 52 percent the governmental staff reporting an assistant role, in contrast to 32 percent for UNRWA, 29 percent for the charitable societies and 31 percent for the popular committees. These results again indicate the need to focus on governmental staff upgrading at the level of concepts, approaches and attitudes and not only in terms of technical upgrading of their activities.

SURVEY RESULTS—THEME 4
Training—Assessment & Demands

In-Service Training

For the purpose of this survey, in-service training was defined as the training that a new employee undergoes to learn about the concepts, systems, and bureaucracy of his or her new job. Of the 270 physicians and nurses, 88 (33 percent) reported having undergone in-service training when they began to work in primary health care. More nurses reported undergoing in-service training than physicians. Forty-four percent of the nurses reported having completed such training, in contrast to 21 percent of the physicians (Chi square =15.95271, p=0.00007). Thirty-one percent of the physicians rejected the need for in-service training for work in primary health care, in contrast to 15 percent of the nurses. A significantly higher number of physicians found in-service training unnecessary having completed medical school, while nurses appeared to be more aware of the importance and their need for such a training program[34]. Of those rejecting the need for in-service training, only 4 were younger than 30, 25 were 30-39, and 32 were 40 years or over. This suggests that as staff get older and more experienced they are less likely to value in-service training. This may indicate an important conceptual problem, present not only among health professionals but also in other sectors, where experience, regardless of where or how obtained, is often considered a substitute for structured learning.

The amount of time spent in in-service training varied greatly with a minimum of one week and a maximum of six months. Such variation illustrates the lack of standardization for such training, as well as the local use of questionable and varied definitions for in-service training.

[34] Those who reported that in-service training was not needed included 40 physicians and 21 nurses. Of those, 26 were government employees, 2 UNRWA employees, 22 charitable society employees, and 11 committee staff. Twenty-four (40 percent) of those reporting no need came from the central part of the West Bank, 9 from the north, 12 from the south, and 16 from Gaza.

Further problems arise from the type of training received. Of those who received training, 74 (85 percent) received training in areas broadly related to primary health care, such as maternal and child health, general nursing care, geriatric nursing, medication provision, and diarrhoeal diseases. The others received training in topics with questionable relevance to primary health care practice or clearly in general curative care. Thirty percent of those who reported receiving training also reported being trained only in general curative care, often in the hospital setting. These results reinforce the importance of clearly defining and standardizing activities in any effort to upgrade the current health care system.

A significant difference was also found between the responses of physicians and nurses as to why they had not undergone in-service training with 43 percent of the physicians reporting that such training was not available, in contrast to 31 percent of the nurses. Of the total, however, 12 and 15 percent of the physicians and nurses, respectively, reported that their organization did not offer in-service training.

TABLE 17
Reasons for Not Undergoing In-Service Training
(percentage of human resource category and total)[35]

REASONS	PHYSICIANS	NURSES	TOTAL
Did not need in-service	31	15	23
Had in-service training	21	44	33
Organization did not offer	12	15	14
Training was not available	43	31	37

[35] The percentages in this table tally to more than 100 because some interviewees responded positively to more than one explanation for the lack of in-service training.

There were 81 persons (37 percent) who reported that in-service training was not available to them, otherwise they would have taken it. Of those, 59 percent were physicians and the rest nurses. Forty-one percent of those who reported that training was not available were government employees, 22 percent were popular committee employees, 26 percent charitable society employees, and 11 percent UNRWA employees. Curiously, unavailability reports came from the central region of the West Bank at a higher rate than other areas of the West Bank. Thirty-five percent of those working in clinics the center reported in-service training unavailable, in contrast to 13 percent and 14 percent in the north and the south of the West Bank, respectively. Thirty-seven percent worked in the Gaza Strip. Due to the scope of this study these results remain unexplained. Perhaps these results reflect an awareness or attitude difference, where central area health personnel represent a group that is more aware of the need for training and, therefore, define it differently than those working in other areas. As one would expect, however, the majority of those listing in-service training as unavailable came from rural clinics (49 percent), the others were divided between towns and refugee camps, with 30 and 21 percent, respectively.

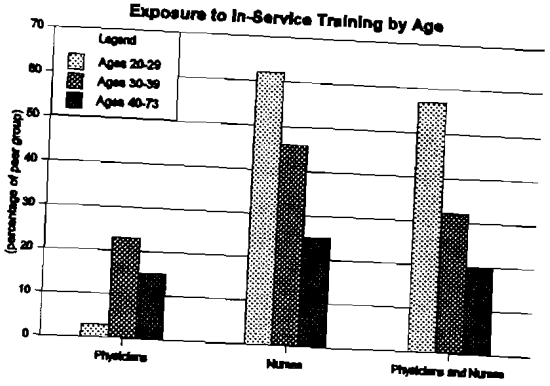
Governmental and UNRWA employees reported to have undergone in-service training most often, with 41 percent of governmental staff and 42 percent of UNRWA staff responding positively in contrast to 19 percent of the charitable society staff and 25 percent of popular committee staff. The study showed that governmental employees received in-service training mostly in urban clinics where they were to be employed. They received training primarily in curative care, raising questions as to the relevance of this type of training to primary health care work. Judging from the clinics where in-service training was provided (almost entirely urban clinics) it appears that in-service training is primarily intended to introduce a new employee to the curative system of the institution, as opposed teach the principles and practice of primary health care.

No relationship was observed between whether interviewers underwent in-service training and the region or setting of their clinic. Health staff of younger ages appear to have been exposed to in-service training more regularly, perhaps an indication of gradual improvement in the system over the years. For both physicians and nurses, 57 percent of those between the ages of 20-29 underwent in-service training, in contrast to 32 percent of those aged 30-39, and 20 percent of those aged 40-73 (chi square = 22.62612, p=0.00001). Once again, the statistical significance disappears when examining the physician population alone, although the pattern

remained, with 33 percent of those 23-29 years of age having had in-service training in contrast to 23 percent of those aged 30-39, and 15 percent for those aged 40-73. The relationship continues to be statistically significant for nurses, with 62 percent of those aged 20-29 reporting having had in-service training in contrast to 46 percent of those aged 30-39, and 25 percent of those 40 years or older (chi square =13.70407, p 0.00106).

