# Clients' Perspective towards Family-centered Care Health Services of Family-health services provider Partnership

# وجهة نظر االمستفيدين تجاه خدمات االرعاية الصحية التي تركز على الأسرة لشراكة الأسرة– مقدمي الخدمات الصحية

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**المستخلص**

**الأهداف:** لتقويم خدمات الرعاية الصحية التي تركز على الأسرة في الشراكة بين الأسرة ومقدمي الخدمة في بغداد / العراق.

**المنهجية:** أجريت دراسة وصفية تقويمية في محافظة بغداد. عينة عنقودية من 440 مراجعاً الذين يقومون بمراجعة مراكز الرعاية الصحية التي تعمل بنظام صحة الاسرة لغرض الخدمات الصحية. تتعامل الأداة الكامنة وراء ظاهرة الدراسة مع الخصائص الاجتماعية والديموغرافية للعميل واستبيان الرعاية المتمحور حول الأسرة والذي يشمل (الشراكة المتعلقة بفريق صنع القرار، ودعم الأسرة باعتباره ثابتًا في حياة الطفل، ودعم الأقران والأسرة. الانتقال إلى مرحلة البلوغ). تم تحديد صلاحية محتوى الاستبيان والموثوقية. تم إجراء التحليلات الإحصائية باستخدام برنامج SPSS الإصدار 20.0 (SPSS).

تتعامل الأدوات الكامنة وراء ظاهرة الدراسة مع الخصائص الاجتماعية والديموغرافية للعملاء واستبيان رعاية صحة الأسرة والذي يشمل (الشراكة المتعلقة بفريق صنع القرار، ودعم الأسرة باعتباره عامل أساسي في حياة الطفل، ودعم الأقران والأسرة. الانتقال إلى مرحلة البلوغ). تم تحقيق مصداقية الاستبيان من خلال دراسة تجريبية ثم عرضه على الخبراء لإثبات مصداقيته. تم جمع البيانات باستخدام أسلوب المقابلة الشخصية وتحليلها من خلال تطبيق التحليل الإحصائي الوصفي والاستنتاجي.

**النتائج:** تظهر النتائج ان عمر المشاركين ضمن الفئة العمرية 20–29 عامًا أعلى نسبة بين (n = 179 ؛ 40.7٪) ، وكانت الإناث هي الجنس السائد بين المراجعين الذين يراجعون مراكز الرعاية التي تعمل بنظام صحة الأسرة ( n = 281 ؛ 63.9٪) ، المراجعون الأميون يسجلون أعلى نسبة (n = 97 ؛ 22٪) ، معظم المراجعات حصلوا على الخدمات الصحية من اللقاحات (n = 188 ؛ 42.7٪). تم التعبير عن المراجعين الذين شملتهم عينة الدراسة بمستوى ضعيف من الشراكة مع مزود الخدمة. كانت هناك فروق ذات دلالة إحصائية في الخدمات الصحية الشراكة بين الأسرة ومقدمي الخدمة فيما يتعلق بمستوى تعليم المراجعين وأنواع الخدمات التي تم تلقيها بقيمة $p < 0.05$.

**الاستنتاجات:** الشراكة بين الأسرة ومقدمي الرعاية خارجة عن المألوف. من أجل أن يكون نظام الرعاية الصحية سريع التطور فعالاً، فإن التعاون بين مقدم الخدمة والأسرة في تصميم الرعاية وتقديمها وتقييمها أمر ضروري. لتحسين الرعاية والنتائج، يدرك أصحاب المصلحة بشكل متزايد أهمية تركيز الرعاية على المريض ودمج وجهات نظر المريض والأسرة

**التوصيات:** تحتاج مراكز صحة الأسرة إلى المراقبة والتقييم بشكل دوري فيما يتعلق بتقديم خدمات الرعاية الصحية وفق المعيار، الأمر الذي ينعكس في كسب ثقة الفرد في المركز الصح، لابد من إجراء المزيد من الأبحاث في تقييم جودة الخدمات الصحية لمراكز رعاية صحة الأسرة، بناءً على المعايير الدولية المعتمدة من قبل المنظمات الصحية الدولية.

**الكلمات المفتاحية:** المراجعين، خدمات الرعاية الصحية، الشراكة، الاسرة، رعاية صحة الاسرة

## Abstract

**Objective:** To evaluate the family-centered health care services of family-health services provider partnership in Baghdad/ Iraq.

