HAIGAZIAN UNIVERSITY

EVALUATING THE SERVICES OF A PRIMARY HEALTH CARE CENTER CASE STUDY: HOWARD KARAGHEUSIAN COMMEMORATIVE CORPORATION – BEIRUT, LEBANON

By

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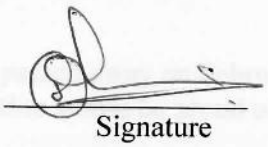

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AN ABSTRACT FOR THE PROJECT OF

Serop Haroutioun Ohanian for Master of Business Adm. & Economics

Title: Evaluating the services of a Primary Health Care Center – Case Study: Howard Karagheusian Commemorative Corporation – Beirut, Lebanon

Primary Health Care Centers aim at responding to people's health needs and demands and at safeguarding, promoting and restoring health. However, health is not an aim *per se,* but a condition for human development and well-being.

The underlying study seeks to evaluate the services of one of the active Primary Health Care Centers (PHC) in Lebanon, the Howard Karagheusian Commemorative Corporation (HKCC). In this attempt, this project defines the role of a Primary Health Care (PHC) in comparison with an Emergency Medical Assistance (EMA), hence summarizes the characteristics of both centers and to focus on the particular services of HKCC as a PHC.

After arriving at an appropriate definition of PHC and EMA, the study highlights the impact of HKCC as a PHC in Bourj Hammoud. For this purpose, a set of questions was distributed to the visitors and staff members of HKCC to explore the level of the respondents' satisfaction and their corresponding suggestions. Descriptive hypothesis statements revolving around the characteristics of a PHC and comparing it to the characteristics of HKCC were developed. Two hundred and nine visitors and twenty two staff members at HKCC during the month of March 2007 have responded to this survey. The research examines the possibility of a relationship between the frequency of the visits of the clients on the one hand and the level of satisfaction of the clients with the services of HKCC on the other hand.

At the end, recommendations were given to HKCC management and board of directors to improve the services of HKCC based on the observations noted throughout this preliminary exploratory research.

Evaluating the Services of a Primary Health Care Center - Case study: Howard Karagheusian Commemorative Corporation (HKCC) – Beirut - Lebanon

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CHAPTER ONE: INTRODUCTION

1.1) Reducing Risks, Promoting Healthy Life

Health, as defined by the World Health Organization, is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity

Every country needs to be able to adapt risk reduction policies to its own needs. People will choose to adopt healthier behaviours – especially when they receive accurate information from authorities they trust, and when they are supported through sensible laws, good health promotion programmes and vigorous public debate.

Reducing risks to health is the responsibility of governments – but not only of governments. It rightly remains a vital preoccupation of all people, in all populations, and of all those who serve them.

World Health Organization's (WHO) report for the year 2002[1] gave several recommendations for reducing health and promoting healthy life. Here are two recommendations, among others:

- A balance between government, community and individual actions is necessary. For example, community actions should be supported by Non-Governmental Organizations (NGOs), local groups, the media and others. At the same time, individuals should be empowered to make positive, life-enhancing health decisions for themselves on matters such as tobacco use, excessive alcohol consumption, unhealthy diet and unsafe sex.

[1] WHO – The World Health Report: Reducing Risks, promoting healthy life. *WHO Report 2002;* xvii

- Preventive risk factors have to be planned within the context of local society, bearing in mind that the success of preventive interventions is only partly a matter of individual circumstances and education.

The result of reducing risks and promoting healthy life will have a wide and lasting social value, even beyond preventing death and disability. All these are encouraging factors that support the necessary creation of Primary Health Care Centers

In evaluating an organization we have to assess its capacity and the level of development in terms of the effectiveness and efficiency of its services. In the sections below, I will define capacity, discuss capacity development and describe dimensions of capacity in a systems context.

1.2) what is Capacity?

Capacity is defined as the ability of individuals and organizations or organizational units to perform functions effectively and efficiently. This definition implies that capacity is not a passive state but part of a continuing process and that human resources are central to capacity development. The overall context within which organizations undertake their functions are also key considerations in capacity development. Capacity is the power of something (a system, an organization, a person) to perform or to produce.[2]

Capacity Development

Capacity development is a concept which is broader than organizational development since it includes an emphasis on the overall system, environment or context within which individuals, organizations and societies operate and interact. In

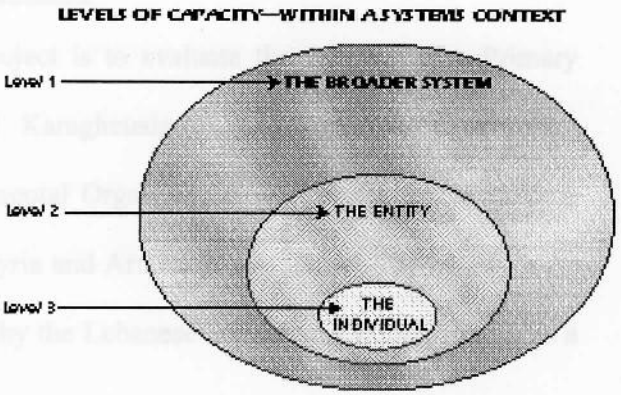
[2] Website: www.magnet.undp.org/docs/cap/ch2.pdf

the case of development programmes, it includes a consideration of all key factors which impact upon its ability to be developed and implemented, and upon the results to be sustained. Of special concern to development planners and to situations where there are limited resources is the need to build on what exists—to utilize and strengthen *existing capacities* , rather than to start from scratch. In most situations, the past or what already exists cannot or should not simply be negated.[3]

Dimensions of Capacity in a Systems Context[4]

The diagram (right) graphically illustrates that capacity issues can be analyzed at three levels. Often, capacity issues are first addressed at the individual level, then at the organizational or entity level.

Diagram 1



However, as noted above, capacity must be understood at the systems level as well. By definition, a system is a regularly interacting or interdependent group of items forming a unified whole. Capacity is defined here in a systems context where a set of entities operate toward a common purpose. [13]

Therefore, to evaluate a Primary Health Care Center, we have to focus on its corresponding Stakeholders. A stakeholder is any individual or entity that is involved, directly or indirectly, in any life cycle stage of an organization, including the ultimate beneficiaries. I will focus on the three aspects of the stakeholders of HKCC and these are the following:

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[3] Website: www.magnet.undp.org/docs/cap/ch3.pdf
[4] Website: www.magnet.undp.org/docs/cap/ch3.pdf

Evaluating the Services of a Primary Health Care Center in Bourj Hammoud – Case Study: HKCC	
The Broader System	An Overview of Socio – Economic situation in Bourj Hammoud
The Entity / Organization	Staff of HKCC
The Individual	The Clients / Beneficiaries

1.4) The Objective of the Research:

The main purpose of this project is to evaluate the services of a Primary Health Care Center called Howard Karagheusian Commemorative Corporation (HKCC). HKCC is a Non - Governmental Organization with headquarters in New York, and three centers in Lebanon, Syria and Armenia. The focus of this study is on HKCC Lebanon, which is recognized by the Lebanese Ministry of Public Health as a Primary Health Care Center.

This research defines the role of a PHC in comparison with an EMA. It summarizes the characteristics of both centers and pinpoints the particular services of HKCC as a PHC. Then, three of the important characteristics of a PHC, geographical accessibility, effectiveness and efficiency of its services, are being closely studied and tested. These characteristics are further defined as follows:

- Geographical accessibility means that the center should be easily accessible to the people.
- Effectiveness of its services means doing the right thing. Are the clients / beneficiaries satisfied from the services of HKCC?
- Efficiency of its services is with respect to its resource allocation: are the care givers available for help or support?

In evaluating the services of HKCC the abovementioned characteristics will be closely monitored, analyzed and tested. Also in this study the suggestions given by the clients and staff of HKCC will be obtained, and recommendations concerning the improvement of HKCC will be drawn

1.4.1) Methodology of the Research:

The methodology employed in the current study comprises a literature review concerning the definition of Primary Health Care Centers (PHCs) and Emergency Medical Assistance (EMAs), their different paradigms, characteristics of care, characteristics of heath services and management and support and sustainability systems. Whether HKCC does have the characteristics of a PHC is tested. The impact of HKCC on the people is assessed. A sample questionnaire distributed to HKCC visitors and staff during the month of March 2007 is used. A number of hypotheses are tested using the Statistical Package for Social Sciences (SPSS) software to arrive at the objectives stated above.

1.4.2) Limitations of the Research

The limitations in this research can be described in terms of:

- Choosing the sample of the quantitative survey. This research focuses only on the stakeholders of HKCC who are:
  - The Clients: those who visit HKCC and benefit from its corresponding services. A sample of 209 visitors was randomly selected who have visited to the different services of HKCC during the month of March 2007. The size of the sample (N=209) is limited compared to the proportion of people benefiting from all of the HKCC services, an average of 1,000 clients per month.

- The working staff of HKCC: Those who are in constant contact with the clients are 32, however only 22 are interviewed.

- The clients / beneficiaries were chosen randomly at the pediatric department of HKCC. It would have been different if equal number of clients were chosen from different departments of HKCC. This would have taken more time but would have been more interesting in its results.

- The respondents represent the clients who were visiting the different departments at HKCC. There are many beneficiaries to which HKCC doctors and social workers reach out outside the HKCC center including these beneficiaries in the study could be enlightening.

- The peers of HKCC were not included in this research. For future research, they can be taken into consideration. Their relationship with HKCC could be enlightening too.

- A Cost analysis study is not included in this research. The cost per beneficiary, the cost per service and the cost per staff should have been taken into account.

- This study outlines the components and activities of HKCC in terms of its local level performances. International level achievements are not evaluated. The comparison of local level performance with the international level remains a matter of further research.

CHAPTER TWO: CONCEPTUAL BACKGROUND OF THE RESEARCH

2.1) Primary Health Care and Emergency Medical Assistance

Primary health care (PHC) and emergency medical assistance (EMA) are discussed as two fundamentally different strategies for delivering health care. PHC is conceptualized as part of overall healthcare development, while EMA is delivered in disaster or emergency situations.

The organizations of health care today invariably refers to the concept of Primary Health Care (PHC).[5]Most authors have described the principles of PHC in generic terms,[6] while others have focused on particular organizational issues,[7] and particularly on district health care.[8] All implicitly refer to stable situations where there is a perspective for development – not to societies struck by disaster.

PHC has a well-developed conceptual substructure; the literature on emergency medical assistance (EMA) has concentrated on technical and logistic considerations.[9] PHC aims at promoting health in a society in development, while EMA concentrates on safeguarding survival in an emergency situation.

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[5] WHO. Declaration of Alma-Ata. The Lancent 1978; 2:1040-1
World Bank. World Development Report 1993: *Investing in health.* New York: Oxford Printing Press, 1993; 1- 329

[6] Cochrane AL. *Effectiveness and Efficiency.* Random reflections on health services. Abingdon, Berks: Burgess & Son, 1971; 1-92
Donabedian A. Models for organizing the delivery of personal health services and criteria for evaluating them. *Milbank Memorial Fund Quarterly* 1972; **50**: 103-54

[7] King M. medical care in developing countries. *A premier on the medicine of poverty and a symposium from Makerere*. Nairobi: Oxford University Press, 1966.

[8] Criel B, Macq J, Bossyns P, Hongoro C. A coverage plan for health centers in Murewa district in Zimbabwe: An example of action research. *Tropical Medicine and International Health* 1996; **1**:699-709
Castello AM, Foster MC. Organizational design and the district health team. *Tropical Doctor* 1993, **23**: 9-12

[9] Toole MJ, Waldman RJ. Prevention of excess mortality in refugee and displaced populations in developing countries. *Journal of American Medical Association* 1990; **263**: 3296-302

2.1.2) Paradigms of Primary Health Care and Emergency Medical Assistance

Primary Health Care

Primary Health Care aims at responding to people's health needs and demands, to safeguard, promote and restore health. However, health is not an aim *per se,* but a condition for human development and well-being (Table 1).[10] Health services should thus be developed in harmony of other aspect of society – education, social and economic infrastructure – and use only a 'reasonable' share of the total financial and human resource available.[11] To produce a maximum of health with these limited financial and human resources, health services must be rationalized to function in an effective and efficient way.[12]

PHC, however, also has important social dimensions: autonomy and participation also referred to as responsiveness.[13] Where possible, health professionals should not make the users dependent on the health services. Instead they have to promote autonomy, and deliver services that are complementary to self care and family care.[14] This requires partnership between health professionals and the population, based on a continuous dialogue. The need for participation has several foundations: "Increasingly, the demand is being made that both consumers and providers participate…this stems, in part, from general social values that indicate a preference for egalitarian and participatory forms of governance. Partly, it stems from more pragmatic arguments. One of these is that consumers and providers have

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[10] Mercenier P. Pour une politique de sante publique. *Intermediare* 1971; 1-6
[11] Sen A. Development as a capability expansion. In: Griffin K, Knight J (eds). *Human Development and the International Development Strategy for the 1990s.* London: Macmillan, 1989: 41-58
[12] Mercenier P. Pour une politique de sante publique. *Intermediare* 1971; 6-9
[13] WHO. *The World Health Roport 2000.* Health systems: improving performance. Geneva: WHO, 2001; 1-215
[14] Van ver Geest S. self-care and the informal sale of drugs in the south Cameroon. *Social Science and Medicine 1987;* **25**: 293-305

somewhat different perspectives on "health" and on its management, and that both viewpoints need to be taken into account and synthesized or reconciled if the agency is to be maximally effective. Another argument is that participation in decision making creates a sense of belonging and commitment and encourages behaviour that is in line with agency objectives".[15]

The technical content of Health care in a PHC perspective can be defined in fairly straightforward and objective terms. Rationalizing its implementation and balancing technical content with autonomy and participation are essentially local issues. Developing autonomy and participation are more difficult and take more time than rationalizing the technical aspects. Fast access in developing participation is less frequent than rationalization. Developing PHC is necessarily slow and requires a long term perspective.

Emergency Medical Assistance

EMA, or medical relief, on the other hand, concentrates on promoting physical survival (Table 1)[16]. WHO defines relief as 'assistance and/or intervention during or after a disaster to meet the life preservation and basic subsistence need'.[17] Physically surviving the emergency is an aim *per se*; it is the pre-condition of human development, once the emergency is over. EMA should be part of a package of emergency relief measures, including provision of water, shelter and food. These emergency relief measures may use 'all resources that can be mobilized'. In EMA, rationalization aims at producing maximum output in terms of lives saved with the

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[15] Donabedian A. Models for organizing the delivery of personal health services and criteria for evaluating them. *Milbank Memorial Fund Quarterly* 1972; **50**: 103-54

[16] Macrae J, Bradbury M, Jaspars S, Johnson D, Duffield M. Conflict, the continuum and chronic emergencies: a critical analyis of the scope for linking relief, rehabilitation and development planning inSudan. *Disaster* 1997; **21**: 223-43.

[17] World Health Organization. *Emergency and humanitarian action. Geneva: WHO, 1996; 1-64*

resources available. Effectiveness is thus the main consideration, even if this means jeopardizing autonomy and creating dependence. Participation is often reduced to compliance. Health professionals work with "beneficiaries", often in a paternalistic way. Safeguarding human dignity is also an ethical imperative. As the technical dimension is dominant, and the short term effectiveness is paramount, there is a tendency to rely on standard strategies.

Table 1. Paradigms of primary health care (PHC) and emergency medical assistance (EMA)

	PHC	**EMA**
Aim	Health, as a condition for human development and well-being	Physical survival, as a pre-condition for human development
Relation to context	In harmony with other sectors of society	Part of a package of 'emergency relief measures'
Resource –use	Use a 'reasonable' share of overall resources	Use 'all resources that can be mobilized'
Technical dimension (rationalization)	Optimization (effectiveness and efficiency)	Maximization (effectiveness)
Social dimension	Autonomy and participation (responsiveness)	Dignity and compliance
Time perspective	Long Term	Short Term

2.1.3) Characteristics of Care

From the different paradigms of PHC and EMA result different characteristics of care (Table 2).[18] The objectives of PHC include maintenance and restoration of health (providing 'cures'); preventing further deterioration; relieving symptoms, particularly pain; offering assistance in coping with the inevitable; and providing reassurance through authoritative interpretation, while still exercising control over one's own health.[19] To reach the triple objective of cure, care and autonomy, health care should find the optimal balance between being effective,

[18] Van Damme W, Van Lerberghe W, Boelaert M, Primary health care vs emergency medical assistance: a conceptual framework. *Health Policy and Planning* **17**:49-60 Oxford University Press 2002

[19] Evans RG, Stoddart GL. Producing health, consuming health care. Social Science and Medicine 1990; **31**: 1347-63

integrated, continuous and holistic.[20] Effectiveness of care should be balanced with its cost and with the importance of holistic care. Integration of curative and preventive care with health promotion is desirable, as it yields the best results in the long term. Continuous health care means health till the end of the episode of disease or risk. Holistic health care takes into account the physical, psychological and social dimensions of health and well-being. In PHC the health care offered is variable according to circumstances and resources. It has to balance, both collectively and individually, the professionally defined need in terms of demand as expressed by the patient.