When asked whether they considered in-service training important in principle, 88 percent of the interviewees responded positively and 12 percent negatively. Of the 33 persons who considered in-service training unimportant, 17 were physicians and 16 nurses. There were no appreciable differences between those working in different types of organizations. Twenty of those working in rural clinics, however, reported that in-service training was unimportant, in contrast to five of those working in refugee camps, and eight working in towns. These responses may indicate that rural area health staff are less inclined to appreciate the importance of in-service training. Age did not seem to affect the response.

Illustration 13

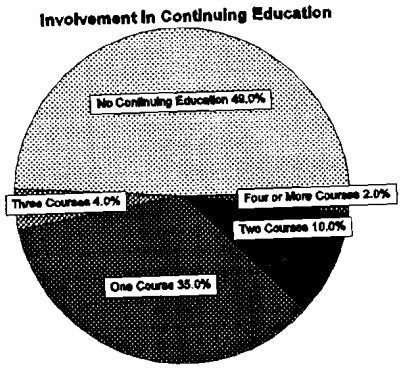


Continuing Education

For the purpose of this survey, continuing education was defined as exposure of employees to new methods, ideas, etc. during the course of their working life. Forty-nine percent of the respondents reported not having participated in continuing education ever during their practical career, 35 percent reported having taken one course, 10 percent two courses, 4 percent three, and 2 percent four courses or more. Of those who took such courses, 77 percent reported taking courses related to primary health care, while the rest trained in topics irrelevant to primary health care practice. A significant differences in participation in continuing education was

noted between physicians and nurses, the difference also falls essentially on gender lines. Sixty-three percent of the nurses reported never having had participated in continuing education, in contrast to 34 percent of the physicians. (Chi square = 23.48972, p=0.00001) The difference points again to the disadvantaged status of females/nurses relative to males/physicians in the present health care system. The disadvantage reflects itself in a lack of opportunities for advancement.

Illustration 14



Responses to this question revealed significant regional variations. Survey results showed that 66 percent of the respondents from the northern region of the West Bank reported never having had participated in continuing education, in contrast to 44 percent of the respondents from the central region of the West Bank, 39 percent from the Gaza Strip, and a surprising 31 percent from southern region of the West Bank. These results reinforce previous findings pointing to the need to focus future training activities on the northern part of the country and on the upgrading of nurses working within this sector.

TABLE 18
Continuing Education of Staff
by Type of Organization
(percent of staff in same type of organization)

	TYPE OF INSTITUTION			
COURSES	GOVERNMENT	UNRWA	CHARITABLE	COMMITTEES
None	54	32	57	36
Once	42	19	31	35
Twice or more	4	49	12	29

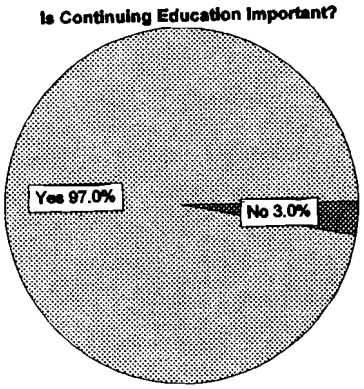
Chi square =47.04938, p=0.00000

Differences in continuing educational attainment was observed among the different organizations operating these projects. As illustrated in Table 18, 57 percent of charitable society employees and 54 percent of governmental personnel reported never having participated in continuing education at all, in contrast to 36 percent for the popular committee employees, and 32 percent of UNRWA staff. These findings reinforce the observation that UNRWA's system of health care is superior to the others in that, among other factors, it systematically offers a wider variety of services, as well as possibilities for continuing education to its staff. The committees also appear to do rather well relative to the remaining two sectors in terms of the continuing education parameter. Such activities should be encouraged as much as possible. Survey results indicate that the charitable societies and governmental sectors require special attention and encouragement in this area.

No appreciable differences were noted when comparing responses to this question in different settings, nor, interestingly, between different age groups. One might have expected that older staff would have more chances to take continuing education courses. Data generated from this study indicates, however, that age or length of practice do not have an impact. This might reflect the relatively recent availability of continuing education courses for health staff, resulting in the temporary homogenization of the age/length of practice differentiation.

When asked why they never had taken continuing education courses, responses were quite varied and rather subjective, sometimes clearly not corresponding to reality. It is the perceptions component of their reports that is, however, of interest here. Of those responding no to continuing education, a high of 50 percent stated that such courses are not available locally and that travelling abroad is too expensive. This is not strictly true, but perhaps these statements pertain to accessibility. Eleven percent listed social/personal reasons as a principal reason for not joining continuing education courses, 7 percent blamed *wasta* (social influence) for not being allowed the opportunity for further training, 7 percent stated that their institution did not allow time off to join such courses, 3 percent said that they did not have access because all continuing education was conducted in English and they did not know the language, and 3 percent thought that continuing education was not needed. The rest provided an array of responses, generally combining personal reasons with the presence of opportunity at the right time. Judging by these responses, a main problem appears to availability/accessibility.

Illustration 15



It appears that the demand exists and is waiting for fulfillment. Indeed, when respondents were asked whether they thought continuing education was important and needed, 97 percent responded positively, only 8 persons thought that continuing education was not important and not necessary. A general understanding of the need for continuing education and its importance for improving quality and fulfilling needs exists. Certainly, such an understanding of the importance of continuing education for physicians and other health human resources has been reached elsewhere in both the developed and developing world. In an attempt to contribute to the international development of health human resource policy, the

World Health Organization stressed the need to develop national level structures and systems that can take charge of the continuing education needs of physicians as well as other health human resources working in the area of primary health care. The World Health Organization declared this a necessary condition for the improvement of health services in any country[36].

An unexpected 51 percent of physicians and nurses reported that their primary health care training was insufficient relative to the type of work that they do or that needs to be done. These results give further credence to the argument that both need and demand for primary health care training are present among the respondents. Of those responding that their training was sufficient for their current work tasks, the large majority stated that their professional (medical or nursing) training was sufficient and that experience also helped them perform their jobs adequately. Those who were not satisfied explained that either training was not available or the institutions they are working with did not place training as a priority.