**Methods**: A descriptive evaluation study is conducted in Baghdad Province. A cluster samples of 440 clients who attend the family centered care for the purpose of health services. The instrument underlying the study phenomenon deals with client's socio-demographic characteristics and family centered care questionnaire which include (partnership related to decision-making team, supporting the family as the constant in the child's life, family-to-family and peer support and supporting transition to adulthood). Content validity of the questionnaire

and reliability has been determined. Statistical analyses were performed using the SPSS version 20.0 software program (SPSS).

**Results**: Findings show participants age of 20-29 years old were recorded the highest percentage (n=179; 40.7%), female were the predominated gender (n=281; 63.9%), the illiterate clients were records the highest percentage (n=97; 22%), most of the participants had health services in terms of vaccinations (n=188; 42.7%). The clients who included in the study sample were expressed a poor level of family-provider partnership. There were significant differences in family-provider partnership health services with regard to clients' education level and types of services were received at p-value <0.05.

**Conclusion:** Partnerships between family and providers are out of the ordinary. In order for a fast-evolving health care system to be effective, family-provider collaboration in care design, delivery, and assessment is essential. To improve care and results, stakeholders are increasingly recognizing the importance of focusing care on the patient and incorporating patient and family viewpoints.

**Recommendations:** Family health centers need to be monitored and evaluated periodically with regards to providing health care services according to the standard, which is reflected in gaining the confidence of the individual in the health center. Further researches need to be conducted in evaluating the quality of health services of family health care centers, based on international standards approved by international health organizations.

**Keywords**: Clients, Health Care Services, Partnership, Family, Family Health Care.

## Introduction

Families and health care providers are increasingly collaborating on their own health-care needs and advising on how to improve care delivery. Crossing the quality chasm: a new health system for the Twenty-First Century, a seminal 2001 report from the Institute of Medicine, promoted patient-centered care and emphasized "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions"[1] .

The new emphasis on patient-centered care has grabbed the attention of both patients and professionals because it responds to a call to respect patient values and preferences [2]; returns to the fundamentals of medicine by stressing trustworthy patient–physician relationships and the ideas that underlie them; and has the potential to enhance results, increase patient safety, and reduce costs [3].

Although research suggests that patient and family partnership can improve a variety of outcomes, there are numerous barriers in engaging patients and families successfully and practically in both individual care exchanges and health-care system governance. A study of over 1400 acute care hospitals in the United States found significant diversity in the adoption of patient and family partnership methods such as participation in shift-change reports and the formation of a patient and family advisory board [4].

Furthermore, the study revealed many implementation difficulties, including competing organizational goals, the perceived time required to engage patients in shift reports and rounding conversations, and clinical training in effectively involving patients [5]. Therefore, the current study aimed to evaluate the family-centered care health services of family-provider partnership in Baghdad/ Iraq.

## Methodology

A descriptive evaluation study is conducted in Baghdad Province. A cluster samples of 440 clients who attend the family health centered care for the purpose of having health services. The instruments underlying the study phenomenon deals with client's socio-demographic characteristics and family centered care questionnaire which include: partnership related to decision-making team, supporting the family as the constant in the child's life, family-to-family and peer support and supporting transition to adulthood.

Data were collected out from clients to verify the reliability of questionnaire; the test was applied to 40 of the study population from outside the sample. Cronbach's alpha was found at 0.79.

Statistical analyses were performed using the SPSS version 20.0 software program (SPSS). The data were normally distributed. One-way analysis of variance to analyze the differences variables according to socio-demographic characteristics. Descriptive data are presented as mean ± standard deviation for continuous variables and number (%) for categorical variables. A $p < 0.05$ was considered as statistically significant.