In EMA 'cure' is dominant over care and autonomy which are the secondary importance. The effectiveness of care takes absolute priority over the other characteristics. Integration is less important; it may even hamper immediate effectiveness. Continuity of care and holistic care are less important.[21] There are no top priority activities that require continuous care. In EMA the focus is on life-saving interventions.

Table 2. Characteristics of care in PHC and EMA

PHC	EMA
Triple objective: cure, care and autonomy	Cure is dominant over care and autonomy
Search for optimal balance between being effective, integrated, continuous and holistic	Effectiveness takes priority over other characteristics
Care provided is a compromise between need and demand	Need gets priority over demand

[20] Galand P, Mercenier P, Vandenbussche F. Du medecin de Famille au centre de sante integer. *Revue Nouvelle* 1971; **27**:73-80

[21] Grodos D. L'aide medicale d'urgance et l'enjeu des soins de sante primiares. *Annales de la Societe Belge de Medecin Tropicale* 1988; **68**:5-9

2.1.4) Characteristics of PHC and EMA health services

In PHC, temporal, geographical and financial accessibility are all important features of a health service that facilitate the delivery of effective, integrated, continuous and holistic care. Permanent facilities, with opening hours in accordance with people's activities, are mandatory for curative care (Table 3).[22] There is also a need for immediate access in case of emergency, even outside opening hours. Indeed, '...access when need arises may be the most salient feature of care for consumers...the stand-by function must be an integral part of the responsibility and of the work...to do otherwise would be, paradoxically, to be least effective when the client is most vulnerable.[23] Health services should be decentralized, to the extent that this is compatible with human and material resources needed for quality care.[24] Financial accessibility is important, but should be balanced with the need for financial participation of the clients. Financial participation can be a lever for community participation in decision-making and for accountability, especially at first line health services.[25] Polyvalence is necessary to enable integrated and holistic care. Acceptability, conditioned by cultural and financial accessibility, requires that all valued aspects of relationship between client and health care provider should be aimed at; for example, stability, maintenance of client autonomy and family ties, active client participation – sharing knowledge, shared decision making, and participation in carrying out therapy – empathy, supportive relationship, maintenance

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[22] Van Damme W, Van Lerberghe W, Boelaert M, Primary health care vs emergency medical assistance: a conceptual framework. *Health Policy and Planning* **17**:49-60 Oxford University Press 2002

[23] Donabedian A. Models for organizing the delivery of personal health services and criteria for evaluating them. *Milbank Memorial Fund Quarterly* 1972; **50**: 103-54

[24] Daveloose O. L'organisation de la zone rurale de sante de Kasongo, Zaire. Annales de la Societe Belge de Medecine Tropicale 1979; **59** (Suppl.): 127-36

[25] Criel B, De Vos P, Van Lerberghe W, Van der Stuyft P. Community financing or cost recovery: empowerment or social dumping? *Tropical Medicine and International Health* 1996; **1**:281-2

of dignity ,privacy and confidentiality. [26] A health information system with patient records, family files and operational cards facilitates integrated and continuous care.

EMA entails mainly the *ad hoc* delivery of life-saving interventions[27] Temporal, geographical and financial accessibility are paramount and take priority over other characteristics.[28] Maximizing access requires permanent facilities for curative activities (Table 3). Preventive activities can be intermittent. Decentralized services are paramount, especially when there is social breakdown. Home visitors are often necessary as outreach contacts, and to guide patients to the health services.[29] The quality of the relationship between the patient and the health care provider is subordinate to other characteristics.

Table 3. Characteristics of health services in PHC and EMA

	PHC	**EMA**
Temporal accessibility	Permanent facilities are mandatory for curative activities and for emergencies	Preventive activities can be intermittent
Geographical accessibility	Decentralization, balanced with quality of care.	Decentralized services are paramount, including home visitors
Financial accessibility and financial participation	A balance should be struck between financial participation and financial accessibility	Services should be free of charge
Polyvalent or specialized?	Polyvalence is necessary for integrated and holistic care	Specialized services are often needed
Relationship between client and health care provider	Whole range of valued aspects should be aimed at.	The quality of relationship is subordinate to other characteristics.

[26] Donabedian A. Models for organizing the delivery of personal health services and criteria for evaluating them. *Milbank Memorial Fund Quarterly* 1972; **50**: 103-54

[27] Perrin P. *Handbook on war and public health.* Geneva: ICRC, 1996; 1-446

[28] Grodos D. De l'aide d'urgence aux soins de sante primaries. Difficultes, pieges, enjeux. Medecine Tropicale 1988; **48**: 53-63.

[29] Hanquet G. Rigal J, Sondrop E, Vautier F. Health care in the emergency phase. In : MSF (ed) *Refugee Health.* An approach to emergency situations. London & Basingstoke: Macmillan, 1997: 124-44

2.1.5) Management and Support

In PHC, a district management team, composed of professionals with operational and administrative authority over the different health facilities, manages a health district. The district health management team should have a certain degree of autonomy to manage human and financial resources, and to establish priorities (Table 4).[30] Coordination with private not-for-profit facilities and regulation of private for-profit practices are needed.[31] District management requires balancing medico-technical logic (such as quality of care, rationalization of health services, etc); sociological logic (such as participation of the population, motivation of the staff, etc); and administrative logic (Health services as part of the Ministry of Health and wider society, civil servants, law, etc).[32] Health services should be responsive to epidemic alerts, and tackle them adequately. Control measures for most epidemic diseases are very effective, and adequate interventions may considerably improve the credibility of routine resources. Good quality of care, empathic relationships, dialogue during care, structure dialogue with the community, education, etc. are methods most indicated to improve utilization, coverage and adherence to therapy.

In EMA, the health system has to be managed by a team of professional people with full operational and administrative authority, and a high degree of autonomy to manage human and financial resources, and to establish priorities (Table 4). In EMA, the medico-technical logic is paramount; the administrative logic is often

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[30] Van Damme W, Van Lerberghe W, Boelaert M, Primary health care vs emergency medical assistance: a conceptual framework. *Health Policy and Planning* **17**:49-60 Oxford University Press 2002

[31] Bennett S. Promoting the private sector: A Review of developing country trends. *Health and Planning* 1992, **7**: 97-110

[32] Unger JP. *Role des districts sanitaires et methodologie de leur developpement en Afrique.* Bruxelles, Aggregation pour l'Enseignement Superieur 1991; 1-187

replaced by adherence to the institutional policy of relief agencies. Very high coverage of preventive activities may be necessary.

In both PHC and EMA the management needs two major supports: supplies and information. In PHC it is the sustainability of the supply system that is crucial; in EMA it is the speed and reliability of the supplies. Supply of standard kits, such as standard drug kit for 10,000 people for 3 months is often preferable. In PHC the design of the information system should support district organization and self-regulation. Its focus is on supporting quality of care, monitoring achievements and managing resources. In EMA the key issue is early detection of epidemics, using a disease surveillance system.

Table 4. Management of the decentralized system in PHC and EMA

	PHC	EMA
Management structure	Team of professionals with authority over the different health facilities in a health district.	Team of professionals with full of operational and administrative authority, high degree of autonomy.
Types of logic in management	Balancing the medico-technical, administrative and sociological types of logic	Medico-technical logic is paramount
Responsiveness to epidemic alert	Important	Paramount

2.1.6) Strategic Aspects

All these differences between PHC and EMA have important strategic implications for sustainability (Table 5), the role of different actors (Table 6) and accountability.

2.1.6.1) Managerial and financial sustainability

In PHC sustainability is paramount.[33] Different components of PHC should be developed harmoniously, and the health sector should be in harmony with the other sectors in the society. A programme format, becoming an integral part of health and

[33] Foltz AM. Donor funding for health reform in Africa: Is non-project assistance the right prescription? *Health policy and planning* 1994; **9**: 371-84

social policy, is thus preferred over a project format (table 5).[34] The 'programme – project' typology is very similar to the 'development – disaster/emergency' typology. Both typologies can be largely superimposed, and thus also many of their characteristics (such as time perspective, role of different actors, funding, etc). The project format can, however, be justified to innovate, or to facilitate management of a particular part of a programme. Most often, however, foreign donors impose a project format to facilitate financial accountability. Institution building and institutional strengthening are important to obtain managerial sustainability (table 6). In PHC there is often cost sharing between government, international donors, and users.[35] Cost constraints are often overriding, efficiency and sustainability are important considerations. To be sustainable, health services should be organized at 'affordable' cost.

In EMA, project format is often preferable. Developing EMA as a programme, with its corollary of institutional building, may hinder timely abolition or integration in the PHC programme. Institutional strengthening is thus of low priority. In EMA, efficiency is less important than PHC. To be effective in the very short term, important resources are needed, and these originate them exclusively from international donors. Funding is thus usually not the main constraint. Sustainability is not a major concern.

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[34] Mburu FM. Non-Governmental Organization in the health field: collaboration, integration and contrasting aims in Africa.*Social Science and Medicine* 1989; **29**: 591-7

[35] Ebrahim GJ. The Bamako initiative *Journal of Tropical Pediatrics1993; 39:66-7*

Table 5. Sustainability in PHC and EMA

	PHC	EMA
Project vs Programme approach	Programme format is usually preferable	The Project format is usually preferable
Institutional Strengthening	Important to obtain managerial sustainability	Of low priority
Importance of cost constraint	Often paramount; to be sustainable health services should be organized at 'affordable' cost.	Limited, funding from international donors. Sustainability is not an aim
Sources of funding	Cost-sharing between government, international donors and users	Often exclusively funded by international donors.

2.1.6.2) Actors

PHC is a local and public responsibility.[36] Collaboration with the local administrative and political authorities is necessary to imbed health services in the overall society (Table 6)[37]. The Central Ministry of Health (MOH) has an important role in resource allocation among areas and programmes; it must set norms and regulate (stewardship).[38]-[39] The MOH should develop policies on manpower and training, on health care financing, on pharmaceutical supply and quality control, etc. Outside assistance may be necessary, but there is then also a higher risk of non-appropriate solutions, with a dominance of the technical dimension over the social one. The role of foreign support should be only of a technical assistance; otherwise, the feeling of 'ownership' may be absent.[40]-[41]

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[36] Chobat HT, Bremmers J, Government Health Services vs community: Conflict or Harmony. *Social Science and Medicine* 1988;**26**:957-62

[37] Van Damme W, Van Lerberghe W, Boelaert M, Primary health care vs emergency medical assistance: a conceptual framework. *Health Policy and Planning* **17**:49-60 Oxford University Press 2002

[38] Anon. Conference consensus statement: toward evidence based health care reform.In: Nitayarumphong S (ed). *Health Care Reform. At the frontier of research and policy decisions.* Notabury: Ministry of Public Health, 1997:12-14

[39] Van Lorberghe W, Ammar W, El Rahidi R, Awar M, Sales A, Mechbal A. Reform follows failure: II. Pressure for change in the Lebanese Health Sector. *Health Policy and Planning* 1997 ; **12**: 312-19

[40] Mburu FM. Non-Governmental Organization in the health field: collaboration, integration and contrasting aims in Africa.*Social Science and Medicine* 1989; **29**: 591-7

[41] Santing CA. Management structure for operation between NGOs and district health authorities. *Memisa Med* 1995; **61**: 69-77

Temporary situations may only be justified as an interim measure in a situation where local capacity is inadequate, and on the condition that there is a perspective for local takeover, otherwise sustainability could be jeopardized.[42]

The long term perspective and the necessary capacity building require long term involvement of the same staff. Staff will thus often be health professionals on long term contracts, with attention of career structure and promotion possibilities. Work with on-the-spot trained auxiliaries may yield some short term results, but often leads into a dead end in the medium term. This is well illustrated by the failure of most so-called primary health care programmes based on the wide-scale training of village health workers. Although they may have generated some short term results they quickly lead to a dead-end.[43] However, training at all levels is an important component of PHC.

In EMA, the decision makers will often be outsiders - UN agencies and other representatives of the international community. Paramount is the expertise and the ability to mobilize and manage the necessary resources. Links with the local health communities are useful, but lines of authority should be simple and straight. Links with administrative and political authorities are necessary. However, this is more to pay respect and to avoid obstruction than to involve them in decision making. The role of central MOH is often limited. Staff will often be recruited among beneficiaries and work with short term contracts. There may be a need to work with on-the-spot trained auxiliaries. Training is often geared to obtaining execution of standardized key

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[42] Kegels G. Sustainability. *Medicus Mundi International Newsletter* 1995;**55**:5-10

[43] Unger JP, Killingsworth JR, Selective a primary health care: A Critical review o methods and results. *Social Science and Medicine 1986*; **22**:1001-13

tasks from auxiliaries. Private non-profit actors, especially international NGOs, presently dominate EMA.[44]

Table 6. Actors in PHC and EMA

	PHC	EMA
Identity of decision-makers	Local.	Often outsiders
Relation with local authorities	Collaboration is necessary	Links are necessary
Role of central MOH	To allocate resources, to set norms and to regulate (stewardship).	Often very limited
Role of foreign assistance	Mainly as technical assistance	Substitution is often needed
Manpower policy	Staff is mainly constituted of health professionals on long-term contracts. Training is important	Staff often recruited among beneficiaries, with short term contracts. Training geared to execution of standardized tasks.
Public / Private	PHC managers will have to come to terms with private health care, both non-profit and for-profit	Dominated by private non-profit actors

2.1.6.3) Accountability

In, PHC and EMA in developing countries, the funding agency, frequently a foreign aid donor, and the clients (the beneficiaries of the aid) more often than not have different agendas and preferences. It seems thus appropriate to distinguish accountability to the donor from accountability to the beneficiaries. In relief and aid, this distinction roughly coincides with the distinction between financial accountability and social accountability.

In PHC, it is now widely accepted that health services have a responsibility to the population, and not only to the users who present to the health service. A step further is being accountable to towards that population.[45] The style of governance and the degree of participation in the wider society will determine how financial and social accountability are valued and practiced in the health services. When client

[44] African Rights, *Humanitarian unbound? Current dilemmas facing multi-mandate relief operations in political emergencies.* London; African Rights 1994; 1-39

[45] Lambory JL, McLaughlin J, Niimi R, Knippenberg R. *Health Centers: from responsibility to accountability.* Antwerp: ITG Press 1997;1-32

participate financially in the health services, this can be used as a lever to increase both financial and social accountability.[46]

In EMA, discussions on accountability have usually focused more on financial accountability than on social one. Financial accountability of implementing agencies to donors – with its corollaries – bureaucratic regulations and financial audits. – have steeply increased over the last decade. But social accountability remains largely on the level of good intensions. In disasters, decision makers often feel accountable to their employees – international agencies and to their NGOs – who claim who claim to be themselves accountable to the beneficiaries, the 'victims'.[47] However, agencies' own agendas, bureaucratic logic and short term timeframe may hamper understanding of the beneficiaries' perspective.

2.1.7) Between Primary Health Care and Emergency Medical Assistance

If PHC is the appropriate strategy in a society in development, and EMA in the case of an emergency, many real life situations are somewhere in between. Figure 1[48] (on the appendix) shows a range of development and emergency situations, characterized by different degrees of political stability, social, sanitary and health situations. Stable situations with economic growth and functioning public services are probably optimal for development. This is the case when government is stable and consistent, and there is economic growth and a strong public service. In other development emergency situations, creative compromise strategies will have to be worked out, adapted to the local situation, and have to be adjusted over time, with changes in the situation. Similarly, HKCC functions as a Primary Health Care in most

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[46] Pangu KA, VanLerberghe W. Self-financing and self-management of basic health services. *World Health Forum 1990*, **11**:451-4

[47] Cuny FC. *Disasters and Development.* Oxford: Oxford University Press ,1983; 1-278

[48] Van Damme W, Van Lerberghe W, Boelaert M, Primary health care vs emergency medical assistance: a conceptual framework. *Health Policy and Planning* **17**:49-60 Oxford University Press 2002

of the times and assumes Emergency Medical Assistance responsibilities in times of crisis

2.2) An Overview of Socio Economic Situation in Bourj Hammoud

2.2.1) Geographical Context

The area of Bourj Hammoud (BH) is situated at the north-eastern side of the city of Beirut. It is the nearest town to Beirut and its city center where the River of Beirut separates the municipal borders of Beirut and Bourj Hammoud. BH is administratively within Caza of Matn and the Mohafazat of Mount Lebanon. BH official borders stretch from Bouchrieh at the North, City of Beirut and its river from the South, Sin el Fil and Dekwaneh from the East and the Mediterranean Sea from the west.