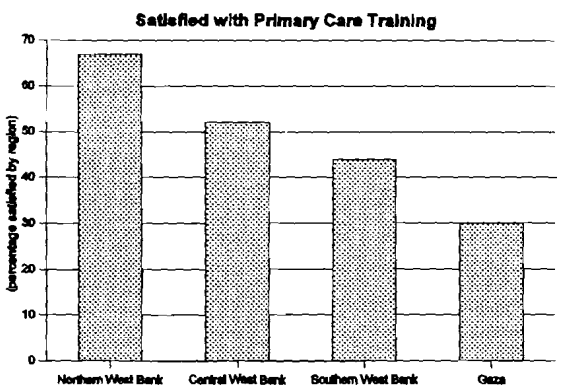
There were no differences in responses between nurses and physicians, nor by sex. Age was important, however, in that older respondents were less likely to think that their training was insufficient: 48 percent of those aged 23-29, and 47 percent of those aged 30-39 responded that their training was sufficient, in contrast to 59 percent among those 40 years or over. This finding, in addition to other findings in relation to age, suggest that it would be best to gear future upgrading training to younger health professionals who appear to be more inclined toward learning than older ones.

The level of dissatisfaction with primary health care training was strongest in the Gaza Strip, only 30 percent of the staff working there reported that their training was sufficient. In contrast, 44 percent in the south of the West Bank, 52 percent in the middle, and a high of 67 percent in the north of the West Bank expressed satisfaction with their level of training. This regional differentiation cannot be explained within the context of this largely statistical study, and must be examined

[36] See Romer, M. and T. Follop, *International Development of Health Manpower Policy (Offset Publication Number 61)* (Geneva: The World Health Organization, 1982).

in the future utilizing other research methodologies that can assess why, how, and under what circumstances this consciousness forms.

Ilustration 16



Cross-tabulating responses to whether staff have had in-service training with responses about continuing education courses, showed no relationship between the two. The exercise of providing in-service training to new staff appears to be disconnected from the provision of continuing education to employed staff. These results affirm the previously noted conclusion that in-service training as practiced by the local institutions serves to introduce the institutional system to a new employee without necessarily providing conceptual and background philosophical support to incoming staff. This also indicates a need to formally link the two components of training into one coherent training schedule, so that continuing education could extend in-service educational schemes.

The importance of in-service training was affirmed by survey results which showed that only 10 percent of those who had completed in-service training reported not to conduct any primary health care related tasks. In contrast, 29 percent of those who had no in-service training at all reported not conducting any primary health care related tasks (chi square =49.78624, p=0.00000). It is important to interpret these results with caution because they pertain to *reports* of practice and not practice *itself*. These results suggest, however, that in-service training influences understanding and attitudes, and possibly practice.

Impact of In-Service Training and Continuing Education on Perception Indicators and Practice Reports

In-service training does not necessarily influence practice, if structural and other conditions are not conducive. Moreover, such training is widely varied and can include a minimal amount of primary health care service training or none at all. Perception indicators and practice are not necessarily positively influenced by in-service training.

Examining reports of perception indicators, such as conducting regular staff meetings, for respondents who underwent in-service training, for instance, showed no relationship between the two. Likewise, positive reports on the importance of team work as well as concerning the role of the village health worker did not correspond with reports concerning in-service training.

These results raise questions as to the quality, relevance, and impact of training on practice. Furthermore, they suggest that future in-service training schemes need to be conceived in new ways, focusing on the elements of primary care that are usually neglected. This must include the pillars of primary health care, including, community mobilization, communications, team work, intersectoral linkages, and appreciation of the role of the village health worker. Such principles must be incorporated into future training schemes because they shape the understanding and approach to primary care that is needed to provide coherent services.

The tragedy in much of what is taking place in the primary health care setting is that often the terminology had been co-opted, to the exclusion of the substance. In this instance, curative care appears to be practiced in lieu of comprehensive community oriented primary health care, but under the name of primary care. The challenge is to reintroduce the substance into today's practice. Although challenging, this is not an impossible task, as different local models of substantive primary care have been developed and are operational today.

Examining the responses of respondents having had continuing education with responses concerning practice indicators and perception showed similar results. There were no appreciable differences between those who had continuing education (both primary health care and non-primary health care related) and those who had not in terms of the specific primary health care activities reported. Such results emerged whether they conducted regular meetings or not, and whether they engaged

in programs of community participation or not. Interestingly, respondents who had participated in continuing education courses better understood the role of village health workers, as well as the importance of the team approach to primary care. Results showed 53 percent of those with no continuing education described the role of health workers in terms of assistance only, in contrast to 27 percent of those who had participated in continuing education (chi square = 18.25498, p=0.00011).

Reports in relation to team work were especially interesting in that 91 percent of those with no continuing education considered team work important for primary health care provision, while 95 percent of those with primary health care related continuing education reported team work as important. In contrast, a lower 81 percent of those who had *non-primary health care related* continuing education reported team work as important (chi square =6.68030, p=0.035). These results suggest that continuing education in non-primary health care related areas might in fact have a negative impact on primary care understanding and approach.

It could also be that those who seek non-primary care related extra training are those who are less inclined to primary care practice, and who might even be seeking to leave primary care through extra training. It has been observed locally that there is a certain proportion of the practitioners at the primary level who are working in this area only because they are unable to find alternative placements. They continue with their work, sometimes taking extra training to improve their opportunities of getting out of the sector altogether. Future training schemes should take into consideration the personal and professional inclinations of staff. Those chosen for training should include only those with a commitment to long term primary care practice.

In summary, then, the principal findings in this section are the following:

1. Reports of in-service training do not correspond to reports of continuing education, suggesting the need to inter-link the two types of training schemes, and the necessity of incorporating them within the formal institutional framework. For training to be effective, it is crucial to integrate training into a continuous rational training model.
2. In-service training seems to have an impact on reports of what should be or is practiced. Actual practice can only be ascertained through alternative investigation methodologies and observation. In-service training appears, however, to influence the understanding of what should be practiced.
3. In-service training does not appear to be of influence in approach to and

perceptions of key tenets of primary care, overall. This may arise either because the training is not accompanied by needed structural and managerial changes needed to implement training, or because training is restricted to an institutional introduction and some curative care without addressing the main tenets and substance of primary health care provision.
4. Continuing education did not seem to influence practice, suggesting that practice is determined by the structure, function, and approach dictated at the institutional level. Continuing education does appear to have an influence on understanding the role of the village health worker, but not on other indicators. Alternatively, continuing education schemes that these human resources were exposed to might have been developed in a vacuum without adequately relating the training topics to the needs of practice at the primary care level.