**Results**

**Table (1): Distribution of the Study Sample by their Demographic Characteristics**

| Variables | Classification | Freq. | % |
|---|---|---|---|
| Age /years<br>Mean± SD=39±15.196 | <20 years old | 16 | 3.6 |
| | 20-29 years old | 179 | 40.7 |
| | 30-39 years old | 35 | 8.0 |
| | 40-49 years old | 74 | 16.8 |
| | 50-59 years old | 81 | 18.4 |
| | ≥60 years old | 55 | 12.5 |
| Gender | Male | 159 | 36.1 |
| | Female | 281 | 63.9 |
| Education | Does not read and write | 97 | 22.0 |
| | Reads and writes | 69 | 15.7 |
| | Primary school | 83 | 18.9 |
| | Intermediate school | 51 | 11.6 |
| | Secondary school | 49 | 11.1 |
| | Institute and above | 91 | 20.7 |
| Types of health services | Caring for the expectant mother | 106 | 24.1 |
| | Child care | 68 | 15.5 |
| | Health promotion | 28 | 6.4 |
| | Emergencies | 2 | 0.5 |
| | Vaccines | 188 | 42.7 |
| | Family planning | 36 | 8.2 |
| | Dental health | 12 | 2.7 |

The findings in this table show participants age (the mean age for clients' is 39) the age between 20-29 years old were recorded the highest percentage among them (n=179; 40.7%), females were the predominated gender (n=281; 63.9%), as compared with those who are males (n=159; 36.1%). In terms of education levels, it is obvious from findings that the illiterate clients were records the highest percentage (n=97; 22%) and most of the attend the centers for vaccinations (n=188; 42.7%),

**Table (2): Family-health Services Provider Partnership related to Decision-Making Team**

| Weighted | Freq. | % | *M ± SD* |
|---|---|---|---|
| Poor | 265 | 60.2 | *29.82± 7.246* |
| Moderate | 155 | 35.2 | |
| Good | 20 | 4.5 | |
| *Total* | 440 | 100.0 | |

***M: Mean for total score, SD: Standard Deviation for total score (Poor= 18-30, Moderate= 31-42, Good= 43-54)***

The analysis of family-centered care health services family-provider partnership decision-making team at M ± SD= 29.82±7.246; and according to the study criteria, clients expressed a poor family-provider partnership related to decision making team (table 2).

**Table (3): Family- health Services Provider Partnership related to Supporting the Family as the Constant in the Child's Life**

| Weighted | Freq. | % | M ± SD |
|---|---|---|---|
| Poor | 253 | 57.5 | 9.45±2.989 |
| Moderate | 132 | 30.0 | |
| Good | 55 | 12.5 | |
| *Total* | 440 | 100.0 | |

***M: Mean for total score, SD: Standard Deviation for total score (Poor= 6-9, Moderate= 10-13, Good= 14-18)***

In table (3), The findings of family-centered care health services related to supporting the family as the constant in the child's life at M ± SD= 9.45±2.989; and according to the study criteria, clients expressed a poor supporting the family as the constant in the child's life.

**Table (4): Family- health Services Provider Partnership related to Family-to-Family and Peer Support**

| Weighted | Freq. | % | M ± SD |
|---|---|---|---|
| Low | 249 | 56.6 | 9.66±3.869 |
| Moderate | 118 | 26.8 | |
| Height | 73 | 16.6 | |
| *Total* | 440 | 100.0 | |

***M: Mean for total score, SD: Standard Deviation for total score (low= 6-9, Moderate= 10-13, height = 14-18)***

The findings of family-centered care health services related to family-to-family and peer support at M ± SD= 9.66±3.869; and according to the study criteria, clients expressed a poor family-to-family and peer support (table 4).

**Table (5): Family- health Services Provider Partnership related to Supporting Transition to Adulthood**

| Weighted | Freq. | % | M ± SD |
|---|---|---|---|
| Poor | 314 | 71.4 | 15.60±6.481 |
| Moderate | 65 | 14.8 | |
| Good | 61 | 13.9 | |
| *Total* | 440 | 100.0 | |

***M: Mean for total score, SD: Standard Deviation for total score (Poor= 11-18, Moderate= 19-25, Good= 26-33)***

The findings of family-centered care health services related to supporting transition to adulthood at M ± SD= 15.60±6.481; and according to the study criteria, clients expressed a poor support transition to adulthood.

**Table (6): Significant Differences between Family-centered Health Care Services and Clients' Age (n=440)**

| Age Variables | Source of variance | Sum of Squares | d.f | Mean Square | F | *p≤ 0.05* |
|---|---|---|---|---|---|---|
| FCC | Between Groups | .459 | 5 | .092 | 2.092 | *0.065 No-sig.* |
| | Within Groups | 19.030 | 434 | .044 | | |
| | Total | 19.488 | 439 | | | |

***d.f: Degree of freedom, F: F-statistic, Sig: Significance***

The findings indicated that there is no-significant differences in family-centered care health services with regard to clients' age at p-value >0.05.