2.2.2) Historical Evolution

The Armenian community arrived in Lebanon in 1922 as a result of the Turkish prosecution and the genocide that Kemalist Turkey committed against the Armenian community in Turkey. Around 10,000 Armenian refugees arrived in 1922 to Beirut fleeing Cilicia and other Turkish regions. It was followed in 1939 by another wave of refugees from Alexandretta.

The Armenians, first settled in the 1920s in temporary housing in the vicinity of Beirut. The first Armenian camp was built in 1922 in the Quarantina area near the port of Beirut, a location used originally as a quarantine area since the 19th century[49]. The Armenians gradually moved outside that camp to relocate in permanent housing in the nearby areas. As early as 1924 and climaxing in 1930s, Armenians re-settled in

[49] Fawaz, Mona and Peillin, Isabelle (2003) ' The Case of Beirut' in Understanding Slums: Case Studies from the global report on human settlements. London: Development Planning Unit

the area of Bourj Hammoud at the east bank of Beirut River, originally a marsh and agriculture area cultivated by local Maronite families.

Today, the Armenian community is well integrated in the Lebanese political life. Armenians have six seats in the Parliament and actively participate in the government.

The town of Bourj Hammoud has currently the highest ratio of Lebanese Armenian citizens, which is estimated at 39.8% of all Armenians living in Lebanon[50].

2.2.3) Demographics

There is no exact figure about the population of Bourj Hammoud. The number of registered population is 50.000 whereas the number of voters is 10.000. The Municipality estimates the current population at 150,000. However, based on number of households (21.000 as estimated by Municipality revenues) and the average family size, the population of BH could be estimated at 90.000.

The average family size of Armenian community of Bourj Hammoud is 3.8[51]; less than the national rate which is 4.3[52]. The Bourj Hammoud community is young where those under 18 represent 29.5% of the population.

2.2.4) Households

Most of the buildings are legal and were built in the 1930s and 1940s. Buildings are 2-3 floors with a number of small flats in each building. One and two-bedroom flats constitute the majority of houses in BH with an estimate of 51.3% of the total houses in BH. Almost half of the community lives as tenants (47.7%) with an average rent of $200 per month[53].

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[50] 'The Survey of Living Conditions and Social Needs of Armenians in Lebanon' conducted by the Jinishian Memorial Program (JMP) in 2002

[51] ibid

[52] CAS findings of living condition study, 2005

[53] ibid

Deficiencies in urban planning have resulted in lack of green and in public spaces. The haphazard urban form carries consequences on the environmental conditions in the cluster by causing crowding, hampering plans for setting-up an infrastructure for youth and children activities, and exacerbating problems of air pollution.

2.2.5) Infrastructure

The infrastructure is gradually improving. Almost all houses are connected to the water network as well as to the wastewater disposal network. Houses are also connected to the power network provided by the Electricicte Du Liban (EDL.)

Roads however are very narrow and street vendors use pavements in some of the inner roads. In the main commercial streets, the Municipality polices the streets and prevents any congestion. Arax Street is also very well-organized in terms of traffic and in making some sections exclusive for pedestrians. Most streets are lighted and the Municipality is planning to install lights in the few remaining streets.

2.3) Recommendations made by World Vision Organization to Upgrade the Living Conditions of Bourj Hammoud

The study that was done by the World Vision Organization entitled "Area Assessment of Bourj Hammoud and Sin El Fil", describes the typical characteristics of areas with urban poverty where poverty is worsened by a combination of socio-economic, demographic, and environmental issues. Social and demographic conditions are accompanied with overcrowding and deterioration of health and environmental conditions of households. The poor social condition coincides with educational underachievement and high dropout rates. It also reflects into un-

specialized and untrained workforce, and limited employment opportunities that are capable of absorbing the increase in the labour force.

In this context, an urgent need to upgrade the living conditions of the communities in the area is identified. Proposed interventions are in line with five main axes:[54]

- Developing the local economy and tapping on the existence of productive and viable economic sectors in the area.
- Improving the educational status of local community.
- Abolishing risks affecting human health (environmental, housing conditions and poor access to medications).
- Increasing potentials for human development (women empowerment, social integration of vulnerable groups, youth development).
- Strengthening social capital and community relations.

As we can see, there is a need for community development efforts. The role of a Primary Health Care Center should be to upgrade the living conditions of Bourj Hammoud.

In the next chapter, we will explore the vision, mission, historical trends and activities of HKCC and investigate its roles. We will pin point the services that HKCC has developed throughout the years that have the basic objective of community development.

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[54] Area Assessment Report: Bourj Hammoud and Sin El fil,Local Situational Analysis, Issues and Possible interventions, **World Vision Publication, P.8-10**

CHAPTER THREE
Howard Karagheusian Commemorative Corporation (HKCC)

3.1) History:

During the First World War, 1914-18, the Armenian population of Turkey was ruthlessly deported, by order of central government, from its ancestral home in Armenia (Eastern Turkey) as well as from other regions of the country where they had long been living. Most of them perished, either through slaughter or privation and disease. Among the survivors were several hundred thousand orphans in a pitiful state. As soon as conditions allowed, Armenian and non Armenian – mostly American- welfare agencies hastened to physically rescue these homeless children and also ensure their mental and moral development.

At the same time as these children were staying in the wastes of Anatolia and Syria, living on herbs and roots, a fourteen year old boy, smitten with pneumonia in the spring of 1918, was breathing his last in a well-to-do-home in New York. His father, MIHRAN KARAGHEUSIAN of New York, rug manufacturer, and his wife Zabel vowed that their beloved Howard would not have died in vain. By 1921 they have made up their minds; they would start a foundation the purpose of which would be: to perpetuate Howard's memory by striving to save from disease and consequences of ignorance deprived children of the Armenian people of which Mihran and Zabel themselves have been part. They were doubtlessly motivated in their choice of this purpose, as much by the topical emergency mentioned above as by the source of their own bereavement. In the same year, a "Howard Karagheusian Commemorative Corporation" was registered in the State of New York. It was to be managed by a board of Directors in New York City, the members of which would consist of Mihran himself and a

few kinsmen and friends of his choice. In 1943 HKCC started its services in Beirut, Lebanon

3.2) HKCC Vision:

- To provide the complete well-being of the child
- To relieve those in distress and endeavour to their physical, moral, and social development within their families and their environment

3.3) HKCC mission:

- To follow the child in the family, in the school, in the street, in his environment, in his leisure time and prepare him or her to meet the difficulties of time.

HKCC will provide all health and social services to the child for his harmonious development in his family and environment.

HKCC will perform its mission through inter-active medical and social services developing programs that answer the needs of physical, mental, moral and social growth of the child.

HKCC will strive to pursue its programs directed by the precepts of professionalism, continuity and long term follow up.

3.4) HKCC Services:

The good health and the full growth of the child being the primary and greatest concern, The Howard Karagheusian Commemorative Corporation extended its Lines of Services in many directions in order to fulfil its mission.

3.4.1 Mother and Child Department

3.4.2 School Health Services

3.4.3 Social Assistant Services

3.4.4 Social Center Activities

3.4.1) Mother and Child Department:

In pursuing its mission, the Karagheusian work developed year by year in medical and social services aiming to help the families to raise up their children healthy and in full bloom.

The health and well-being of the children and the mothers remained the core of HKCC actions. It is from here that all of the other services proceed and extend to follow the child in the family, in the school, in the street, in his environment, in his leisure time and to prepare him or her to meet the difficulties of life.

3.4.1.1) Pediatric Clinic: Consultation for TREATMENT

The pediatric service is for infants mainly up to five years old. In the pediatric clinic HKCC has two doctors, two nurses, two auxiliary nurses and one secretary. The clinic is open 6 days per week.

3.4.1.2) Vaccination for PREVENTION:

The vaccination program is greatly influenced by the vaccination campaign launched by the government, the media, and also by the supply of vaccine through the ministry of health.

3.4.1.3) Milk Distribution Service for ASSISTANCE:

Social Workers and Nurses continue to keep a list of needy mothers with babies above six months and below two years who have difficulties to feed their babies normally. The Milk Mothers program is of great help for such families. HKCC provide yearly almost two tons and a half of powdered milk, full cream, and a few cans of formula milk.

3.4.1.4) Well Baby Service for EDUCATION:

The Well-Baby Service is part of mothers' education system. Besides the lectures, demonstrations and counseling, this service proposed to mothers the regular medical follow-up of their baby's growth by a pediatrician at least once a month without waiting that a health problem occurs.

About thirty young mothers of babies below 18 month of age benefit from the regular complete pediatric consultation and counseling. The well baby service is aimed to teach young mothers to keep a watchful eye on the health and growth of their babies with regular visits to the pediatricians.

3.4.1.5) Obstetric and Gynecologic Services (OBS-GYN)

The Gynecologic clinic started in 1988. The aim of the OBS-GYN clinic is to serve the young mothers who come to seek advice and some instructions or to consult a gynecologist.

Frequent lectures and talks are organized by this department to encourage the tests and exams for early detection of breast cancer and regular follow up during pregnancies.

3.4.2) School Health Services:

In order to continually follow up the well-being of the child, HKCC extended its arms to reach Armenian and non Armenian schools. Today HKCC serves 33 schools.

From the first week of October circular letters are sent too all Armenian school administrations offering HKCC school health services as follows:

3.4.2.1) Medical check up for all elementary classes:

The school health staff is divided into two teams, each team having a pediatrician and two nurses.

3.4.2.2) Ophthalmologic services for all students

Besides pediatric care, ophthalmology was a great concern due to the prevalence of trachoma and eye diseases in several countries of the region in the forties and fifties. Systematic vision testing in school started in 1954 with 2574 children tested in 10 schools .The vision testing team is composed of an ophthalmologist and three nurses.

3.4.2.3) Dental care and tooth decay prevention programs

Dental care and department is also divided in to two teams. The first team is composed of a doctor and an auxiliary nurse who visit the schools for dental check ups. The second team is composed of a dentist and two auxiliary nurses who stay at the clinic and treat the children who have dental and teeth decay problems.

3.4.2.4) Milk drinking in kindergartens and first elementary classes:

In providing nutrition support to the children, one ton and a half of milk powder together with cookies is distributed to the schools and nurseries every year.

3.4.2.5) Audiology services / Speech therapy sessions

The Audiology services started in 1989 went on with frequent interruptions with self trained audiometrists who succeeded one another.

Parallel to the audiology service, and with the same staff, two weekly sessions of speech therapy are held on computerized speech viewer to correct some minor speech defects for some children.

3.4.2.6) School sanitation products

The school health team workers during their visit to the schools, check up the school sanitation system to see and appreciate cleanliness and sanitary conditions. All schools are offered primary products and first aid kits.

3.4.3) Social Assistant Services

Social assistance program have grown during the years of Lebanese Civil war (1975-1991) and continued to grow since, because of economic crisis and in the aftermath of war.

The social Assistance service is divided into four parts:

3.4.3.1) Medical Assistance:

According to a survey of the international labor office, it was reported already in 1999 that 48 per cent of the Lebanese population were living below poverty level. Now the situation is not better.

Families can hardly survive with limited income, if any. Half of the population in general cannot cope with the medical and hospitalization expenses. Furthermore, HKCC medical assistance program has been generated to provide help and support for the families who need medical assistances

3.4.3.2) Family Service:

The general stagnation of the Lebanese economy continued and aggravated the living conditions of the Lebanese people.

Education and health expenses put a series of strain on the average middle class family budget hardly enough for the daily living.

How the families with children and without regular income or completely destitute families will survive? HKCC strives to do its best through its devoted social workers to be always available for counseling and guidance, and also for aid and encouragement, despite its modesty of help compared to the huge needs.

3.4.3.3) School Social service:

The increasing social problems in the families affect directly the school children in their school life. Teachers at the school are not properly trained to detect or handle some social problem child cases. The presence of psychologists or a trained social worker is necessary. Hence, HKCC was proactive to enter in that area and opened a new service under the umbrella of social assistance services.

3.4.3.4) Community Empowerment:

Community development / community empowerment can be defined as a system of social interventions in which the worker by entering into people's familial and social lives, and by helping developed groups within the community, tries to empower people with the basic knowledge of coping with everyday problems.

Working with a community should have common purposes and should deal with specific circumstances that are of interest and concern to the community.

To start a community work, it is a necessary step to form a group within the community, since people have a basic need for the group experience, believing that from our earliest beginnings we have bended together for help, survival and security.

Community work should be planned on the basis of established needs, so that the service is relevant to their concerns.

Strongly believing in prevention social workers turned their attention lately (the last three years) to community empowering campaign. Instead of trying to solve a problem or a breakdown individually or after occurrence, HKCC aims at enabling the families through community empowerment projects, to manage people's life more easily, and avoid the occurrence of crisis or a breakdown. This is done through educating young mothers with the basic needs of familial and social life and creating an atmosphere of belongingness.

For community empowerment campaign, HKCC has divided the area that it serves into three separate groups, where each group is about 70 women, and each group has its own social worker as its responsible.

3.4.4) Social Center Activities

Family, schools, churches, associations and social agencies like HKCC have to work together for the physical, mental, moral, and spiritual uplift of children. HKCC's role is to stress the importance of a common effort toward the achievement of this sacred mission.

HKCC has been the place where these endeavours are joined for a better result.

Thus, HKCC Social Center remained open to all the community around for children's programs as well as for youth and adults social and educational activities in order to develop in them their potentialities to face life's hardships and work their place and dignity in the society.

Programs for out of school children, for working youth, for illiterate adult and for ignorant young mothers are valuable support to enhance development of the community. This is the mission of the Beirut social center activities. Hence, the Social Center activities are divided into the following parts:

3.4.4.1) Social Reintegration and Empowerment of school Drop Out Programme:

Bourj Hammoud area is considered one of the poor suburbs of Beirut district. Social problems are more noticeable in these areas because of overpopulation. A quick investigation in the 8 schools in the area under the HKCC social and medical supervision brought out that about 7% of the school children in the area leave classes before reaching the sixth elementary. These drop outs are threatened to become social delinquents. Exhaustive

programmes of prevention, reintegration and follow up of school drop outs are necessary to diminish the problem. The objective of this programme is the following:

3.4.4.1. Preventive work: in order to prevent school children from drop outs, a study room is created. The purpose of this study room is for tutorial sessions given to the students who need further help with their lessons.

3.4.4.2. Integrating young drop outs into the life of community: this programme is two folds: Morning Programme called "Girls at Risk" and Evening Programme called "Evening Sessions for Working Teens"

3.4.4.2.1) Girls at Risk Programme: (8:00 am till 2:30 pm) the focus of this programme is to gather teenage school drop out girls and teach them basic languages, computer skills, hygiene courses, baby care, nutrition, arts, home economics and cooking sessions.

3.4.4.2.2) Evening Sessions for Working Teens: The evening programme runs three days per week for working teens (boys and girls). Language sessions, computer courses, preventive lectures and group works are given to the evening classes having a social worker as a supervisor. This programme is similar to the Girls at Risk Programme but on a smaller scale.

3.4.4.2) Vocational Training Programmes

These Vocational Training Programmes are implemented because the visitors at HKCC have suggested to have these skills. Currently HKCC has the following Vocational Training Programmes:

3.4.4.2)1. Cooking Class: This class is run by a young chef. These re series of courses, demonstrations, cooking, dish decorations and table setting activities. Besides cooking classes, the ladies take sessions related to nutrition and healthy habits in cooking and eating. Upon the completion of the course the attendants receive certificates.

3.4.4.2)2. Make Up Course: This course emanated by a group of ladies who organized themselves and made arrangements with the teacher to run this course. This course is given with great expertise and knowledge and proved to be very helpful, not only attractive but also profitable. Some of the students found a job right away and began to earn some money to help their families.

3.4.4.2)3. Macramé, Ceramics, and Beading Embroidery: As the demands for hand made products are increasing and becoming fashionable, the launching of HKCC handicrafts courses were at time useful and geared to meet the demand for the beneficiaries. Here they have a unique opportunity to explore the world of creation and the nuances of handicrafts, showcase their traditional strength and use the acquired skills

in different prospects. In 2006 25 ladies benefited from the given courses.

3.4.4.3) Children's summer playground:

For the children aged 5 to 10 years old. This is an age when children can learn a lot and assimilate easily good principles of healthy behaviour, respect, cooperation, cleanliness, safeguard of environment and service. The playground activities consist of indoor and outdoor games, handicrafts, outings, playing and eating together, celebrating birthdays.

3.5 Internal Organization's Culture:

A strategy supportive culture reflects the Organization's own ingrained beliefs, behaviour and thought patterns, business practices and personalities.