Summary of Responses on Training in General

Responses pertaining to appropriateness of training in relation to present work in primary care and the general need for training schemes indicated the following points:

1. The majority of human resources working in the primary health sector have not had in-service training. Only 33 percent of the physicians and 44 percent of the nurses reported some sort of training at the beginning of their employment in the health sector.
2. On the whole, in-service training, the way it is currently offered in this country, provides an introduction to the curative and minimal institutional aspects of operations, leaving the principles and practice of primary health care in a compromised situation. Moreover, in-service training continues to be conducted erratically both in terms of time spent in training and the curriculum of the training.
3. About half of those interviewed reported never having had any continuing education of any sort, with more nurses (63 percent) reporting not having had any continuing education than physicians (34 percent). Of those who have had continuing education courses at least once, 77 percent reported training in areas relevant to primary care, and 33 percent reported having had training in areas unrelated to their work.
4. The north and the south of the West Bank consistently face a disadvantage in that human resources working there reported significantly less exposure to training schemes than those working in the central part of the West Bank and the Gaza Strip.

5. The large majority (97 percent) felt that they needed continuing education, but that such schemes were unavailable, expensive, and/or out of reach.

These results confirm the presence of a country-wide need for the development of systems and programs specifically aiming at training health human resources. This could include in-service, continuing education, or other special training schemes, with attention to improving service availability and quality. Results further emphasize the need to prioritize the north and south of the West Bank when planning future programs. Finally, they indicate the importance of considering the training needs of nurses, as well as physicians. If primary care practice is to truly be effective, nurses as well as other health human resources need to be incorporated into the primary health care team in new ways that go beyond the hierarchical relationships of curative care.

Demand for Further Training

Ninety-three percent of the health workers interviewed reported a desire for further training in the field of primary care. Such strong interest indicates an overall high demand for future training schemes, without regard to motive. Of the interviewees who responded positively, the large majority (94 percent) reported a need for primary health care related training, mixing curative with preventive needs. The principal focus was on health education, methods of home visiting, and communications. Clearly, the awareness of the need for such skills and the demand for them are widespread. This represents a substantial change in consciousness from 10-15 years ago when village and community health care was equated with curative care by the large majority of health professionals and institutions, and indicates a very positive attitude change. None, however, mentioned the need for additional training in managerial skills or the principles and practice of team work, strategic planning, data gathering, and basic research skills. This reflects the need to encourage a better understanding in further training, as well as in public debate and lobbying, of the importance of these components to effective primary care practice.

TABLE 19
Willingness to Train in Specific
Primary Health Care Related Tasks
(percentage of total)

TASK	PERCENTAGE
Health education	54
Management of patients with specific ailments	53
Family planning	45
Principles of primary care	39
Community awareness techniques	38
Local health status studies	36
Communication skills	35
Team work	28
Health project management	27
Maternal and child health	11
First aid	2
Immunization schedules and techniques	1.1
Rehabilitation of disabled people	1
Public health	0.7
Managerial and administrative skills at the clinic level	0.4

Table 19 illustrates the willingness of respondents to train in specific fields, and confirms the previous finding that health education, an important component of primary care, is on top of the list of priorities for further training. Indeed, 54 percent of those questioned reported the need for training in health education, followed on the list of priorities by the management of patients with specific conditions, with 53 percent interest, an unexpected interest of 45 percent for family planning, 39 percent interest in primary care principles, 38 percent in community awareness techniques, and 36 percent for health status studies on the major health problems and patterns of health and disease locally. There seems to be a lack of interest or understanding of the importance of managerial and administrative skills in daily activity, with only 0.4 percent of respondents reporting needing such training. In contrast 27 percent of interviewees indicated interest in project level/mid-supervisory level managerial training. This documents a consciousness problem that links managerial and administrative skills only to bigger projects and higher positions than those currently occupied by the respondents. This is ironic in view of the observation that a fundamental problem in the operation of primary care centers in this country today relate primarily to managerial aspects within the clinic. This finding reinforces observations concerning the need to work toward increasing local awareness of the need for managerial and administrative skills in the primary care sector.

INTERVIEWS WITH EXPERTS

Overview

To combine the study team's knowledge of the present problems of the primary health care system with the results obtained from the clinic survey, open-ended structured interviews were conducted with 22 health professionals, including physicians, nurses, researchers, and trainers. Care was taken to include knowledgeable persons from all sectors operating primary health care services. Selected secondary care providers were also included, as it was thought useful to include the perspective of those who work with the consequences of primary health care problems and to consider the workings of the health care system as a whole. Interviews focused on identifying the principal elements inhibiting the adequate operation and further development of the primary health care system in the country. This was followed by discussions concerning different options for corrective action, with particular attention to the need for human resource development and training. A list of potential training topics and areas were identified by categorizing, collating, and tabulating the responses of the experts.

Dominant Problems in Primary Health Care Delivery

Experts emphasized six major areas of difficulty, as noted in Table 20. Twenty-one of the respondents concluded that a principal problem afflicting the primary health care system is the lack of coordination and cooperation among the parties involved in the delivery of service. Bureaucracies inhibiting needed horizontal linkages, different sorts of rivalries (institutional, factional, and personal), and tensions between the governmental and non-governmental sectors were thought to all contribute to the inability to cooperate and, consequently, the serious distortion of the national level system.

Twenty-one of the respondents agreed that a critical problem afflicting the primary health care system is the absence of clear health policies and plans that are compatible with current health care needs and that can assist in prioritizing actions. A number of explanations were provided for this problem. The absence of a participatory professional platform that can develop and shape country-wide health

policies was emphasized as one explanation. Erratic policymaking and ungrounded planning was listed as another factor, as well as the existence of different health policies in different sectors and the absence of accountable legal and other structures that define guidelines for action and cooperation.

Twenty experts noted that a main constraint that needs to be addressed stems from the lack of understanding of the principles and practice of primary health care. In relation to this, experts emphasized the lack of understanding of the importance of team work in primary care, the bias towards curative services, underdeveloped programs, failure to involve the local community in health work, and, interestingly, the low status and priority that primary health care work is afforded by the medical professionals, policymakers and planners.

TABLE 20
Dominant Problems in Primary Health Care Delivery
(number of interviewees)

PROBLEM	NUMBER OF RESPONSES
Lack of coordination and cooperation	21
Lack of national level policymaking and planning, including lack of standardization	21
Lack of understanding of principles and practice of primary health care	20
Managerial/referral problems	19
Inadequacy or absence of training in tasks that need to be performed	17
Medical technical problems	14

Managerial problems, including the absence of a referral system linking primary to secondary and tertiary care, was found to be an important problem by 19 of the interviewees. Here, explanations focused on the lack of training of those operating

primary health care in management techniques; the absence of supervision, and subsequent problems in implementation; inadequate distribution of human resources in the primary care system; and the absence of protocols or even guidelines for action. The majority pointed out that a referral system, linking primary care to secondary care, is either seriously defective or altogether absent.