**Table (7): Significant Differences between Family-centered Health Care Services and Clients' Gender (n=440)**

| | Gender | Mean | S.D | t-value | d.f | *p≤ 0.05* |
|---|---|---|---|---|---|---|
| FCC | Male | 1.56 | 0.2056 | 0.540 | 438 | *0.498 No-sig.* |
| | Female | 1.57 | 0.2137 | | | |

***d.f: Degree of freedom, F: F-statistic, Sig: Significance***

The findings demonstrated that there is no-significant differences in family-centered care health services with regard to clients' gender at p-value >0.05.

**Table (8): Significant Differences between Family-centered Health Care Services and Clients' Education (n=440)**

| Education Variables | Source of variance | Sum of Squares | d.f | Mean Square | F | *p≤ 0.05* |
|---|---|---|---|---|---|---|
| FCC | Between Groups | .805 | 5 | .161 | 3.742 | *0.003 Sig.* |
| | Within Groups | 18.683 | 434 | .043 | | |
| | Total | 19.488 | 439 | | | |

***d.f: Degree of freedom, F: F-statistic, Sig: Significance***

The findings indicated that there were significant differences in family-centered care health services with regard to clients' education level at p-value <0.05.

**Table (9): Significant Differences between Family-centered Health Care Services and Types of Health Services (n=440)**

| Health services | Source of variance | Sum of Squares | d.f | Mean Square | F | *p≤ 0.05* |
|---|---|---|---|---|---|---|
| FCC | Between Groups | .562 | 6 | .094 | 2.145 | *0.047 Sig.* |
| | Within Groups | 18.926 | 433 | .044 | | |
| | Total | 19.488 | 439 | | | |

***d.f: Degree of freedom, F: F-statistic, Sig: Significance***

The findings indicated that there were significant differences in family-centered care health services with regard to types of health services at p-value <0.05.

## Discussion

### Family-centered Care Health Services Related to Family-provider Partnership

Clients and family-centered care is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. In present study findings of family-centered care health services related to family-provider partnership at M ± SD= 64.56±12.012; and according to the total mean of scores, clients expressed a poor family-centered care health services related to family- health services provider partnership. This finding come consistent with a study on family-providers partnership, 14,393 papers of which 55 met the criteria and were included. Family-centered care models are most commonly available for pediatric patient populations (n = 40) were expressed poor family-providers partnership in the health care services [6].

It is reported that family-provider partnership was unsatisfactory and associated with fewer missed school days (16% less) and more preventive care visits (11% more). Family provider partnership is an important factor in the family health care systems. This relationship, along with other factors such as family strain, health insurance, gender, and racial/ethnic differences play a large role in a family's experience of health.

The poor family-centered care health services related to family-health services provider partnership due to barriers to

clients and family centered care were staffing constraints and reduced levels of staff experience, high staff workloads and time pressures, physical resource and environment constraints and unsupportive staff attitudes.

It redefines the relationships in health care by placing an emphasis on collaborating with people of all ages, at all levels of care, and in all health care settings. In patient- and family-centered care, patients and families define their "family" and determine how they will participate in care and decision-making. A key goal is to promote the health and well-being of individuals and families and to maintain their control [7].

**Family-provider Partnership related to Decision-Making Team**

Work with families is providing opportunities for sharing experiences and resources in a non-judgmental, supportive environment. These opportunities have been created through the development of family support groups. In current study, the family-centered care health services family-provider partnership decision-making team at M ± SD= 29.82±7.246; and according to the study criteria, clients expressed a poor family-provider partnership related to decision making team.

A multivariate model showed that health care services associated with family-provider partnership decision-making in not to the required level, due to they are not in line with the standard for services, it was only limited to decisions health care providers. Families share the power and responsibility of making decisions about the way services are not provided. Family members are involved in all facets of their child's care. Families are active members of the treatment team and participate on program committees aimed at improving our quality of services to children and families [8].

Since the decision-making team partnership is considered collaboration between family members and health care providers, consideration of family contexts, policies and procedures, and patient, family, and health care professional education. But it is not in line with the standard in providing the service due to the policies of the decision that is limited to health care providers [9].

**Family-provider Partnership related to Supporting the Family as the Constant in the Child's Life**

In the current study findings of family-centered care health services related to supporting the family as the constant in the child's life were poor health services (M ± SD= 9.45±2.989).