The taproot of corporate culture is the organization's belief and philosophy about how its affairs ought to be conducted – the reason why it does the way it does. An Organization's culture is manifested in the values and business principles that management preaches and practices in its ethical standards and official policies, in its stakeholder relationships, in the traditions the organization maintains, in its supervisory practices, in staffs' attitudes and behaviours, in the legends people repeat about happening in the organization as well as in the organization's politics. All these sociological forces combine to define an organizational culture.

The culture of HKCC:

- The role of the story: every member of HKCC knows the history and the purpose of The Howard Karagheusian Commemorative

Corporation. Hence, the story vividly communicates the kind of commitment the company wants every member of the Karagheusian family to exhibit in helping the company to live up to its service and ministry.

- Service oriented:

The work of HKCC from its origin is based on service oriented culture. The ultimate aim of HKCC is to provide the necessary support needed for the complete well-being of the child - whether it is physical, social or educational. Hence knowing its purpose, the management, the staff, the nurses as well as the doctors at HKCC emphasize the importance to be service oriented. This service oriented attitude makes a positive influence on the public they serve. The service attitude generates out of love, compassion, generosity, humility and concern to the people in need.

Being service oriented, the staff feels that their efforts actually contribute to the organization's objectives.

- Internal meetings / gatherings / Celebrations:

Every month HKCC staff gather with the management in order to discuss some critical cases that each department has faced. The gathering is an open discussion and the management is always open to new and creative suggestions or ideas that arise from the staff for the purpose of providing the best service needed for the complete well-being of the child.

Furthermore, in the effort of perpetuating the culture, the management reminds the employees the purpose and role of HKCC through regular ceremonies and yearly requiem in memory for Howard, Mihran and Zabel Karagheusian. Every member of Karagheusian Association knows the purpose, role and the vision of HKCC.

3.6) Managerial and Financial Sustainability:

Today HKCC has its Board of Directors who manage from its headquarters in New York. HKCC has its own Local Advisory Committees who are elected to support the different districts where HKCC has its branches. In Lebanon, along with the director of HKCC Rev. Robert Sarkissian, a Local Advisory Committee meets with the director regularly to evaluate and manage the center in an effective manner.

The staff profile at HKCC is balance in (1) medico – technical logic, through its doctors and nurses, (2) sociological logic, through its social workers and (3) administrative logic by having its administration, accountant, secretary and assistant to the director.

HKCC is a sustainable association and has its own fund delegated for different programmes. Of course, in health and development domain, programme approach is used instead of the project one.

The financial chart for the HKCC Lebanon (for the last three years: from 2004 till 2006) is included in the appendix.

CHAPTER FOUR

RESEARCH METHODOLOGY

Prior to moving to the details of hypothesis development and statistical analysis, the current chapter shall discuss the research methodology applied in the treatment of the data employed in the study.

4.1 The Research Method Used

The research method utilized in this study is the descriptive one; it attempts to portray the impact of HKCC as a PHC as it exists at the time of the study and to explore the causes of particular phenomena. Thus this study utilized only primary data via questionnaire survey.

Through a standardized questionnaire developed in order to acquire uniform information and quantify responses, two hundred and nine clients (beneficiaries) were interviewed as well as twenty two of HKCC staff.

4.2 The Respondents of the Study

A Questionnaire was distributed randomly to the beneficiaries who have visited the different departments at HKCC during the month of March 2007 (from March 1st till March 31st of the year 2007). Similar questionnaires were distributed to twenty two staff members of HKCC during the same month. One to one approach was used with each beneficiary. It was stated clearly during the filling of the questionnaire about the purpose and importance of answering each question sincerely. Both quantitative and qualitative methods were used to analyze the responses.

4.3 The Instruments Used (Appendix B)

The questionnaire survey through direct personal interviews was the primary statistical tool used in the research. Such a tool was selected for the research for more then one reason: first, the sensitivity of the information gathered and the need for accurate and honest responses; the sensitivity of the interviewees towards the nature of information disclosed as most of them asked for confidentiality; and the opportunity of getting additional useful information that might help build hypotheses.

In order to evaluate the services of HKCC, a survey-questionnaire (Appendix B) was prepared along with five major sections; these sections are the following:

- Section 1: Introductory section highlighting background information of the respondent such as age, gender, place of birth, current location, family status, sect, number of children.
- Section 2 is designed to allow the collection of specific information regarding the social background of the respondent such as employment status, family income and family medical insurance coverage.
- Section 3 is designed to see the number of times that the respondents visit other Primary Health Care Centers in the region of Bourj Hammoud. A Primary Health Care Center in Bourj Hammoud called Armenian Relief Cross in Lebanon (ARCL) and a Community Development Center called Jinishian Memorial Program (JMP).
- Section 4 includes questions relating directly to HKCC, it has several parts that deal with the degree of availability, satisfaction (with the staff and different services of HKCC), degree of effectiveness, degree of medical satisfaction and degree of autonomy / participation of the respondents in the decision making process of HKCC. Likert Scale was used with five response

choices to address the level of satisfaction by the respondents (1 as being not satisfied and 5 as being satisfied)

If the average level of satisfaction is greater or equal to 4.5 then, the people on the sample questionnaire are satisfied.

- Section 5: The last section is the qualitative part. Three different questions were addressed to the respondents to collect different suggestions and to see the people's perspective regarding the strengths and the weaknesses of HKCC

4.4 The Statistical Treatment of the Data

Upon the collection of all data, the Statistical Package for Social Sciences (SPSS), version 11.5, was used as an aid in the process of the statistical analysis of the data. The data analysis focused on the assessment of the perceptions of the different clients of HKCC.

Moreover, a cross-tabulation was used in describing the demography of all respondents, and an analysis of variance (ANOVA) test was used to compare the means for various levels of satisfactions.

Hypothesis is a statement about the population which is either true or false. Null Hypothesis (H0) is the hypothesis being tested and Alternative Hypothesis (H1) is the opposite of H0.

The hypotheses being tested of this study are described on pages number 45 - 48 and 51 – 52:

In addition of the abovementioned hypothesis testing, we have conducted chi square test to further clarify geographical accessibility of HKCC.

CHAPTER FIVE
RESEARCH FINDINGS

This chapter will be divided into two major sections; the first one is the descriptive statistics of the clients visiting HKCC, the second section is hypothesis and relationships testing

5.1) Descriptive Statistics of the clients visiting HKCC

Response Rate of the clients

The response rate of the study was 100%, since all the interviewees accepted to participate in the study. However, my sample constituted 17.65% (or 209 respondents) of the total population which was 1184 visitors of the different departments at HKCC during the month of March 2007. The breakdown of the clients who have visited all the departments of HKCC is the following:

Table 7: the total clients who have visited HKCC

Department / service	Number of visits
Obstetric and Gynecologic (OBS – GYN)	193
Pediatric clinic & Vaccination	295
Ophthalmologic Clinic at HKCC (OPTH)	248
Dental Clinic	138
Social Workers Department	310
Total number of visits at HKCC	1184

Response Rate of the HKCC staff

The overall response rate of the HKCC staff was again 100%. The sample size was 70.96% (or 22 respondents) of the total population of HKCC staff which was 33 during the month of March 2007.

Exploratory Survey Results (Appendix C)

The exploratory survey results are found on the appendix C.

5.2) Hypotheses and Relationship testing:

In this part we will examine whether HKCC is accessible for all. Then its services will be evaluated in terms of their level of effectiveness and efficiency.

By effectiveness we mean doing the right things, hence the level of satisfaction of the clients is tested. This satisfaction level has two dimensions; the satisfaction about the effectiveness of the staff (or care givers) and the satisfaction about the different services of HKCC.

By efficiency we mean doing the things right, hence this time the level of satisfaction is tested in accordance to the availability of staff and their time management.

5.2.1) Geographical Accessibility

A PHC should be geographically accessible to all. In this research, the respondents who live in the area of Bourj Hammoud, those who live outside Bourj Hammoud, and the frequency of their visits are as follows:

Table 8: The visitors who live in Bourj Hammoud and outside Bourj Hammoud and the frequency of the visits

Number of visits	Living in Bourj Hammoud	Living outside Bourj Hammoud	**Total**
more than once/week	8	1	**9**
Once/week	11	2	**13**
Once/month	105	17	**122**
Once / 3 months	31	10	**41**
Once / 6 months	20	4	**24**
TOTAL	**175**	**34**	**209**
Percentage	83.73%	16.27%	16.27%

If we look at the table above, we notice that 83.73% of the visitors are from the Bourj Hammoud while 16.27% are from outside Bourj Hammoud. We can say either that the center is accessible for the Bourj Hammoud population only or the center is equally accessible to all. To do this, we have to calculate the proportions of the visitors from inside Bourj Hammoud and from outside the area.

Table 9: the proportions of visitors who live in Bourj Hammoud and outside Bourj Hammoud and the frequency of their visits

Frequency of visits	Proportions of visitors Living in Bourj Hammoud	Proportion of visitors Living outside Bourj Hammoud
more than once/week	4.57%	2.94%
Once/week	6.29%	5.88%
Once/month	60.00%	50.00%
Once / 3 months	17.71%	29.41%
Once / 6 months	11.43%	11.76%

Can we conclude that the proportion of visitors from the Bourj Hammoud area visiting the center more than once per week is significantly different from the proportion of visitors outside Bourj Hammoud area? Here we have to set the hypothesis statements for the five visiting status:

5.2.1.1. Visiting more than once / week

5.2.1.2 Visiting once / week

5.2.1.3.Visiting once / month

5.2.1.4.Visiting Once / 3 months

5.2.1.5.Visiting once / 6 months

5.2.1.1.) Visiting the center more than once / week

Null Hypothesis: Proportion of visitors from the Bourj Hammoud area visiting the center *more than once per week* is equal to the proportion of visitors living outside Bourj Hammoud area.

Alternative Hypothesis: Proportion of visitors from the Bourj Hammoud area visiting the center *more than once per week* is **not** equal to the proportion of visitors living outside Bourj Hammoud area.

Table 10: Hypothesis test for two independent proportions of visiting the center more than once / week

	p1	*p2*	p_c	
	0.0457	0.0294	0.0431	p (as decimal)
	8/175	1/34	9/209	p (as fraction)
	8.	1.	9.	X
	175	34	209	n
		0.0163	difference	
		0.	hypothesized difference	
		0.038	Std. error	
		0.43	Z	
		.6683	p-value (two-tailed)	

According to the sample data, we do not have enough evidence to reject that the two proportions are equal because the p-value is very high (0.6683)

5.2.1.2. Visiting the center once / week

Null Hypothesis: Proportion of visitors from the Bourj Hammoud area visiting the center *once per week* is equal to the proportion of visitors living outside Bourj Hammoud area.

Alternative Hypothesis: Proportion of visitors from the Bourj Hammoud area visiting the center *once per week* is **not** equal to the proportion of visitors living outside Bourj Hammoud area.

Table 11: Hypothesis test for two independent proportions of visiting the center once / week

	p1	*p2*	p_c	
	0.0629	0.0588	0.0622	p (as decimal)
	11/175	2/34	13/209	p (as fraction)
	11.	2.	13.	X
	175	34	209	N
		0.004	difference	
		0.	hypothesized difference	
		0.0453	std. error	
		0.09	Z	
		.9290	p-value (two-tailed)	

According to the sample data, we do not have enough evidence to reject that the two proportions are equal because the p-value is very high (0.9290)

5.2.1.3. Visiting the center once / month

Null Hypothesis: Proportion of visitors from the Bourj Hammoud area visiting the center *once per month* is equal to the proportion of visitors living outside Bourj Hammoud area.

Alternative Hypothesis: Proportion of visitors from the Bourj Hammoud area visiting the center *once per month* is **not** equal to the proportion of visitors living outside Bourj Hammoud area.

Table 12: Hypothesis test for two independent proportions of visiting the center more than once / month				
	p1	*p2*	p_c	
	0.6	0.5	0.5837	p (as decimal)
	105/175	17/34	122/209	p (as fraction)
	105.	17.	122.	X
	175	34	209	N
		0.1	Difference	
		0.	hypothesized difference	
		0.0924	std. error	
		1.08	Z	
		.2791	p-value (two-tailed)	

According to the sample data, we do not have enough evidence to reject that the two proportions are equal because the p-value is very high (0.2791)

5.2.1.4. Visiting the center Once / 3 months

Null Hypothesis: Proportion of visitors from the Bourj Hammoud area visiting the center *twice per month* is equal to the proportion of visitors living outside Bourj Hammoud area.

Alternative Hypothesis: Proportion of visitors from the Bourj Hammoud area visiting the center *twice per month* is **not** equal to the proportion of visitors living outside Bourj Hammoud area.

Table 13: Hypothesis test for two independent proportions of visiting the center once / 3 months				
	p1	*p2*	p_c	
	0.1771	0.2941	0.1961	p (as decimal)
	31/175	10/34	41/209	p (as fraction)
	30.993	9.999	40.992	X
	175	34	209	N
		-0.117	Difference	
		0.	hypothesized difference	
		0.0744	std. error	
		-1.57	Z	
		.1159	p-value (two-tailed)	

According to the sample data, we do not have enough evidence to reject that the two proportions are equal because the p value is 0.1159 at a level of significance of 0.05.

5.2.1.5. Visiting the center once /6 months

Null Hypothesis: Proportion of visitors from the Bourj Hammoud area visiting the center *once per 6 months* is equal to the proportion of visitors living outside Bourj Hammoud area.

Alternative Hypothesis: Proportion of visitors from the Bourj Hammoud area visiting the center *once per 6 months* is **not** equal to the proportion of visitors living outside Bourj Hammoud area.

Table 14: Hypothesis test for two independent proportions of visiting the center once/ 6 months

	p1	*P2*	p_c	
	0.1143	0.1176	0.1148	p (as decimal)
	20/175	4/34	24/209	p (as fraction)
	20.	4.	24.	X
	175	34	209	N
		-0.0034	Difference	
		0.	hypothesized difference	
		0.0598	std. error	
		-0.06	Z	
		.9551	p-value (two-tailed)	

According to the sample data, we do not have enough evidence to reject the hypothesis that the two proportions are equal because the p-value is very high (0.9551)

5.2.1.6.Chi Square Test

5.2.1.6.1. Proportions living outside Bourj Hammoud and proportions of total visitors:

Chi square test is run in order to see the goodness of fit test of two different proportions.

Table 15: The proportions of visitors living in Bourj Hammoud and outside Bourj Hammoud			
	Proportions living inside Bourj Hammoud	Proportions living outside Bourj Hammoud	Proportions of total visitors
more than once/week and Once per week	10.46%	8.82%	10.53%
Once/month	60.00%	50.00%	58.37%
Twice/month	17.71%	29.41%	19.62%
Once/6months	11.43%	11.76%	11.48%

Table 15 - 1
Goodness of Fit Test of proportions living outside Bourj Hammoud with respect to the proportions of the total visitors

observed	expected	O - E	$(O-E)^2 / E$	% of chisq
0.108571429	0.105	0.003	0.000	4.32
0.6	0.584	0.016	0.000	18.84
0.177142857	0.196	-0.019	0.002	76.73
0.114285714	0.115	-0.001	0.000	0.11
1	1.000	0.000	0.002	100.00

.00	chi-square
3	Df
1.0000	P – value

Here, we can notice a very high p value of 1.0000, which means that the proportions who live outside Bourj Hammoud are similar to the proportions of the visitors overall.

Table 15 - 2
Goodness of Fit Test of proportions living outside Bourj Hammoud with respect to the proportions living inside Bourj Hammoud

observed	Expected	O - E	$(O-E)^2 / E$	% of chisq
0.088235294	0.109	-0.020	0.004	3.89
0.5	0.600	-0.100	0.017	17.04
0.294117647	0.177	0.117	0.077	78.97
0.117647059	0.114	0.003	0.000	0.10
1	1.000	0.000	0.098	100.00

.10	chi-square
3	Df
0.9921	P - value

Here, we can notice a very high p value of 0.9921, which means that the proportions who live outside Bourj Hammoud are similar to the proportions of the visitors living inside Bourj Hammoud.

If the center is not accessible, then the larger proportion of visitors living outside Bourj Hammoud will visit the center less frequently. However, because the frequency is the same for both populations (living inside Bourj Hammoud and living outside Bourj Hammoud), then we can say the center is geographically accessible.

5.2.2) **Relationship Testing**

In this section I will test the level of satisfaction of the different sets of visitors from the services at HKCC. The objective of this part is to see whether people think that the services of HKCC are effective and efficient.

In terms of effectiveness, I want to test whether HKCC staff and services are doing the right thing. The effectiveness of Doctors' consultation, as well as the effectiveness of different services of HKCC will be evaluated by asking the satisfaction level of the clients visiting HKCC with different frequencies.

In terms of efficiency, I want to test whether HKCC staff are doing the things right. The level of efficiency will be evaluated by the satisfaction level of the clients visiting HKCC with different frequencies. However, this time questions relating to the availability of care givers (such as doctors and nurses), as well as the amount of time spent with them will be asked and evaluated.