Of the group of experts, 17 noted a serious problem with the lack training for practitioners in the primary care system. Because physicians in this country are trained in different international systems, many interviewees believed that even the basic medical training of some physicians working in the primary health care sector is deficient and requires major training and supervision efforts. Furthermore, a lack of understanding of the link between health and socioeconomic conditions was noted as a training problem, pushing physicians to focus on rudimentary curative service provision, often without even talking to the patient.

Interestingly, the respondents raised questions about the utility of current training schemes for primary health care providers. Many such schemes were described as generally vertical, disconnected from the realizability of the training in practice, and, more often than not, lacking in post-training supervision and animation. Overall, most agree that current efforts in training health personnel in primary care are insufficient and fail to consider strategic training needs, focusing instead on vertical programs not linked to longer-term training objectives.

Finally, 14 of the respondents reported basic medical technical problems as key components of the current crisis in the primary health care system. More detailed responses here noted the absence or insufficiency of basic equipment and facilities for good medical practice, the lack of knowledge of practitioners on how to deal with specific disease states, and the absence of quality control and supervision over medical and health care practice.

Way to Improve the Primary Health Care System

When questioned on how the primary health care system could be upgraded and improved, the respondents identified a number of areas for possible effective action. To solve the technical and managerial problems, 20 believed that the creation of training schemes for supervisors and trainers of primary care would be a good first step. Such training would address policy and planning issues including management, control, and evaluation, as well as possibly contributing to the development of needed protocols and a referral system. Opinions differed

substantially over the issue of how to solve the national level policy planning problem. The overall inclination, however, was to support the development of health policies based on ``professional" considerations (as opposed to others), with the participation of all those actively working in the field. Respondents focused on the need for training schemes to address the curative bias in primary health care.

In response to more specific questions about immediate priorities in training primary health care physicians and nurses, the priority topics listed in Table 21 were identified.

TABLE 21
Priorities in Primary Health Care Training
(number of interviewees)

TRAINING	POSITIVE RESPONSES
Management and supervision	20
Medical technical skills, in communicable and non-communicable diseases	17
Communication and training techniques, including techniques in health education and home visiting	17
Epidemiology	11
Computer skills	11
Research and planning skills	10
Principles of primary health care	9

CONCLUSIONS

This training needs assessment identifies primary health care human resource development as a priority for the future rehabilitation and development of the health care system in the West Bank and Gaza Strip. It attempts to elucidate the training needs of physicians and nurses working at the primary care level. It begins with an historical overview of the current health care system, focusing on the distortions and biases that evolved out of years of national subjugation and neglect under Israeli military rule to form the present system of subsystems working almost independently of each other. It then reviews the number, type, and place of work of the human resources working in the health sector in the first part of the 1990s, in an attempt to define the target population for future training.

In the field investigation portion of this study, a mixed methodology is utilized. This combined the administration of a structured questionnaire to health human resources working in primary health care centers with semi-structured interviews with key health experts, to produce the study results and a list of training priorities. Staff of about 50 percent of the primary health care centers operating in 1994 were surveyed. Policymakers, practitioners, and researchers composed the set of experts. The assessment ends with the identification of immediate training needs of physicians and nurses working in the primary health care sector and establishes the guidelines for future training action.

The following conclusions have been drawn from the study results. The conclusions have been divided into three sections: staffing and program development within clinics, human resources, and the health care system.

Staffing and Program Development within Clinics

Approximately 50 percent of the clinics located in the West Bank and Gaza Strip in 1994 were reached by this survey. This comprised of visiting 193 clinics.

- *The NGO sector is substantially involved in service delivery at the primary care level.* Forty-seven percent of the clinics visited were operated by the governmental sector, 44 percent by the non-governmental sector, and 9 percent by UNRWA.

- *An unexpected high of 43 percent of the clinics surveyed were staffed by part-time general practitioner physicians.* The majority of those (75 percent) were governmental clinics. The rest of the clinics surveyed were staffed by either one full-time physician (39 percent) or 2 to 8 physicians. The large majority of clinics with a high rate of physician employment were located in the Gaza Strip and operated by UNRWA.

- *A generally low utilization rate of health staff other than physicians was noted.* Sixty-seven percent of the clinics did not employ a laboratory technician, 89 percent did not employ pharmacists, 75 percent were without pharmacy assistants, 92 percent without rehabilitation workers, 67 percent without administrators (either clinic-based or regional), and 95 percent without health educators.

- *In terms of staffing levels, governmental clinics were noted to fare least well compared to UNRWA and NGO clinics with 32 percent of governmental clinics staffed by either one or two persons, compared to 15 percent in the NGO sector and none for UNRWA.* The average number of staff per clinic was found to be 6.7 for the West Bank and a high of 23.2 for the Gaza Strip.

- *Significant differences in staffing levels among urban, rural and refugee camp settings were noted.* Rural areas were generally found to be significantly less well staffed than urban areas or refugee camps. Likewise, urban and rural sectors of the northern part of the country were found to have significantly lower staffing levels than the central and southern parts of the West Bank and the Gaza Strip. Sixty-five percent of northern clinics were found to be staffed by 1-3 persons, in contrast to 35 percent in the south, 26 percent in the central West Bank, and only 6 percent in the Gaza Strip. While the differences in staffing levels can be explained partially in terms of patient loads in heavily urban areas, even when analyzing the sample of rural clinics alone and correlating them with staffing level by region the differences by region persisted and were found to be statistically significant. These results confirm the view from the perspective of staffing levels within clinics that the north of the country is one of the most disadvantaged areas in terms of health care delivery.

- *A high of 24 percent of all the clinics reported not operating any programs other than simple curative care.* Thirty-five percent operated 1-2 additional programs, 30 percent operated 3-6 additional, and 11 percent operated 7-14 additional programs. In terms of program operation, UNRWA was noted to fare best and the governmental sector least well. Thirty-five percent of governmental clinics did not operate any programs at all other than rudimentary curative services, in contrast to only 6 percent of UNRWA clinics, 15 percent of the popular committee clinics, and 24 percent of charitable society clinics. Once again, the central area of the West Bank and the Gaza Strip were noted to offer a larger number and wider variety of services than the other areas and the northern region was found to be the most deprived. Only 6 percent of central area and Gaza Strip clinics offered no programs other than curative care, in contrast to 15 percent in the south and a 54 percent in the north of the West Bank. Rural urban refugee camp differences were also found to be substantial, with 4 percent of refugee camp clinics, 22 percent of urban clinics, and 30 percent of rural clinics offering no programs other than curative care.