It is stated that the humanize the management of children in family health care services has become a serious concern of civil society and one of the main goals of public health centers, health care providers and governments, because of the services provided to the family-child's become bad services. Family-centered and family-oriented care concepts should be incorporated into all aspects of pediatricians' professional practice, whether it is private practice or in public health, to better serve the needs of children from both health centers and families [10].

Family has a significant role in constant in the child's life, since it can provide effective psychological and emotional support to child undergoing growth properly. This can make them capable of providing effective support to inside with share health care providers [11].

Family-centered need to be programs offer a variety of services in tune with what the parents as individuals and as a group need and want. When parents and health care works together they enhance children's emotional security, which facilitates development and makes is easier for them to development properly [12].

**Family-provider Partnership related to Family-to-Family and Peer Support**

Family-to-family and peer supports are ways to bring together families, youth and others who share similar life situations so they can share their knowledge, concerns, and experiences with each other. Peer support workers aim to support, educate and empower parents whose children were removed and placed in care or may be at risk of being removed. They are part of a team of parent peers who have successfully navigated child protection systems and use their experiences to help others. The findings of family-centered care health services related to family-to-family and peer support were poor peer support (M ± SD= 9.66±3.869).

There is a low level of client satisfaction with peer family support services in Tanzania. Improving this level will require improvements in the provision of staff training and the availability of equipment support these services [13].

A study found that the magnitude of client satisfaction with the services was found to be low. Many of the factors that attributed to the low level of client satisfaction are modifiable. There is a need for organizing the family center care as per standards, maintaining privacy, minimizing waiting time, and describing the side effects during the provision of service [14].

**Family-provider Partnership related to Supporting Transition to Adulthood**

The period of time during which families, youth and providers plan for and develop the process to assure that youth will able to successfully manage all aspects of their healthcare and be prepared to take on adult responsibilities, and ultimately, live as independently as possible and continue to receive high quality healthcare services. The findings of the present showed that the poor family-centered care health services related to supporting transition to adulthood (M ± SD= 15.60±6.481).

The poor support transition to adulthood in family centered care is supported by study deals with 15–20% of youth in North America affected by a chronic health condition (e.g., type 1 diabetes, cystic fibrosis) and /or mental health or neurodevelopment disorder (e.g., depression, eating disorder, Attention Deficit-Hyperactivity Disorder), many often require lifelong specialist healthcare services. Ongoing primary care during childhood and into young adulthood is recommended by best practice guidelines according of the study investigated adult care [15].

Another study found that there was poor family health services deals with support transition to adulthood. Despite the well-documented risks and costs associated with a poor transition from pediatric to adult care, little policy attention has been paid to this issue. It is recommend that healthcare providers engage with health system planners in the design and evaluation of system-level, policy-sensitive transition strategies [16].

**Differences in Family-centered Care Health Services with regards to Clients' Socio-demographic Characteristics**

Findings indicated that there is no-significant differences in family-centered care health services with regard to clients' age at p-value >0.05.

This result agrees with a study which find that there was no significant differences in age groups with regarding health services provided in family centered care [17].

Also, there is no-significant differences in family-centered care health services with regard to clients' gender at p-value >0.05.

No significant differences in male and female with regarding health services provided in family centered care. Because the same use of those services especially during COVID-19 [18].

The findings revealed significant differences in family-centered care health services with regard to clients' education level at p-value <0.05. Because the evaluation was from the reviewers, so we find differences according to the educational level.

Education level plays an importance roles in evaluation of family health care services [19].

There were significant differences in family-centered care health services with regard to types of health services at p-value <0.05.

A study in Babylon/Iraq, find a significant differences in client's satisfaction with regarding health services provided by the health care centers, according to the difference of those services from one unit to another in the same health center [20].

**Conclusion**

Partnerships between family and providers are out of the ordinary. In order for a fast-evolving health care system to be effective, family-provider collaboration in care design, delivery, and assessment is essential. To improve care and results, stakeholders are increasingly recognizing the importance of focusing care on the patient and incorporating patient and family viewpoints.

**Recommendations**

Family health centers need to be monitored and evaluated periodically with regards to providing health care services according to the standard, which is reflected in gaining the confidence of the individual in the health center and further researches need to be conducted in evaluating the quality of health services of family health care centers, based on international standards approved by international health organizations.

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