Hence, here is the summary of the relationship tests between different groups of visitors and their level of satisfaction of HKCC:

5.2.2.1 Level of Effectiveness

5.2.2.1.1. Different groups of visitors and their level of satisfaction about the effectiveness of the doctors' consultation.

5.2.2.1.2. Effectiveness of HKCC services

5.2.2.1.2.1. Different groups of visitors and their level of satisfaction about the Pediatric Clinic

5.2.2.1.2.2. Different groups of visitors and their level of satisfaction about the Vaccination Department

5.2.2.1.2.3. Different groups of visitors and their level of satisfaction about the Obstetric and Gynaecologists Vaccination Department

5.2.2.1.2.4. Different groups of visitors and their level of satisfaction about the Ophthalmologic department

5.2.2.1.2.5. Different groups of visitors and their level of satisfaction about the Audiology Department

5.2.2.1.2.6. Different groups of visitors and their level of satisfaction about the School Health Department

5.2.2.1.2.7. Different groups of visitors and their level of satisfaction about the Dental clinic

5.2.2.1.2.8. Different group of visitors and their level of satisfaction about the Social Assistant Services

5.2.2.1.3. Conclusion about the level of effectiveness

5.2.2.2. Level of Efficiency

5.2.2.2.1. Availability of care - givers

5.2.2.2.2.2. Different groups of visitors and their level of satisfaction about the availability of HKCC doctors

5.2.2.2.2.2. Different groups of visitors and their level of satisfaction about the availability of HKCC nurses

5.2.2.2.2. Amount of time spent with care – givers

5.2.2.2.2.2. Different groups of visitors and their level of satisfaction about consultation time that they spent with the doctors.

5.2.2.2.2.2. Different groups of visitors and their level of satisfaction about time that they spent with the nurses.

5.2.2.2.3. Low Cost of Health Coverage

5.2.2.2.4. Conclusion about the level of efficiency

5.2.2.2. Reliability Analysis

5.2.2.1 Level of effectiveness

5.2.2.1.1 Visitors and the level of satisfaction about the doctors' effectiveness

Setting up the hypothesis:

H0: The level of satisfaction of the respondents with different frequencies of visits about the effectiveness of the doctors' consultation at HKCC is the same.

H1: The level of satisfaction of the respondents with different frequencies of visits about the effectiveness of the doctors' consultation at HKCC is **not** the same.

Table 16: Hypothesis test for degree of satisfaction of different groups regarding the effectiveness of HKCC doctors

	Number of Visits					
Degree of satisfaction with the effectiveness of HKCC doctors	More than once/week	Once/week	Once/ month	Once / 3 months	Once / 6 months	**TOTAL**
Not Satisfied = 1			1		1	**2**
Somewhat unsatisfied = 2						
So – so = 3	2	2	5	2		**11**
Somewhat satisfied = 4	0	1	9	6	3	**19**
Satisfied = 5	6	10	101	30	20	**167**
Not applicable	1		6	3		10
TOTAL	**9**	**13**	**122**	**41**	**24**	**209**

One factor ANOVA						
	Mean	*n*	*Std. Dev*			
	4.5	8	0.93	more than once/week		
	4.6	13	0.77	Once/week		
	4.8	116	0.59	Once/month		
	4.7	38	0.55	Once / 3 months		
	4.7	24	0.86	Once / 6 months		
	4.8	199	0.65	Total		
ANOVA table						
Source	*SS*	*df*	*MS*	*F*	*p-value*	
Treatment	1.09	4	0.273	0.65	.6298	
Error	81.84	194	0.422			
Total	82.93	198				

According to the sample data, we do not have enough evidence to reject that the level of satisfaction of the respondents with different frequencies visits about the effectiveness of the doctors' consultation at HKCC is the same, because the p-value is very high (0.6298)

5.2.2.1.2 Visitors and the level of Satisfaction with HKCC services:

5.2.2.1.2.1. Visitors and the level of satisfaction with Pediatric clinic

Setting up the hypothesis:

H0: The levels of satisfaction of the respondents with different frequencies of visits about the pediatric department at HKCC are the same.

H1: The levels of satisfaction of the respondents, with different frequencies of visits about the pediatric department at HKCC are **not** the same.

Table 17: Hypothesis test for degree of satisfaction of different groups regarding pediatric department at HKCC

	Number of Visits					
Degree of satisfaction with the pediatric department at HKCC	More than once/week	Once/week	Once/ month	Once / 3 months	Once / 6 months	**TOTAL**
Not Satisfied = 1	1					**1**
Somewhat unsatisfied = 2						
So – so = 3			6		1	**7**
Somewhat satisfied = 4			7	5	2	**14**
Satisfied = 5	8	12	99	29	17	**165**
Not applicable		1	10	7	4	**22**
TOTAL	**9**	**13**	**122**	**41**	**24**	**209**

One factor ANOVA					
	Mean	*n*	*Std. Dev*		
	4.7	9	1.00	more than once/week	
	5.0	12	0.00	Once/week	
	4.8	112	0.50	Once/month	
	4.9	34	0.36	Once / 3 months	
	4.8	20	0.52	Once / 6 months	
	4.8	187	0.50	Total	
ANOVA table					
Source	*SS*	*df*	*MS*	*F*	*p-value*
Treatment	0.62	4	0.155	0.62	.6467
Error	45.24	182	0.249		
Total	45.86	186			

According to the sample data, we do not have enough evidence to reject that the level of satisfaction of the respondents with different frequencies of visits about the pediatric department is the same because the p value is very high (0.6298)

5.2.2.1.2.2.Visitors and the level of satisfaction with the Vaccination department

Setting up the hypothesis:

H0: The levels of satisfaction of the respondents with different frequencies of visits about the Vaccination department at HKCC are the same.

H1: The levels of satisfaction of the respondents, with different frequencies of visits about the Vaccination department at HKCC are **not** the same.

Table 18: Hypothesis test for degree of satisfaction of different groups regarding vaccination department at HKCC

	Number of Visits					
Degree of satisfaction with the vaccination department at HKCC	More than once/week	Once/week	Once/ month	Once / 3 months	Once / 6 months	**TOTAL**
Not Satisfied = 1			4		1	**5**
Somewhat unsatisfied = 2			1			**1**
So – so = 3	1		4	1		**6**
Somewhat satisfied = 4			6	5	1	**12**
Satisfied = 5	8	12	97	32	17	**166**
Not applicable		1	10	3	5	**19**
TOTAL	**9**	**13**	**122**	**41**	**24**	**209**

One factor ANOVA					
	Mean	*n*	*Std. Dev*		
	4.8	9	0.67	more than once/week	
	5.0	12	0.00	Once/week	
	4.7	112	0.88	Once/month	
	4.8	38	0.46	Once / 3 months	
	4.7	19	0.93	Once / 6 months	
	4.8	190	0.77	Total	
ANOVA table					
Source	*SS*	*df*	*MS*	*F*	*p-value*
Treatment	1.15	4	0.287	0.47	.7559
Error	112.23	185	0.607		
Total	113.37	189			

According to the sample data, we do not have enough evidence to reject that the level of satisfaction of the respondents with different frequencies of visits about the Vaccination Department is the same, because the p-value is very high (0.7559)

5.2.2.1.2.3. Visitors and the level of satisfaction with OBS – GYN department

Setting up the hypothesis:

H0: The levels of satisfaction of the respondents with different frequencies of visits about the OBS – GYN department at HKCC are the same.

H1: The levels of satisfaction of the respondents, with different frequencies of visits about the OBS - GYN department at HKCC are **not** the same.

Table 19: Hypothesis test for degree of satisfaction of different groups regarding the OBS – GYN department at HKCC

	Number of Visits					
Degree of satisfaction with the OBS - GYN department at HKCC	More than once/week	Once/week	Once/ month	Once / 3 months	Once / 6 months	**TOTAL**
Not Satisfied = 1	1	2	2	1		**6**
Somewhat unsatisfied = 2	1					**1**
So – so = 3	1			1	2	**4**
Somewhat satisfied = 4	1	1	5		1	**8**
Satisfied = 5	4	5	42	16	6	**73**
Not applicable	1	5	73	23	15	**117**
TOTAL	**9**	**13**	**122**	**41**	**24**	**209**

One factor ANOVA					
	Mean	*n*	*Std. Dev*		
	3.8	8	1.58	more than once/week	
	3.9	8	1.81	Once/week	
	4.7	49	0.84	Once/month	
	4.7	18	1.03	Once / 3 months	
	4.4	9	0.88	Once / 6 months	
	4.5	92	1.09	Total	
ANOVA table					
Source	*SS*	*df*	*MS*	*F*	*p-value*
Treatment	10.75	4	2.688	2.38	.0575
Error	98.15	87	1.128		
Total	108.90	91			

According to the sample data, we do not have enough evidence to reject that the levels of satisfaction of the respondents with different frequencies of visits about the OBS – GYN Department are the same at the level of significance 0.05

However, since the p value is not very high, is 0.0575 only, the hypothesis may be rejected at a higher level of significance.

5.2.2.1.2.4. Visitors and the level of satisfaction of the Ophthalmology clinic

Setting up the hypothesis:

H0: The levels of satisfaction of the respondents with different frequencies of visits about the Ophthalmology department at HKCC are the same.

H1: The levels of satisfaction of the respondents, with different frequencies of visits about the Ophthalmology department at HKCC are **not** the same.

Table 20: Hypothesis test for degree of satisfaction of different groups regarding the OPTH department at HKCC

	Number of Visits					
Degree of satisfaction with the OPTH department at HKCC	More than once/week	Once/week	Once/ month	Once / 3 months	Once / 6 months	**TOTAL**
Not Satisfied = 1			1			**1**
Somewhat unsatisfied = 2	1				1	**2**
So – so = 3	0					**0**
Somewhat satisfied = 4	1		1	2	1	**5**
Satisfied = 5	2	5	35	7	9	**58**
Not applicable	5	8	85	32	13	**143**
TOTAL	**9**	**13**	**122**	**41**	**24**	**209**

One factor ANOVA					
	Mean	*n*	*Std. Dev*		
	4.0	4	1.41	more than once/week	
	5.0	5	0.00	Once/week	
	4.9	37	0.67	Once/month	
	4.8	9	0.44	Once / 3 months	
	4.6	11	0.92	Once / 6 months	
	4.8	66	0.74	Total	
ANOVA table					
Source	*SS*	*df*	*MS*	*F*	*p-value*
Treatment	3.17	4	0.791	1.49	.2167
Error	32.43	61	0.532		
Total	35.59	65			

According to the sample data, we do not have enough evidence to reject that the levels of satisfaction of the respondents with different frequencies of visits about the Ophthalmology Department at HKCC is the same because the p – value is 0.2167

5.2.2.1.2.5.Visitors and the level of satisfaction with the Audiology department.

Setting up the hypothesis:

H0: The levels of satisfaction of the respondents with different frequencies of visits about the Audiology department at HKCC are the same.

H1: The levels of satisfaction of the respondents, with different frequencies of visits about the Audiology department at HKCC are **not** the same.

Table 21: Hypothesis test for degree of satisfaction of different groups regarding the Audiology department at HKCC

	Number of Visits					
Degree of satisfaction with the Audiology department at HKCC	More than once/week	Once/week	Once/ month	Once / 3 months	Once / 6 months	**TOTAL**
Not Satisfied = 1						
Somewhat unsatisfied = 2					1	**1**
So – so = 3		1				**1**
Somewhat satisfied = 4	1		1	1	1	**2**
Satisfied = 5	1	1	10	2	2	**16**
Not applicable	7	11	111	38	20	**187**
TOTAL	**9**	**13**	**122**	**41**	**24**	**209**

One factor ANOVA					
	Mean	*n*	*Std. Dev*		
	4.5	2	0.71	More than once/week	
	4.0	2	1.41	Once/week	
	4.9	11	0.30	Once/month	
	4.7	3	0.58	Once / 3 months	
	4.0	4	1.41	Once / 6 months	
	4.6	22	0.80	Total	
ANOVA table					
Source	*SS*	*df*	*MS*	*F*	*p-value*
Treatment	3.24	4	0.811	1.37	.2865
Error	10.08	17	0.593		
Total	13.32	21			

According to the sample data, we do not have enough evidence to reject that the levels of satisfaction of the respondents with different frequencies of visits, about the Audiology Department are equal because the p – value is 0.2865

5.2.2.1.2.6. Visitors and the School Health Department

Setting up the hypothesis:

H0: The levels of satisfaction of the respondents with different frequencies of visits about the School Health department at HKCC are the same.

H1: The levels of satisfaction of the respondents, with different frequencies of visits about the School Health department at HKCC are **not** the same.

Table 22: Hypothesis test for degree of satisfaction of different groups regarding the School Health department at HKCC

	Number of Visits					
Degree of satisfaction with the School Health department at HKCC	More than once/week	Once/week	Once/ month	Once / 3 months	Once / 6 months	**TOTAL**
Not Satisfied = 1						
Somewhat unsatisfied = 2						
So – so = 3	1	1	1		1	**4**
Somewhat satisfied = 4	1		1	2	3	**7**
Satisfied = 5	3	5	45	9	12	**74**
Not applicable	4	7	75	30	8	**124**
TOTAL	**9**	**13**	**122**	**41**	**24**	**209**

One factor ANOVA					
	Mean	*n*	*Std. Dev*		
	4.4	5	0.89	more than once/week	
	4.7	6	0.82	Once/week	
	4.9	47	0.32	Once/month	
	4.8	11	0.40	Once / 3 months	
	4.7	16	0.60	Once / 6 months	
	4.8	85	0.49	Total	
ANOVA table					
Source	*SS*	*df*	*MS*	*F*	*p-value*
Treatment	1.94	4	0.484	2.10	.0880
Error	18.42	80	0.230		
Total	20.35	84			

According to the sample data, we do not have enough evidence to reject that the level of satisfaction of the respondents with different frequencies of visits about the School Health Department at HKCC is the same.

However, since the p value is not very high, is 0.0880 only, the hypothesis may be rejected at a higher level of significance.

5.2.2.1.2.7.Visitors and the Dental clinic department

Setting up the hypothesis:

H0: The levels of satisfaction of the respondents with different frequencies of visits about the Dental Clinic department at HKCC are the same.

H1: The levels of satisfaction of the respondents, with different frequencies of visits about the Dental Clinic department at HKCC are **not** the same

Table 23: Hypothesis test for degree of satisfaction of different groups regarding to Dental clinic department at HKCC

	Number of Visits					
Degree of satisfaction with the Dental department at HKCC	More than once/week	Once/week	Once/ month	Once / 3 months	Once / 6 months	**TOTAL**
Not Satisfied = 1			4	1	1	**6**
Somewhat unsatisfied = 2			2			**2**
So – so = 3			1			**1**
Somewhat satisfied = 4			2	2		**4**
Satisfied = 5	1	3	21	6	7	**38**
Not applicable	8	10	92	32	16	**158**
TOTAL	**9**	**13**	**122**	**41**	**24**	**209**

One factor ANOVA					
	Mean	*n*	*Std. Dev*		
	5.0	1	0.00	more than once/week	
	5.0	3	0.00	Once/week	
	4.1	30	1.50	Once/month	
	4.3	9	1.32	Once / 3 months	
	4.5	8	1.41	Once / 6 months	
	4.3	51	1.39	Total	
ANOVA table					
Source	*SS*	*df*	*MS*	*F*	*p-value*
Treatment	3.12	4	0.780	0.38	.8189
Error	93.47	46	2.032		
Total	96.59	50			

According to the sample data, we do not have enough evidence to reject that the levels of satisfaction of the respondents with different frequencies of visits, about the Dental department are the same.

5.2.2.1.2.8. Visitors and the Social Assistance Services

H0: The levels of satisfaction of the respondents with different frequencies of visits about the Social Assistance Service department at HKCC are the same.

H1: The levels of satisfaction of the respondents, with different frequencies of visits about the Social Assistance Service department at HKCC are **not** the same.