- *The least developed clinics are the governmental ones; the rural areas are the most disadvantaged; and the north of the country, and secondarily the south, continues to suffer serious inequalities in basic health care provision.* This is based on the number and types of staff working in clinics and the programs offered by these clinics.

Human Resources

A total of 140 nurses and 130 physicians were interviewed.

- *The average age of physicians and nurses was found to be 37 years, with an average of 9.6 years experience in primary health care delivery for nurses and 7.2 years for physicians.*

- *The data reveals an expected division of labor between the sexes and gender bias within the primary health care system.* Fifty-six percent of the sample was men and 44 percent women. As expected, the majority of men were physicians with 88 percent of the physicians being men; the majority of nurses were women, with 73 percent of the nurses being women. This probably affects not only service provision but also team dynamics.

- *Once again a clear division of labor between the physicians (men) and nurses (women), emerged, re-enforcing the presence of a hierarchical structure within clinics that contradicts the team work principle central to primary health care.* Analysis of data reports on tasks performed and task distribution between physician and nurse revealed that physicians tended to focus on curative

work while nurses performed some elements of preventive work and carried out basic clinic administrative functions. Nurses duties included stock taking, record keeping and the like, functions that are generally considered less prestigious than curative care. Specifically, 82 percent of the total time of physicians was reported spent on curative care, in contrast to 39 percent of nurses' time.

- *The data suggests that tasks and activities performed relate to personal initiative rather than the performance of systematic, supervised, and evaluated activities.* An analysis of task distribution in relation to the presence of specific programs within the clinic revealed no appreciable difference between those who performed primary health care tasks and those who did not, in relation to the presence of specific programs within the clinic.

- *The results demonstrate a conceptual problem, especially among physicians, where the belief is that experience in curative care, regardless where and how obtained, can substitute for structured learning.* Thirty-three percent of the physicians and nurses interviewed reported having had in-service training at the beginning of their employment. Looking at physicians and nurses separately, the study found 44 percent involvement in-service training for nurses and a lower 21 percent for physicians. Thirty-one percent of the physicians reported that they do not need any in-service training to work in primary health care, in contrast to 15 percent for nurses. Clearly, much can be done in the area of developing the understanding of in-service training and how medical school education often does not prepare one for quality primary health care provision.

- *These results point to a standardization problem and reinforce the need to define and standardize clearly the purpose and activities of in-service training.* Those who had participated in in-service training reported a wide range of time spent in such training, ranging from one week to six months. Thirty percent of those who received in-service training reported training in general curative care only, often in the hospital setting.

- *These results confirm a country-wide need to develop systems and programs to train human resources working in primary health care.* Forty-nine percent of health human resources interviewed reported never having taken any continuing education during their practical career in primary health care, 35 percent reported having taken one course, and the rest 2-4 courses. Of those reporting to have taken at least one course of continuing education, 77 percent reported training in areas relevant to primary health care, and 33 percent reported

training in other unrelated areas. As the average years of experience in primary health care was found to be 9.6 years for nurses and 7.2 years for physicians, continuing education is clearly needed.

- *These results raise concerns about quality control, supervisory, and managerial aspects of clinic operation, and the potential for positive clinic dynamics and good team work.* Forty-seven percent of the clinics visited were reported not to have staff meetings at all, whether internal or central; 18 percent reported to schedule staff meetings ``as needed''; and 35 percent reported regular meetings. These are all important aspects of primary health care operations.

- *The results illustrate the presence of an institutional rather than an individual consciousness problem.* Sixty-one percent of staff interviewed reported not to engage communities where they work in any level of activity. Explanations varied for this lack of community involvement. They included the unavailability of funds to carry out such operations, ``lack of community responsiveness'', time constraints, and institutional constraints. In contrast, 98 percent of respondents considered community involvement important for their work, denoting a basic understanding of the importance of this principle to health care provision.

- *The results point to the need address a perception/consciousness problem at different levels, perhaps beginning with retraining and continuing with on the job supervision and evaluation.* Thirty-five percent of the respondents described the role of community health workers as ``assistants'' to physicians and nurses; 57 percent designated different primary health care tasks and the rest provided unclear or semi-clear responses. Nurses appeared to fare substantially less well than physicians in their assessments of what community health work constitutes; 51 percent of nurses considered community health workers assistants or with no role at all. These results appear to vindicate physicians, who are often blamed for degrading community health workers and their roles. Nurses appear to negate a role for community health workers within the primary health care team to a much larger extent than physicians. Perhaps this results from a feeling of competition. Nurses might feel that health workers would gradually replace them in primary health care work. This negates the very principles of team work essential to primary health care.

- *For training to be effective, it is crucial to integrate it into a continuous rational training model, with clear aims and objectives, and periodic evaluation.* The results of this study indicate that reports of in-service training

are not related to reports of continuing education. Those who have had in-service training are not necessarily those who have been exposed to continuing education. These results emphasize the need to inter-link the two types of training schemes and the necessity of incorporating them within the formal institutional framework.

- *This study found that in-service training appears to have an impact on reports of what should be practiced.* Actual practice can only be ascertained through alternative investigation methodologies and observation. In-service training appears to influence the understanding in positive ways. In-service training did not appear to be of influence in approaches to and perception of the key tenets of primary health care. This may reflect that the training is not accompanied by needed structural and managerial changes or that training is restricted to institutional introduction and some curative care, without introducing the main substance of primary care.

- *Continuing education was not found to influence reports of practice of primary health care.* Such results may suggest the presence of structural constraints that limit the implementation of new knowledge. Alternatively, the available continuing education schemes may have been developed in a vacuum, without adequately relating the training topics to the needs of practice at the primary care level.

- *The study revealed a high demand to develop structured training schemes.* Ninety-three percent of the respondents reported a desire for further training in the field of primary care. A high of 54 percent reported needing training in health education as a priority, 53 percent reported the management of patients with specific ailments, such as diabetes and hypertension, as a priority, 45 percent listed family planning, 39 percent principles of primary health care, 38 percent community awareness techniques, 36 percent action oriented research methods, 35 percent communication skills, 28 percent team work, 27 percent health project management, and 11 percent maternal and child health care. Other topics with lower priority were also listed.

Health Care System

- *A large majority of the 22 West Bank and Gaza health experts interviewed agreed on six areas for special concern and attention.* All but one agreed that lack of coordination and cooperation among the three sectors and among health institutions in general and the lack of national level policymaking and planning were key problems to address. Twenty named the lack of understanding of the principles and practice of primary care as a main problem; 19 believed that managerial/referral problems were a main impediment to the improvement of the system; 17 noted improper or inadequate training of staff was a main problem; and 14 believed that medical technical problems, or bad practices, were an important problem facing primary health care provision.

- *Experts also helped formulate an immediate list of priorities for training.* Twenty listed management and supervisory training as a priority, 17 listed medical technical training in both communicable and non-communicable diseases, 17 listed training and communication skills, 11 listed both the study of epidemiology and of computer use, 10 listed research and planning skills, and 9 denoted the principles of primary health care.

Studying information obtained from physicians and nurses working in the primary health care sector along with information obtained from the local health experts, this study concludes that future human resources training schemes aiming at the rehabilitation and re-construction of the Palestinian health care system must take into consideration the following:

- *Training of mid-level supervisors trainers is a national level priority because of the ineffective or absent supervisory managerial system within the current primary health care structures.* Such supervisors trainers are key personnel that can link the practice with the policy. On one hand, they can feed into policy formulation and planning by generating and organizing data from the field. On the other, they can test, model, build, and implement programs based on policy.

They can also carry out the functions of monitoring and evaluation. It is precisely at this level, the mid-level supervisor juncture, that much remedy can begin to be accomplished. Simultaneously, such supervisors can function as trainers of personnel already working in the primary health sector. This enhances the cost effectiveness of the initial training and can extend the training by training others within their institutions. This would reduce the burden of training substantially.

By training such a team together, it can serve as a future mid-level working link among different institutions. The team could provide a forum for the dialogue among the sectors and institutions that is needed to integrate the systems into one rational whole and to begin the process of standardization.

- *Future training schemes need to focus on the following topics:* technical medical skills, epidemiology, principles of primary health care, communication and training skills, managerial skills, and research skills.

SUMMARY

- *In broad terms, with some interesting exceptions, governmental, UNRWA, and non-governmental clinics continue to focus mostly on curative care, and some elements of maternal and child care, and other selected programs.*

- *With the exception of UNRWA clinics, programs continue to be underdeveloped.* Clinics are short of the staff needed to combine needed curative care with the other elements of primary health care; referral systems are lacking; and supervisory and managerial systems appear to either be deficient or lacking altogether.

- *The governmental sector seems to do least well overall, relative to the other service providers.* This is understandable, in view of the control of this sector by the Israeli military authorities until very recently. The difficulty of this manifests itself not only in policy formulation and planning processes, but in severe funding shortages, general demoralization of staff, and other constraints faced under military rule. Such conditions resulted in the distortion of this particular system and its dependence on the Israeli medical establishment. It must be recognized that 27 years of military rule and control over the health sector led to a serious degeneration of the system, especially in terms of adequate policy formulation and planning. This observation is not meant to underestimating the efforts of Palestinians working within this sector to push the system forward.

These factors have stunted the system to a point where major efforts in the area of structural development are required. Work must not focus exclusively on physical infrastructural development. The governmental system was not allowed the chance to be innovative and creative. It continued to operated based on old principles, notwithstanding some rhetoric on primary care. Certain selected programs operated well, such as the immunization/vaccination program; however, much remains entirely undeveloped. It is in the area of creative service provision and model building, that the governmental sector could learn from selected NGOs and UNRWA. Such information and experience exchanges require the development of genuinely participatory platforms where all actors in the field can share in equal ways the process of rehabilitation and development.

- *A substantial amount of variation in type and quality of service was noted among the Palestinian NGO sector.* Different service providers are operating under different systems and different approaches to health care delivery. This system is eclectic, and cannot be seen as one. Some NGO clinics appear to be doing exceptionally good work considering the general conditions; still others are focusing on the provision of curative care with very questionable quality; others are moving in the right direction but face a serious lack of resources, both financial, human-technical, and managerial.

  Despite the eclecticism, the NGO sector has been one of the principal actors contributing to the building of an infrastructure of resistance to occupation through health care service provision. Some remarkably innovative models were built, such as appropriate for context primary health care provision, the development of new human resources, including village and rehabilitation workers. Community based action and experience in system building as well as in the processes of democratization were also built. These processes and experience are crucial not only for the future development of the health care sector, but also for the gradual move of Palestinians toward civil society. Considering the exceptional political circumstances under which these service providers operated, what exists today in the field remains a substantial achievement, despite some of the failings of this sector.

- *Study results highlight the potential for serious health care system crises in the near future and emphasize the likelihood that such crises will affect the disadvantaged sectors most severely.* A considerable proportion of Palestinian non-governmental clinics—probably over 150 out of a total of about 440 clinics—had closed down by the end of 1994. This is believed to result from the financial crisis that gripped NGOs during the past two years or so. It appears that regions that are already deprived, such as the northern part of the West Bank, are also the ones that have been affected most severely by clinic closures. Perhaps most importantly, this survey clarifies the dangers of the collapse of the very system upon which experience and participatory processes were built. The experience of this system are crucial for the future development of the Palestinian health care system, as well as democracy building, as well as for the fulfillment of present health care needs.

- *The UNRWA health care system has an internal coherence, with a rather developed programmatic component relative to the other sectors.* Because of the very high patient load in these clinics—with an average allotment of four minutes per patient—activities remain focused on curative care, prenatal care, immunization, and selected newly-developed programs for the care of special groups. Interviews consistently revealed questions and comments, from persons working inside and outside the system, regarding the ability of staff to perform their assigned functions adequately. Questions were raised pertaining to the excessively bureaucratic nature of the operation, making genuine team work in primary care difficult. The vertical nature of managerial linkages, among other factors, make linkages with other sectors, even UNRWA's educational sector, almost impossible. Questions were also raised regarding UNRWA's structures that make real community involvement un-realizable.