Table 24: Hypothesis test for degree of satisfaction of different groups regarding to Social Assistance Service at HKCC

	Number of Visits					
Degree of satisfaction of with Social Assistance Service at HKCC	More than once/week	Once/week	Once/ month	Once / 3 months	Once / 6 months	**TOTAL**
Not Satisfied = 1	2			1		**3**
Somewhat unsatisfied = 2			2	1		**3**
So – so = 3	2	1	3	2	1	**9**
Somewhat satisfied = 4		1	7	1		**9**
Satisfied = 5	3	6	39	11	1	**64**
Not applicable	2	5	71	25	18	**121**
TOTAL	**9**	**13**	**122**	**41**	**24**	**209**

One factor ANOVA						
	Mean	*n*	*Std. Dev*			
	3.3	7	1.80	more than once/week		
	4.3	8	0.74	Once/week		
	4.6	51	0.77	Once/month		
	4.6	16	1.29	Once / 3 months		
	4.7	6	0.82	Once / 6 months		
	4.5	88	1.04	Total		
ANOVA table						
Source	*SS*	*df*	*MS*	*F*	*p-value*	
Treatment	12.26	4	3.065	3.12	.0192	
Error	81.56	83	0.983			
Total	93.82	87				
Post hoc analysis						
Tukey simultaneous comparison t-values (d.f. = 83)						
		more than once/week	Once/week	Once/month	Once/ 3 months	Once / 6 months
		3.3	4.3	4.6	4.6	4.7
more than once/week	3.3					
Once/week	4.3	2.15				
Once/month	4.6	2.61	0.87			
Once / 3 months	4.6	3.36	1.33	0.01		
Once / 6 months	4.7	2.50	0.88	0.08	0.09	
critical values for experiment wise error rate:						
		0.05	2.79			
		0.01	3.38			

The sample has a p-value of 0.0192; therefore, we have strong evidence to reject that the levels of satisfaction of the respondents with different frequencies of visits, about the Social Assistance Service is the same. This means that for at least one group the level of satisfaction is different that the other groups. Clearly one group (more than once / week) is not satisfied from the Social Assistance Service.

Conclusion about the level of effectiveness:

- ***We do not have enough evidence to reject that the levels of satisfaction of the respondents with different frequencies of visits about the effectiveness of HKCC services are the same. The levels of satisfaction about the health care services provided by the HKCC to visitors with different frequencies are the same. The only exception is with the Social Assistant Services. Clearly the levels of satisfaction of visitors with different frequencies of visits about the Social Assistance Services were not the same. Here, the purpose and the objectives of the Social Assistance Department have to be more clarified to the people so that they understand the difference between a PHC and a Social Service Center or the limited role of a Social Assistance Service in a PHC.***

5.2.2.2. Level of Efficiency

5.2.2.2.1. Availability of Care – givers

5.2.2.2.2.2. Visitors and the levels of satisfactions about the availability of Doctors at HKCC

Setting up the hypothesis:

H0: The levels of satisfaction of the respondents with different frequencies of visits, about the availability of the doctors at HKCC are the same

H1: The levels of satisfaction of the respondents with different frequencies of visits, about the availability of the doctors at HKCC are **not** the same

Table 25: Hypothesis test for degree of satisfaction of different groups regarding the availability of HKCC doctors

	Number of Visits					
Degree of satisfaction with the availability of HKCC doctors	More than once/week	Once/week	Once/ month	Once / 3 months	Once / 6 months	**TOTAL**
Not Satisfied = 1		1	3		1	**5**
Somewhat unsatisfied = 2				1		**1**
So – so = 3	1	1	9	5	1	**17**
Somewhat satisfied = 4	4	2	11	6	6	**29**
Satisfied = 5	4	9	96	26	16	**151**
Not applicable			3	3		6
TOTAL	**9**	**11**	**122**	**41**	**24**	**209**

One factor ANOVA results					
	Mean	*n*	*Std. Dev*		
	4.3	9	0.71	more than once/week	
	4.4	13	1.19	Once/week	
	4.7	119	0.83	Once/month	
	4.5	38	0.83	Once / 3 months	
	4.5	24	0.93	Once / 6 months	
	4.6	203	0.86	Total	
ANOVA table					
Source	*SS*	*df*	*MS*	*F*	*p-value*
Treatment	2.12	4	0.529	0.71	.5858
Error	147.45	198	0.745		
Total	149.57	202			

According to the sample data, we do not have enough evidence to reject that the levels of satisfaction of the respondents with different frequencies of visits, about the availability of the doctors at HKCC are the same, at a level of significance of 0.05 because the p-value is very high (0.5858)

5.2.2.2.2.2. Visitors and the Availability of Nurses at HKCC

Setting up the hypothesis:

H0: The levels of satisfaction of the respondents with different frequencies of visits, about the availability of the nurses at HKCC are the same

. **H1:** The levels of satisfaction of the respondents with different frequencies of visits about the availability of the nurses at HKCC are **not** the same

Table 26: Hypothesis test for degree of satisfaction of different groups regarding the availability of nurses at HKCC

	Number of Visits					
Degree of satisfaction with the availability of the nurses at HKCC	More than once/week	Once/week	Once/ month	Once / 3 months	Once / 6 months	**TOTAL**
Not Satisfied = 1			1			**1**
Somewhat unsatisfied = 2			1			**1**
So – so = 3	3		5	2		**10**
Somewhat satisfied = 4	1	2	15	5	7	**30**
Satisfied = 5	5	11	100	31	17	**164**
Not applicable				3		**3**
TOTAL	**9**	**13**	**122**	**41**	**24**	**209**

One factor ANOVA					
	Mean	*n*	*Std. Dev*		
	4.2	9	0.97	more than once/week	
	4.8	13	0.38	Once/week	
	4.7	122	0.65	Once/month	
	4.8	38	0.54	Once / 3 months	
	4.7	24	0.46	Once / 6 months	
	4.7	206	0.62	Total	
ANOVA table					
Source	*SS*	*df*	*MS*	*F*	*p-value*
Treatment	2.55	4	0.637	1.67	.1586
Error	76.68	201	0.381		
Total	79.23	205			

According to the sample data, we do not have enough evidence to reject that the levels of satisfaction of the respondents having different frequencies of visits, about the availability of the nurses at HKCC because the p-value is very high.

5.2.2.2.2. Amount of time spent with the care – givers

5.2.2.2.2.2. Visitors and the amount of consultation time that they spent with the doctors.

Setting up the hypothesis:

H0: The levels of satisfaction of the respondents with different frequencies of visits, about the amount of time that they spent with the doctor at HKCC are the same

H0: The levels of satisfaction of the respondents with different frequencies of visits, about the amount of time that they spent with the doctor at HKCC are **not** the same

Table 27: Hypothesis test for degree of satisfaction of different groups regarding the amount of time spent with HKCC doctors during consultation

	Number of Visits					
Degree of satisfaction of the amount of time patient / doctor at HKCC	More than once/week	Once/week	Once/ month	Once / 3 months	Once / 6 months	**TOTAL**
Not Satisfied = 1		1				**1**
Somewhat unsatisfied = 2	1	1				**2**
So – so = 3			8	6	1	**15**
Somewhat satisfied = 4	2	2	14	5	5	**28**
Satisfied = 5	6	9	95	27	18	**155**
Not applicable			9	3		8
TOTAL	**9**	**13**	**122**	**41**	**24**	**209**

One factor ANOVA					
	Mean	*n*	*Std. Dev*		
	4.4	9	1.01	More than once/week	
	4.3	13	1.32	Once/week	
	3.6	22	0.49	Once/month	
	4.6	38	0.76	Once / 3 months	
	4.7	24	0.55	Once / 6 months	
	4.4	106	0.86	Total	

ANOVA table					
Source	*SS*	*df*	*MS*	*F*	*p-value*
Treatment	15.94	4	3.985	6.45	.0001
Error	62.44	101	0.618		
Total	78.38	105			

Post hoc analysis

Tukey simultaneous comparison t-values (d.f. = 101)

		Once/month	Once/week	more than once/week	Once / 3 months	Once / 6 months
		3.6	4.3	4.4	4.6	4.7
Once/month	3.6					
Once/week	4.3	2.44				
more than once/week	4.4	2.60	0.40			
Once / 3 months	4.6	4.35	0.97	0.37		
Once / 6 months	4.7	4.62	1.48	0.86	0.76	

critical values for experiment wise error rate:

0.05	2.78
0.01	3.36

p-values for pair wise t-tests

		Once/month	Once/week	more than once/week	Once / 3 months	Once / 6 months
		3.6	4.3	4.4	4.6	4.7
Once/month	3.6					
Once/week	4.3	.0164				
more than once/week	4.4	.0108	.6892			
Once / 3 months	4.6	3.26E-05	.3346	.7113		
Once / 6 months	4.7	1.14E-05	.1421	.3925	.4493	

The sample has a p-value of 0.0001, therefore, we have strong evidence to reject that the levels of satisfaction of the respondents having different frequencies of visits about the amount of time that they spent with the doctor at HKCC are the same. Hence, we can conclude that the level of the satisfaction of the different groups is not the same. This means that for at least one group the level of satisfaction is different than the other groups. Clearly one group (once / month) is not satisfied from the amount of time that they spent with the doctors during the consultation.

5.2.2.2.2.2. Visitors and their level of satisfaction about the amount of time that they spent with nurses at HKCC for guidance and direction

Setting up the hypothesis:

H0: The levels of satisfaction of the respondents with different frequencies of visits about the amount of time that they spent with the nurse at HKCC are the same.

H1: The levels of satisfaction of the respondents with different frequencies of visits about the amount of time that they spent with the nurse at HKCC are **not** the same.

Table 28: Hypothesis test for degree of satisfaction of different groups regarding the amount of time that they spent with the nurses at HKCC

	Number of Visits					
Degree of satisfaction with the amount of time / patient with the nurses at HKCC	More than once/week	Once/week	Once/ month	Once / 3 months	Once / 6 months	**TOTAL**
Not Satisfied = 1			1			**1**
Somewhat unsatisfied = 2	1		1			**2**
So – so = 3	1		6	2		**9**
Somewhat satisfied = 4	1	2	12	9	4	**28**
Satisfied = 5	6	11	98	28	20	**163**
Not applicable			4	2		**6**
TOTAL	**9**	**13**	**122**	**41**	**24**	**209**

One factor ANOVA					
	Mean	*N*	*Std. Dev*		
	4.3	9	1.12	more than once/week	
	4.8	13	0.38	Once/week	
	4.7	118	0.67	Once/month	
	4.7	39	0.58	Once / 3 months	
	4.8	24	0.38	Once / 6 months	
	4.7	203	0.64	Total	
ANOVA table					
Source	*SS*	*Df*	*MS*	*F*	*p-value*
Treatment	2.00	4	0.501	1.23	.2989
Error	80.55	198	0.407		
Total	82.55	202			

According to the sample data, we do not have enough evidence to reject that the levels of satisfaction of the respondents with different frequencies of visits about the amount of time that they spent with the nurse at HKCC is the same because the p-value is very high 0.2989.

5.2.2.2.3. Low cost health coverage

When asked about why you appreciate the contribution of HKCC, 56 % answered about the low cost / service. This low cost is very encouraging for the people to get any type of health services related to their children. Below are the details of other reasons why people are satisfied from HKCC

Table 29: satisfaction about the services of HKCC.

	Low Costs / service	Doctor's consultation	Nurses Guidance	Social Workers	TOTAL
more than once/week	4	2	3		9
Once/week	7	1	3	2	13
Once/month	71	22	20	9	122
Once / 3 months	25	7	6	3	41
once/6months	10	2	10	2	24
TOTAL	117	34	42	16	209
TOTAL in percentage	55.98%	16.27%	20.10%	7.66%	

This is another good demonstration of efficiency

5.2.2.2.4. Conclusion about efficiency:

- ***We do not have enough evidence to reject that the levels of satisfaction of the respondents with different frequencies of visits about the efficiency of HKCC services are the same.***
- ***However, the levels of satisfaction of visitor with different frequencies of visits about the amount of time that they spent during consultation with the doctor are not the same. Clearly there are certain groups of visitors (once per month, once per 3 months, once per 6 months) who are not as satisfied with the amount of time that***

they spent with the doctors. Hence, people tend to visit more often HKCC to have the chance to spend more time with the doctor. There is a gap in time management or the appointment system. HKCC management should follow up on this matter.

5.2.2.3. Reliability Analysis:

A reliability analysis allows us to study the properties of measurement scales and allows the items that make them up. The reliability analysis procedure calculates a number of commonly used measures of scale reliability and also provides information about the relationships between individual items in the scale. In this research I have used alpha (Cronbach) model of reliability analysis. This is a model of internal consistency based on the average inter – item correlation.

The result is of the following:

Table 30: Reliability Analysis

RELIABILITY ANALYSIS-SCALE (ALPHA)	
Reliability Coefficients	
N of Cases = 209.0	N of Items = 19
Alpha = 0.7918	

Therefore, we can say that the reliability of the answers are at the rate of 0.7918. Hence, the finding of the research is 79.18% reliable.

6.1) Suggestions made to HKCC :

Suggestions made by the visitors:

Table 31: Suggestions made by the visitors

	The services are sufficient	Nursery / Kindergarten / Day care center	More Milk to be given for the needy children	Generalist Doctor for all	Summer School	High cost of Vaccines should be covered by HKCC	Financial aid	TOTAL
more than once/week	5		4					9
Once/week	8		2	3				13
Once/month	79	10	12	3	5	9	4	122
Once / 3 months	16	4	11	3	1	3	3	41
Once / 6 months	16		5	2		1		24
TOTAL	124	14	34	11	6	13	7	209
TOTAL in percentage	59.33%	6.7%	16.26%	5.26%	2.87%	6.22%	3.34%	

Approximately 60% of the respondents find that the services that are available at HKCC are sufficient as a PHC. Others have suggested different services are not necessarily provided by a typical PHC.

Table 32: Suggestions made by the staff

	Nursery / Kindergarten / Day Care Center	Education campaign for the staff	Generalist Doctor for all	Home Visits	Asthma service	Nutritionist	Human Resource Management	TOTAL
	15	1	2	1	1	**2**	**22**	**22**
TOTAL in percentage	68.18%	4.55%	9.09%	4.55%	4.55%	9.09%	100%	100%

Here we can notice that the staff of HKCC see the need of a kindergarten. In case the board of directors of HKCC want to expand their services they should consider a kindergarten. We also see the need for a generalist physician, but this need should be further elaborated.

It is important to notice the need for Human Resource Management (HRM) System suggested by the staff. Each staff member, while filling the survey questionnaire, suggested different services that pin point the need for a Human Resource Management System at HKCC. Some said time management, others said training, others said performance appraisal. In summary, they all identified different dimensions of an HRM system at HKCC.

This HRM system would also address the time management problem identified in the HKCC clients' survey.

6.2) Summary of HKCC Case study

1. HKCC is geographically accessible for everyone
2. HKCC is managerially and financially sustainable
3. HKCC has a clear vision and a shared culture
4. The visitors are satisfied by the effectiveness of the doctors' consultation at HKCC
5. The visitors are satisfied by the effectiveness of the services at HKCC, some services need to be closely monitored such as:
    - Dental Clinic service
    - OBS – GYN service
    - School Health Services
    - Social Assistance Service
6. The services of HKCC are affordable
7. Visitors are satisfied by the amount of time that they spent with the nurses at HKCC for guidance
8. 60% of the visitors said that they think that the services at HKCC are sufficient
9. The time management issue has to be addressed as there are certain groups of visitors who are not satisfied by the amount of time that they spent with doctors during consultation at HKCC
10. The suggestions made by the visitors need to be taken into consideration
11. Create Human Resource Management System at HKCC

6.3) Create Human Resource Management System at HKCC

The Human Resource Management (HRM) is the process of acquiring, training, appraising and compensating employees. The Howard Karagheusian Commemorative Corporation in its essence, is an entity whose basic purpose is to serve the community. Maintaining and developing the employees' knowledge, involvement, commitment, skills and training within the association is essential to implement its mission and goals.

Linking the HRM to HKCC's strategic planning will make its services more efficient. Through Human Resource (HR) the staff commitment will be stronger, and the staff, in its turn will provide excellent community service.

In order to implement HR practices at HKCC, it is important to have the commitment of the management. Without the management's commitment and support, the HR practices will not reach their goal. To apply HR practices, the management must appoint an HR officer.

The HR practices are divided into three main parts and they are the following:

1. Recruitment and placement
2. Training and development
3. Appraising and managing performance

6.3.1) Recruitment and Placement:

The first step in implementing the HRM at HKCC is to have good job analysis data.

Job Analysis: Analyzing the job involves determining, in detail, what the job entails and what kind of people the association should hire for the job. Job analysis produces information used for job descriptions (a list of what the job entails) and job specifications (what kind of people to hire for the job)

Writing Job Descriptions: A job description is a written statement of what the worker actually does, how he or she does it, and what the working conditions are. The job description should contain sections that cover:

- Job identification: job title, department, reports to, hours worked, pay scale, grade level, date job description was written, prepared by, approved by and approved date.
- Job Summary: describes the general nature of the job, and includes only its major functions or activities, the more important or regularly performed tasks.
- Responsibilities and Duties: A list of the job's major responsibilities and duties. This includes relationships (supervisors works with), record keeping, use of machine, tools and equipment. A description, for each duty, what the employee does and, if possible, how the employee does it, and why.
- Authority of Incumbent: defines the limit of job holder's authority: decision making and budgetary limitations.
- Standard of Performance: lists the standards the staff is expected to achieve under each of the job description's main duties and responsibilities.