- Comments made by health care practitioners within and outside UNRWA and by the local experts, as well as observations made throughout the fieldwork raised the important questions concerning the quality of care within the UNRWA system, as well as its effectiveness from the primary health care perspective. While a thorough examination of these issues requires a different type of investigation, the initial results of this study point to the presence of problem areas that need to be addressed.

  These questions need to be raised now because the UNRWA system is being propagated as a model for the development of the Palestinian national health care system. While there is no question that in terms of planing and design the UNRWA system fares best, a number of factors suggest that the system might not be the model that Palestinians would choose for themselves. These factors include the non-participatory development of policies and plans, inherent gender bias in service provision, excessive bureaucratization, and others[37].

[37] For instance, a refugee woman married to a non-refugee man cannot include her children as beneficiaries of UNRWA services, because UNRWA's definition of refugee is based on the principle of male head of household. See Cervenack, C., "Promoting Inequality: Gender Based Discrimination in UNRWA's Approach to Palestine Refugee Status," *Human Rights Quarterly*, Vol. 16(2) (May 1994). As for the promotion of women's rights and local participation in UNRWA policymaking and planning, it is curious that a recent document produced by UNRWA concerning future planning espouses the principle of community participation and the cause of women and their rights, but proceeds to be almost completely oblivious of the activities of NGOs, where almost all of the women's movement's activism is couched. This omission forces the question as to what exactly is meant by community participation and the promotion of women's rights. See *UNRWA Four Year Forward Planning, 1995-1998* (Geneva:

It is important to learn from the experience UNRWA generated over the years while at the same time maintaining a critical attitude toward some of the system's unyielding problems.

In conclusion, the challenges that Palestinians face during this interim phase are no less than monumental. Many years of subjugation have led not only to the distortion of systems, but of the consciousness as well. With all sorts of rivalries (factional, institutional, personal and other) afflicting the health care system, it is clear that what is required for genuine rehabilitation is real cooperation and democratic/participatory system building. Efforts must focus on human development first and foremost, i.e. the exchange of experiences, pooling of resources, and the utilization of the different experiences to affect change, in contrast to attempts for control. Despite the burdens and problems of each of the three health care systems, the benefits are also evident and must not be forgotten as they can provide the template for future effective action. Within this context, systematic studies of different aspects of operation of the three systems can prove to be useful in determining which models or parts of models could be adopted to produce a national level health care system. An important step would be undertaking a cost/benefit analysis of each of the three systems, as it is not sufficient to look at service availability and quality without also looking at the costs incurred in providing health services to the population. Cost/benefit analyses would complement other types of information in providing a basis to allow Palestinians to make rational choices when they expand their health care systems into the national level.

At this stage, it is clear that cooperation among the sectors is a precondition for future success. To achieve this aim, many barriers must be broken and different actors must begin to dialogue with each other with respect for each other's experience and with the common goal of building the nation for the best interest of the majority. Unfortunately, the cracks among the different sectors stand as enormous barriers to national level, rational, and effective system development.

UNRWA Program Planning and Evaluation office, 1994).

Ironically, the newly emerging Palestinian Authority, Palestinian NGOs, and UNRWA all need each other, if they are to effectively rehabilitate and develop a health care system for Palestinians. In the end, the struggle for health and the struggle within the health sector can be seen as a litmus test of success. Health care has been an important arena of struggle for historical reasons. If Palestinians succeed to rebuild a viable national health care system in democratic ways, perhaps Palestinians will succeed in building a democratic Palestine. To this end, it is hoped that this study assists in the delineation of the salient features of the health care system and the formulation of policies and plans of action, focusing on human resources, the most important element in health care development.

APPENDICES

APPENDIX ONE
Regional Overview of Clinics Surveyed

REGION	NUMBER OF CLINICS
Bethlehem	17
Gaza Strip	32
Hebron	26
Jenin	23
Jericho/Jordan Valley	6
Jerusalem	9
Nablus	20
Ramallah	34
Tulkarem	26
TOTAL SURVEYED	193

APPENDIX TWO
Regional Overview of Closed Clinics
from Original Sample

REGION	NUMBER OF CLINICS
Bethlehem	4
Gaza Strip	0
Hebron	6
Jenin	7
Jericho/Jordan Valley	1
Jerusalem	2
Nablus	5
Ramallah	9
Tulkarem	4
TOTAL SURVEYED	38

APPENDIX THREE
Overview of Closed Clinics from Original Sample
By Operating Institution

Operating Institution	Number of Clinics Closed
Palestinian Health Services Council	19
Union of Palestinian Medical Relief Committees	1
Union of Palestinian Health Work Committees	2
Union of Palestinian Health Care Committees	8
Charitable Societies	8
TOTAL	38

APPENDIX FOUR (A)
List of Interviewed Experts
West Bank

Name	Title	Institution
Abu Teir, Na'im	Director	Union of Palestinian Health Care Committees
Barghouthi, Mustafa	Chairman Director	• Union of Palestinian Medical Relief Committees • Health Development Information Project
Daibes, Ibrahim	Researcher & Trainer	Health Development Information Project
Dudin, Anwar	Head, Pediatrics	Maqassed Islamic
Ibrahim, Dayan	Dean, Faculty of Nursing	Bethlehem University
M'addi, Khadijeh	Lecturer, Nursing	Women's Community
Mas'ad, Amin	Preventive Medical Officer	UNRWA
Nabris, Khaled	Project Officer	UNICEF
Qassis, Hilweh	Director, Nursing Department	Maqassed Islamic Hospital
Rizkallah, Najwa	Consultant & Trainer	Ramallah
Siam, Hussam	Deputy Field Health Officer	UNRWA
Smith, Chris	National Program of Action Coordinator	UNICEF

Thalji, Amin	Director	Maqassed Islamic Hospital
Toubasi, Nadim	Director, Public Health Department	Governmental sector
Wick, Laura	Assistant Health Project Officer	UNICEF
Yasmineh, Maha	Director, Nursing Department	Augusta Victoria Hospital

APPENDIX FOUR (B)
List of Interviewed Experts
Gaza Strip

NAME	TITLE	INSTITUTION
Abdul Shafi, Haidar	Head	Red Crescent Society
Abed, Yahya	Director, Preventive Services	Governmental Health Department
Abu Musa, Hamid	Preventive Medical Officer	UNRWA
Al-Za'noun, Riad	Minister	Health Ministry
Bin Said, 'Aaisha	Director, Nursing Department	UNRWA
Tarazi, Suhaila	Director	Al-Ahli Arab Hospital