Standard of Performance used to evaluate employee include

- Quality: accuracy, thoroughness, and acceptability of work performed
- Productivity: Quality and the efficiency of the work produced
- Job knowledge: Practical / Technical skills and information used on the job
- Reliability: the extent to which the employee can be relied upon regarding task completion and follow up
- Availability: Punctuality, attendance record
- Independence: work with little or no supervision.

Writing job Specifications: The job specification takes the job description and answers the question, "What human traits and experience are required to do this job well?" It shows what kind of person to recruit and what qualities that person should be tested.

Job analysis system used at HKCC:

There is no specific written job analysis system at HKCC. All the jobs at different departments are analyzed and explained orally to the staff. There are no specific guidelines that the staff can use to follow systematic criteria in his / her job. There is no standard of performance; each staff has the freedom to work according to their own expectations. There are general understandings among the staff themselves about the work flow process. During the hiring process, the director interviews the candidate, explains the content of the job, and gives freedom to the staff to work. Hence, there are no measurements of performance because there are no guidelines of performance.

During the hiring process, no job description is given to the candidate. Because there is no job description, then there is no standard of performance. Furthermore, there is no appraisal, no motivating, no follow up processes. The training system is done once in a while without tracking down who went to which training seminary and what was the benefit of that training.

The job specifications differ from department to department according to the job title. For the doctors, for example, the only criterion is that they should have a license, and a service oriented attitude. The motto that is used for the doctors at HKCC is that they should diagnose the patient from "head to toe" as if the patient is being diagnosed at the doctor's own clinic. As for the job specifications regarding to "nurses" the idea is very vague. Also, because of lack of job specifications, the HKCC management has lost the line between the need and the skills and suddenly began hiring those who do not have the qualifications and experience required to do the job well. Having job specifications will eliminate this mismatching system and it will evaluate the qualification experiences that are really required to do certain jobs well.

Recommendations for having written job descriptions and specifications:

For HKCC to function efficiently, and for complete job analysis, it has to have written job descriptions and job specifications. In order to have a written job description and job specifications, HKCC management should gather its staff and educate them to write their own job description. To be more professional, strict and efficient, the HKCC management should seek an HR consultant, who can come and train the employees in writing job descriptions and job specifications.

6.3.2) Training and Development

Recruiting and selecting high-potential employees does not guarantee they will perform effectively. For one thing, people who do not know what to do or how to do it can not perform effectively even if they want to. Therefore, the next step is to ensure that the employees know what to do or how to do. This is the responsibility of the management.

Training Process:

Training is the process of teaching new employees the basic skills they need to perform their jobs. After the recruitment process, the HR specialist should analyze the training needs and give the new employees, as well as the current staff the skills and knowledge they need to do their job well.

Recommendations about training and development of the staff:

After having developed clear job descriptions and job specifications, the HR manager has to create training and development plans for the staff. These trainings have the following forms:

- Lectures
- Job Rotations
- Outside training: Send them into training seminars that the Lebanese Ministry of Health and Social Affairs organize

6.3.3) Appraising and Managing Performance:

Performance appraisal means evaluating an employee's current or past performance relative to the person's performance standards. Appraisal involves:

1. Setting work standards
2. Assessing the staff's actual performance relative to these standards
3. Providing feedback to the staff with the aim of motivating the person to eliminate deficiencies or to continue to perform above par.

- Appraisal and Performance System Used at HKCC:

The only appraisal and performance system used at HKCC is financial appraisal. At the end of every year, the director gives a salary raise to some of the staff. This raise in the salary is not done systematically. It is done according to the director's indirect follow-up of the performance of some of its staff. The staff members, on the other hand, are unaware of their performance. They expect a salary raise at the end of every year. If there is no salary raise, they are disappointed, if there is a salary raise, they think that their performance was noticed and therefore appraised. There are no work standards, no assessment of staff's actual performance relative to those standards. And, most importantly, there is no feedback to the staff regarding his/her performance.

- Recommendations about Appraisal and Performance System:

HKCC management should conduct a performance appraisal system. The performance appraisal process, as I mentioned before, contains three steps: defining the job, appraising performance, and providing feedbacks. Defining the job means making sure that the management and the staff agree to his/her duties and job standards. Here, the job description and

job specifications play an important role. Appraising performance means comparing the staff's performance to the standards that have been set. This usually involves some type of rating form. Performance appraisal usually requires one or more feedback sessions.

6.3.4) Summary of HRM at HKCC

Linking HRM to the management system of HKCC will yield positive results to the staff and patients alike.

Determining what type of people should be hired; recruiting prospective employees, selecting employees, setting performance standards, appraising and compensating employees, evaluating performance, counseling employees, training and developing employees enhance the distinctive competencies of the work force of an institution.

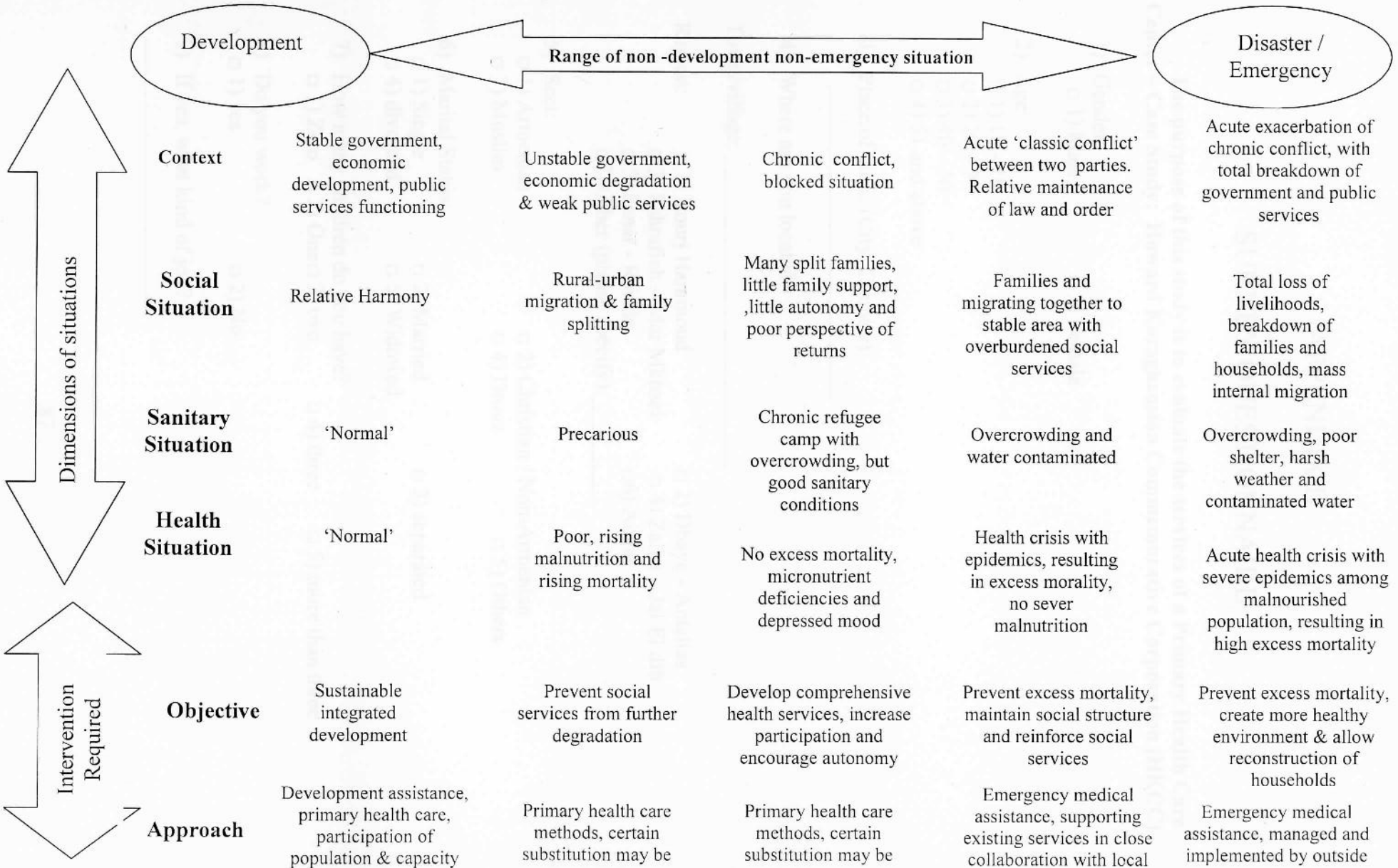
Today the role of HR is shifting from protector and screener to a strategic partner and change agent. As a flat style organization, HKCC should have trained and committed staffs. The only way to invest in the staff is to implement HRM and link HRM practices to the management system of HKCC.

6.3. Future Studies

Given the exploratory nature of this project, future research may be constructive and recommended.

- One future study could further develop the findings of the current research aiming for more comprehensive outcomes through the selection of a larger sample size representative of all clients benefiting from HKCC services, in and outside the center
- Another project could modify the current questionnaire to include more quantitative indicators enabling other statistical tests to be run and regression models to be developed concerning the profiles of the HKCC visitors.
- Instead of looking at one PHC, future study could focus on the role of the PHCs in the development of a nation.
- Another study could be about the role of Human Resource Management in PHC and the developing of staff in an NGO.
- Another useful study could be a comparative one; for example, between the Lebanese environment and that of the other Middle Eastern nations as Jordan, Syria, Egypt, and the impact of the PHCs in those countries.

APPENDIX


Development
Range of non -development non-emergency situation
Disaster / Emergency
Dimensions of situations
Intervention Required
Context
Stable government, economic development, public services functioning
Unstable government, economic degradation & weak public services
Chronic conflict, blocked situation
Acute 'classic conflict' between two parties. Relative maintenance of law and order
Acute exacerbation of chronic conflict, with total breakdown of government and public services
Social Situation
Relative Harmony
Rural-urban migration & family splitting
Many split families, little family support, ,little autonomy and poor perspective of returns
Families and migrating together to stable area with overburdened social services
Total loss of livelihoods, breakdown of families and households, mass internal migration
Sanitary Situation
'Normal'
Precarious
Chronic refugee camp with overcrowding, but good sanitary conditions
Overcrowding and water contaminated
Overcrowding, poor shelter, harsh weather and contaminated water
Health Situation
'Normal'
Poor, rising malnutrition and rising mortality
No excess mortality, micronutrient deficiencies and depressed mood
Health crisis with epidemics, resulting in excess morality, no sever malnutrition
Acute health crisis with severe epidemics among malnourished population, resulting in high excess mortality
Objective
Sustainable integrated development
Prevent social services from further degradation
Develop comprehensive health services, increase participation and encourage autonomy
Prevent excess mortality, maintain social structure and reinforce social services
Prevent excess mortality, create more healthy environment & allow reconstruction of households
Approach
Development assistance, primary health care, participation of population & capacity
Primary health care methods, certain substitution may be
Primary health care methods, certain substitution may be
Emergency medical assistance, supporting existing services in close collaboration with local
Emergency medical assistance, managed and implemented by outside

APPENDIX B

SURVEY QUESTIONNAIRE

The purpose of this study is to evaluate the services of a Primary Health Care Center – Case Study: Howard Karagheusian Commemorative Corporation (HKCC)

1) Gender:
   □ 1) Male □ 2) Female

2) Age:
   □ 1) 18 - 28
   □ 2) 29 – 39
   □ 3) 40 – 50
   □ 4) 51 and above

3) Place of birth: (City, Country)
   _____

4) Where are you located?

Town/village: _____

Region: □ 1) Bourj Hammoud □ 2) Dbaye - Antelias
□ 3) Eshrafieh – Mar Mkhael □ 4) Zalka – Jal El dib
□ 5) Fanar - Rawda □6) Ainjar
□7) Other (please specify) _____

5) Sect:
   □ 1) Armenian □ 2) Christian / Non-Armenian
   □ 3) Muslim □ 4) Drouz □ 5) Others

6) Marital Status:
   □ 1) Single □ 2) Married □ 3) separated
   □ 4) divorced □ 5) Widowed

7) How many children do you have?
   □ 1) Zero □ 2) One□ 3) two □ 4) three □ 5) more than three

8) Do you work?
   □ 1) yes □ 2) No

9) If yes, what kind of job?
   _____

10) Does your husband (or wife) work?
□ 1) yes □ 2) No

11) If yes, what kind of job

_____

12) Family Income / month
1)□ 0 - 300,000 LL 2)□ 300,000LL – 600,000LL
3)□ 601,000LL – 900,000LL 4)□ > 901,000LL

13) Members contributing to income
1)□ Father 2)□ Mother 3)□ Child 4)□ Father & Mother

14) Family medical insurance:

1)□ None 2)□ NSSF 3)□ Insurance co. Specify.....

15) Number of times that you have visited these Primary Health Care Centers in Bourj Hammoud?

Number	PHC	More than once per week	Once per week	Twice per week	Once per month	Once / 3 months	Once per 6 months	Comme
15-1	Howard Karagheusian Commemorative Corporation (HKCC)							
15-2	Jinishian Memorial Program (JMP)							
15-3	Armenian Relief Cross in Lebanon (ARCL)							

Questions Relating HKCC:

16) Degree of availability:

5 = very satisfied .....1 = not satisfied

Number	Question	5	4	3	2	1	N/A	Comments
16-1	HKCC Doctors are always available for helping and guiding me (or my children)							
16-2	HKCC nurses (or staffs) are always available for helping and guiding me (or my children)							
16-3	HKCC Social Workers are always available for helping and guiding me (or my children)							

17) Degree of satisfaction – staff (the amount of time spend during consultation / or during the service)

5 = satisfied ..... 1 = not satisfied

Number	Question	5	4	3	2	1	N/A	Comments
17 – 1	I am satisfied by the amount of time that I spent with doctors during consultation							
17 – 2	I am satisfied by the amount of time that I spent with nurses for guidance							
17 – 3	by the amount of time that I spent with social workers for guidance							

18) Degree of Satisfaction – services: Please rate your degree of satisfaction with the services that HKCC offers

5 = very satisfied ..... 1 = not satisfied

Number	Question	5	4	3	2	1	N/A	Comments
18 – 1	OBS – GYN							
18 – 2	Pediatric Clinic / Doctor's consultation							
18 – 3	Pediatric Clinic / Vaccination							
18 – 4	Pediatric Clinic / Well Baby Services							
18 – 5	Pediatric Clinic / Milk Mother's Program							
18 – 6	First Aid Program							
18 – 7	School health Services							
18 – 8	Cardiology Services							
18 – 9	Dental Clinic							
18 – 10	Ophthalmologic Clinic							
18 – 11	Audiology Clinic							
18 – 12	Social Worker's Services							

19) Degree of Effectiveness

5 = satisfied ..... 1 = not satisfied

Number	Question	5	4	3	2	1	N/A	Comments
19 – 1	The doctor's service that I get from HKCC is very effective and I benefit from it.							

20) Degree of Medical Satisfaction

5 = satisfied ..... 1 = not satisfied

Number	Question	5	4	3	2	1	N/A	Comments
20 – 1	The medicines that I should receive from HKCC are always available							
20 – 2	The medicines that I receive from HKCC are very effective							
20 – 3	The financial amount that I pay for the medicines are very satisfactory							

21) Apart from the above mentioned services what do you expect more from HKCC?

_____

_____

_____

22) Please give three reasons why you appreciate the contribution of HKCC

1) _____

2) _____

3) _____

23) Please give three reasons why you are not satisfied with the contribution of HKCC and give your suggestions

Reasons	**Suggestions**
1)	
2)	
3)	

Questionnaire to the staff of HKCC

The purpose of this study is to evaluate the impact of a Primary Health Care Center – Case Study: Howard Karagheusian Commemorative Corporation (HKCC)

24) Gender:
☐ 1) Male ☐ 2) Female

25) Age:
☐ 1) 18 - 28
☐ 2) 29 – 39
☐ 3) 40 – 50
☐ 4) 51 and above

26) Place of birth: (City, Country)
_____

27) Where are you located?

Town/village: _____

Region: ☐ 1) Bourj Hammoud ☐ 2) Dbaye - Antelias
☐ 3) Eshrafieh – Mar Mkhael ☐ 4) Zalka – Jal El dib
☐ 5) Fanar - Rawda ☐6) Ainjar
☐7) Other (please specify) _____

28) Sect:
☐ 1) Armenian ☐ 2) Christian / Non-Armenian
☐ 3) Muslim ☐ 4) Drouz ☐ 5) Others

29) Marital Status:
☐ 1) Single ☐ 2) Married ☐ 3) separated
☐ 4) divorced ☐ 5) Widowed

30) How many children do you have?
☐ 1) Zero ☐ 2) One ☐ 3) two ☐ 4) three ☐ 5) more than three

31) Job Title:

☐ 1) Practical Nurse ☐ 2) Doctor / Physician ☐ 3) Social Worker
☐ 4) Secretary / Receptionist ☐ 5) Teacher

32) Income / month

1)☐ 300,0000 - 600,000 LL 2)☐ 601,000LL - 900,000LL
3)☐ 901,000LL - 1,200,000LL 4)☐ 1,201,000LL - 1,500,000LL

33) Department of work at HKCC?

☐ 1) OBS - GYN ☐ 2) Pediatric Clinic & Vaccination
☐ 3) School Health Service ☐ 4) Dental Clinic
☐ 5) OPTH Clinic ☐ 6) Social Workers department
☐ 7) Social Center / Vocational Training ☐ 8) Girls' at Risk Programme

34) Number of years working at HKCC

☐ 1) two – three years ☐ 2) three – four years
☐ 3) four – five years ☐ 4) five – six years
☐ 5) six– seven years ☐ 6) seven – eight years
☐ 7) eight – nine years ☐ 8) nine – ten years
☐ 9) ten – fifteen years ☐ 10) fifteen – twenty years
☐ 7) twenty – twenty five years ☐ 12) > twenty six years

35) Educational Status – Degree Obtained

☐ 1) None ☐ 2) Elementary Degree ☐ 3) Brevet
☐ 4) Lebanese Bacc II ☐ 5) University Degree (BS or BA)

Questions Relating HKCC:

36) Degree of availability:

5 = satisfied .....1 = not satisfied

Number	Question	5	4	3	2	1	N/A	Comments
13-1	HKCC Doctors are always available for helping and guiding the people							
13-2	HKCC nurses are always available for helping and guiding the people							
13-3	HKCC Social Workers are always available for helping and guiding the people							

37) Degree of satisfaction – staff (amount of time spend during consultation or during service)

5 = satisfied .....1 = not satisfied

Number	Question	5	4	3	2	1	N/A	Comments
14 - 1	I am satisfied with the Doctors help to the people							
14 - 2	I am satisfied with nurses help and support to the people							
14 - 3	I am satisfied with HKCC Social Workers help and support to the people							

38) Degree of Satisfaction – services: Please rate your degree of satisfaction with the services that HKCC offers

5 = satisfied .....1 = not satisfied

Number	Question	5	4	3	2	1	N/A	Comments
15 - 1	OBS - GYN							
15 - 2	Pediatric Clinic / Doctor's consultation							
15 - 3	Pediatric Clinic / Vaccination							
15 - 4	Pediatric Clinic / Well Baby Services							
15 - 5	Pediatric Clinic / Milk Mother's Program							
15 - 6	School health Services							
15 - 7	Cardiology Services							
15 - 8	Dental Clinic							
15 - 9	Ophthalmologic Clinic							
15 - 10	Audiology Clinic							
15 - 11	Social Worker's Services							

39) Degree of Effectiveness

5 = satisfied .....1 = not satisfied

Number	Question	5	4	3	2	1	N/A	Comments
16 - 1	The doctor's services are effective to the people							
16 - 2	The social benefit / services are effective to the people							

40) Degree of Medical Satisfactions

5 = satisfied .....1 = not satisfied

Number	Question	5	4	3	2	1	N/A	Comments
17 - 1	The medicines that the people need are found at HKCC							
17 - 2	The medicines that HKCC give is very effective							
17 - 3	The financial amount that the people pay are very satisfactory							

41) Apart from the above mentioned services what do you expect more from HKCC to the community?

_____

_____

_____

42) What do you expect more from HKCC as internal management?

_____

_____

_____

43) Please give three reasons why you appreciate the contribution of HKCC to the community?

1) _____

2) _____

3) _____

44) Please give three reasons why you are not satisfied with the contribution of HKCC to the community and give your suggestions.

Reasons	**Suggestions**
1)	
2)	
3)	

APPENDIX C

EXPLORATORY SURVEY RESULTS

Table C1: Gender

	Frequency	Percentage
Male	5'	2.4 %
Female	204	97.6 %
Total	209	100 %

Table C2: Age

	Frequency	Percentage
18 – 28	43	20.6 %
29 – 39	116	55.5 %
40 – 50	42	20.1 %
51 and above	8	3.8 %
Total	209	100 %

Table C3: Place of Birth

	Frequency	Percentage
Bourj Hammoud – Lebanon	94	45 %
Beirut – Lebanon	24	11.5 %
North of Lebanon	5	2.4 %
South of Lebanon	5	2.4 %
Syria	60	28.7 %
Armenia	9	4.3 %
Philippine	1	0.5 %
Becaa Valey – Lebanon	11	5.3 %
Total	209	100 %

Table C4: Current Location place

	Frequency	Percentage
Bourj Hammoud – Dora	175	83.7 %
Dbayeh – Antelias	14	6.7 %
Eshrafieh – Mar Mkhael	7	3.3 %
Fanar Rawda	13	6.2 %
Total	209	100 %

Table C5: Religious Sect

	Frequency	Percentage
Armenian	145	69.4 %
Christian – Non Armenian	39	18.7 %
Muslim	25	12 %
Total	209	100 %

Table C6: Marital Status

	Frequency	Percentage
Single	1	0.5 %
Married	200	95.7 %
Separated	1	0.5 %
Widowed	7	3.3 %
Total	209	100 %

Table C7: Number of Children

	Frequency	Percentage
None	2	1 %
One	49	23.4 %
Two	94	45 %
Three	38	18.2 %
More than three	26	12.4 %
Total	209	100 %

Table C8: Do you work?

	Frequency	Percentage
Yes	28	13.4 %
No	181	86.6 %
Total	209	100 %

Table C9: Kind of Job

	Frequency	Percentage
Employee	24	11.5 %
Goldsmith	1	0.5 %
Car Mechanic / Electrician	1	0.5 %
None	182	87.1 %
Army	1	0.5 %
Total	209	100 %

Table C10: Husband or wife work

	Frequency	Percentage
Yes	189	90.4 %
No	18	8.6 %
Dead	2	1 %
Total	209	100 %

Table C11: Kind of Job

	Frequency	Percentage
Employee	77	36.8 %
Shoe maker	31	14.8 %
Goldsmith	21	10 %
Car Mechanic / Electrician	31	14.8 %
Blacksmith	9	4.3 %
None	20	9.6 %
Army	4	1.9 %
Taxi Driver	16	7.7 %
Total	209	100 %

Table C12: Family Income per month

	Frequency	Percentage
0 – 300,000 LL	17	8.1 %
301,000 – 600,000 LL	82	39.2 %
601,000 – 900,000 LL	91	43.5 %
901,000 LL and above	19	9.1 %
Total	209	100 %

Table C13: Members contributing to Income

	Frequency	Percentage
Father	174	83.3 %
Mother	8	3.8 %
Child	11	5.3 %
Father & Mother	16	7.7 %
Total	209	100 %

Table C14: Medical Insurance

	Frequency	Percentage
None	144	68.9 %
CNSS	55	26.3 %
Medical Insurance Company	10	4.8 %
Total	209	100 %

Table C15: HKCC Visit

	Frequency	Percentage
None	0	0 %
More than once / week	9	4.3 %
Once / week	13	6.2 %
Once / month	122	58.4 %
Once / 3 months	41	19.6 %
Once / 6 month	24	11.5 %
Total	209	100 %

Table C16: JMP Visit

	Frequency	Percentage
None	171	81.8 %
More than once / week	0	0 %
Once / week	0	0 %
Once / month	26	12.4 %
Once / 3 months	1	0.5 %
Once / 6 month	11	5.3 %
Total	209	100 %

Table C17: ARCL Visit

	Frequency	Percentage
None	137	65.6 %
More than once / week	1	0.5 %
Once / week	0	0 %
Once / month	33	15.8 %
Once / 3 months	2	1 %
Once / 6 month	36	17.2 %
Total	209	100 %

Table C18: Degree of satisfaction: Availability of HKCC Doctors

	Frequency	Percentage
Not Satisfied	5	2.4 %
Somewhat unsatisfied	1	0.5 %
So – So	17	8.1 %
Somewhat satisfied	29	13.9 %
Satisfied	151	72.2 %
Not applicable	6	2.9 %
Total	209	100 %

Table C 19: Degree of satisfaction: Availability of HKCC Nurses

	Frequency	Percentage
Not Satisfied	1	0.5 %
Somewhat unsatisfied	1	0.5 %
So – So	10	4.8 %
Somewhat satisfied	30	14.4 %
Satisfied	164	78.5 %
Not applicable	3	1.4 %
Total	209	100 %

Table C 20: Degree of satisfaction: Availability of HKCC Social Workers

	Frequency	Percentage
Not Satisfied	4	1.9 %
Somewhat unsatisfied	2	1.0 %
So – So	5	2.4 %
Somewhat satisfied	10	4.8 %
Satisfied	73	34.9 %
Not applicable	115	55 %
Total	209	100 %

Table C 21: Degree of satisfaction: Consultation time / patient

	Frequency	Percentage
Not Satisfied	1	0.5 %
Somewhat unsatisfied	2	1.0 %
So – So	15	7.2 %
Somewhat satisfied	28	13.4 %
Satisfied	155	74.2 %
Not applicable	8	3.8 %
Total	209	100 %

Table C 22: Degree of satisfaction: Amount of time spent with Nurses

	Frequency	Percentage
Not Satisfied	1	0.5 %
Somewhat unsatisfied	2	1.0 %
So – So	9	4.3 %
Somewhat satisfied	28	13.4 %
Satisfied	163	78.2 %
Not applicable	6	2.9 %
Total	209	100 %

Table C 23: Degree of satisfaction: Amount of time spent with Social Workers

	Frequency	Percentage
Not Satisfied	3	1.4 %
Somewhat unsatisfied	1	0.5 %
So – So	7	3.3 %
Somewhat satisfied	14	6.7 %
Satisfied	68	32.5 %
Not applicable	116	44.5 %
Total	209	100 %

Table C 24: Service satisfaction: OBS - GYN

	Frequency	Percentage
Not Satisfied	6	2.9 %
Somewhat unsatisfied	1	0.9 %
So – So	4	1.9 %
Somewhat satisfied	8	3.8 %
Satisfied	73	34.9 %
Not applicable	117	56 %
Total	209	100 %

Table C 25: Service satisfaction: Pediatric clinic

	Frequency	Percentage
Not Satisfied	0	0 %
Somewhat unsatisfied	1	0.5 %
So – So	7	3.3 %
Somewhat satisfied	14	6.7 %
Satisfied	165	78.9 %
Not applicable	22	10.5 %
Total	209	100 %

Table C 26: Service satisfaction: Vaccination

	Frequency	Percentage
Not Satisfied	5	2.4 %
Somewhat unsatisfied	1	0.5 %
So – So	6	2.9 %
Somewhat satisfied	12	5.7 %
Satisfied	166	79.4 %
Not applicable	19	9.1 %
Total	209	100 %

Table C 27: Service satisfaction: Well Baby Service

	Frequency	Percentage
Not Satisfied	0	0 %
Somewhat unsatisfied	0	0 %
So – So	3	1.4 %
Somewhat satisfied	1	0.5 %
Satisfied	54	25.8 %
Not applicable	151	72.2 %
Total	209	100 %

Table C 28: Service satisfaction: Milk distribution program

	Frequency	Percentage
Not Satisfied	0	0 %
Somewhat unsatisfied	4	1.9 %
So – So	3	1.4 %
Somewhat satisfied	2	1 %
Satisfied	30	14.4 %
Not applicable	170	81.3 %
Total	209	100 %

Table C 29: Service satisfaction: School Health

	Frequency	Percentage
Not Satisfied	0	0 %
Somewhat unsatisfied	0	0 %
So – So	4	1.9 %
Somewhat satisfied	7	3.3 %
Satisfied	74	39.4 %
Not applicable	124	59.3 %
Total	209	100 %

Table C 30: Service satisfaction: Cardiology Service

	Frequency	Percentage
Not Satisfied	0	0 %
Somewhat unsatisfied	0	0 %
So – So	1	0.5 %
Somewhat satisfied	0	0 %
Satisfied	0	0 %
Not applicable	208	99.5 %
Total	209	100 %

Table C 31: Service satisfaction: Dental Clinic

	Frequency	Percentage
Not Satisfied	6	2.9 %
Somewhat unsatisfied	2	1 %
So – So	1	0.5 %
Somewhat satisfied	4	1.9 %
Satisfied	38	18.2 %
Not applicable	158	75.6 %
Total	209	100 %

Table C 32: Service satisfaction: OPTH Clinic

	Frequency	Percentage
Not Satisfied	1	0.5 %
Somewhat unsatisfied	2	1 %
So – So	0	2.4 %
Somewhat satisfied	5	1.9 %
Satisfied	58	27.8 %
Not applicable	143	68.4 %
Total	209	100 %

Table C 33: Service satisfaction: Audiology service

	Frequency	Percentage
Not Satisfied	0	0 %
Somewhat unsatisfied	1	0.5 %
So – So	1	0.5 %
Somewhat satisfied	4	1.9 %
Satisfied	16	7.7 %
Not applicable	187	89.5 %
Total	209	100 %

Table C 34: Service satisfaction: Social workers service

	Frequency	Percentage
Not Satisfied	3	1.4 %
Somewhat unsatisfied	3	1.4 %
So – So	9	4.3 %
Somewhat satisfied	9	4.3 %
Satisfied	64	30.6 %
Not applicable	121	57.9 %
Total	209	100 %

Table C 35: Degree of effectiveness: Doctor's Services

	Frequency	Percentage
Not Satisfied	2	1 %
Somewhat unsatisfied	0	0 %
So – So	11	5.3 %
Somewhat satisfied	19	9.1 %
Satisfied	167	79.9 %
Not applicable	10	4.8 %
Total	209	100 %

Table C 36: Degree of effectiveness: Social Services

	Frequency	Percentage
Not Satisfied	4	1.9 %
Somewhat unsatisfied	1	0.5 %
So – So	9	4.3 %
Somewhat satisfied	14	6.7 %
Satisfied	57	27.3 %
Not applicable	124	59.3 %
Total	209	100 %

Table C37: Medicine are found at HKCC

	Frequency	Percentage
Not Satisfied	11	5.3 %
Somewhat unsatisfied	0	0 %
So – So	55	26.3 %
Somewhat satisfied	69	33 %
Satisfied	62	29.7 %
Not applicable	12	5.7 %
Total	209	100 %

Table C 38: Medicines are effective at HKCC

	Frequency	Percentage
Not Satisfied	3	1.4 %
Somewhat unsatisfied	2	1 %
So – So	20	9.6 %
Somewhat satisfied	89	42.6 %
Satisfied	91	43.5 %
Not applicable	4	1.9 %
Total	209	100 %

Table C 39: Medical financial participation is very good

	Frequency	Percentage
Not Satisfied	6	2.9 %
Somewhat unsatisfied	1	0.5 %
So – So	8	3.8 %
Somewhat satisfied	52	24.9 %
Satisfied	137	65.6 %
Not applicable	5	2.4 %
Total	209	100 %

Table C 40: My suggestions are taken in to consideration

	Frequency	Percentage
Yes	0	0 %
No	2	1 %
Not applicable	207	99%
Total	209	100 %

Table C 41: What do you expect from HKCC

	Frequency	Percentage
Nothing	124	59.3 %
Nursery / kindergarten	14	6.7 %
Milk distributed to the needy	34	16.3 %
Generalist doctor for adults	11	5.3 %
Summer School	6	2.9 %
Expensive Vaccines to be reduced price	13	6.2 %
Financial Aid to the needy	7	3.3 %
Total	209	100 %

Table C 42: What do you appreciate the contribution of HKCC

	Frequency	Percentage
Low Cost	117	56 %
Doctors' consultation	31	14.8 %
Medical Aid	3	1.4 %
Nurses guidance	42	20.1 %
Social workers	15	7.2 %
None	1	0.5 %
Total	209	100 %

Table C 43: Favoritism at HKCC?

	Frequency	Percentage
Yes	65	31.1 %
Not applicable	144	68.9 %
Total	209	100 %

Table C 44: Too much waiting / unorganized management system at HKCC?

	Frequency	Percentage
Yes	71	34 %
Not applicable	138	66 %
Total	209	100 %

Table C 45: High price for some vaccines at HKCC?

	Frequency	Percentage
Yes	36	17.2 %
Not applicable	173	82.8 %
Total	209	100 %

Table C 46: Doctors are not vaccinating

	Frequency	Percentage
Yes	3	1.4 %
Not applicable	206	98.6 %
Total	209	100 %

Table C 47: Nurses are not available / need more nurse

	Frequency	Percentage
Yes	5	2.4 %
Not applicable	204	97.6 %
Total	209	100 %

Table C 48: Too little time for consultation per child

	Frequency	Percentage
Yes	10	4.8 %
Not applicable	199	95.2 %
Total	209	100 %

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