Findings of
Focus Group Research on
Integrated Response of Health Care Systems to Rapid
Population Ageing In Damascus - Syria

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Executive Summary

Purpose of the Study

Objectives of INTRA II

The specific aim of the focus group study is to assess current situation and the potential for integration in PHC. The concept of integration is operationalized here as collaboration/co-ordination and continuity of care. The following dimension/objectives have been defined reflecting the overall scope of the study:

- **Needs and sources of care**
  
  To define the health-related needs of 50 yr+ PHC users.  
  To define the different sources of care potentially available to them.

- **Collaboration/Co-ordination**
  
  To describe the current degree of collaboration and co-ordination between the various components of PHC and their interface with other areas of care provisions (secondary and tertiary care; LTC; social welfare; NGO sector).  
  To ascertain the potential for increased collaboration/co-ordination.  
  To establish the factors which facilitate collaboration/co-ordination.  
  To establish the factors which act as barriers to collaboration/co-ordination.

- **Continuity of care**
  
  To describe current practices that ensure continuity of care.  
  To ascertain the potential for increased continuity of care.  
  To establish the factors which facilitate continuity of care.  
  To establish the factors which act as barriers to continuity of care.

Method and tools

**Type of the study**: qualitative study, focus group.

**Place of the study**: Damascus, Syria (as part of the INTRA II).

**Date of the study**: It was conducted during the period between 13/4/2004 and 04/05/2004, one group per day.

**Sources of the data**: The data in this study were obtained from three sources: 1. PHC regular users; 2. PHC professionals; and 3. Representatives of the different sectors that may be involved in elderly health services.
Preparations for the groups:
The guides of the focus groups, suggested by the principal investigators, were adapted to suit the local situation of Syria.

Field workers were trained to use these guides. Three of them were selected to moderate and assist recording of the focus groups in addition to the study coordinators.

Informed consents were obtained immediately before the beginning of the groups according to the conventional forms (the forms that were suggested by the Principal investigators and translated into Arabic language).

Composition of the groups:
Total participants were 128 persons. They were clustered in 14 groups as follow:

Participants of the care providers were three groups (29 persons). They were selected from all nine health centers that have clinics that are devoted to elderly health care in Damascus, one of doctors, one of nurses, and one of the other personnel in these centers (8-10 persons in each group).

Participants from the elderly persons were ten groups (89 persons). They were selected from all the nine health centers of Damascus that have elderly health clinic. They represented all age, sex, and social groups that attend these centers (7-10 persons in each group). Two groups were excluded from the analysis for non meeting of the specifications (Fayez Mansour group, and El-Thyabieh female group).

The inclusion and exclusion criteria of the older persons were:

- 50+
- frequent users of PHC
- presenting with at least one chronic condition

Those with dementia, who were very ill, or who had hearing and speech difficulties were excluded from the study.

Participants of the representatives of other sectors are ten. They are from different sectors that are responsible for elderly health care and services. Those representatives are from the following sectors: Ministry of Health, Ministry of Social affairs, Ministry of Local Administration, Ministry of Information, Ministry of Industry, Ministry of Culture, Board of Planning, NGOs, Sport Association, and Syrian Red Crescent.

Setting:
Focus groups were held in different health centers (4 in Eight March center, one in Zuhair Hubby center, one in Fayez Mansour center, one in Seven April center, one in El-Taliby center, one in Abi-Thar El-Ghifary center, one in El-Adawi
center, one in Dummar El-Balad center, two in El-thyabieh center, and one in AIDS control center.

Health education wards in these centers were used. In these wards, sitting of the participants and the moderator was round. There was a table for transcriber. Sometimes two tape-recorders were used to guarantee the persistence of recording. In other situations, and in addition to writing, one tape-recorder only was used due to the local circumstances. No serious problems were occurred in recording except in the situation of Fayez Mansour center.

**Moderation:**
Focus groups of the care providers, and the free discussion with the representatives of the other sectors, were moderated by the coordinator of the study due the limited time that does not enable us to train somebody for this purpose. They were assisted by two trained field workers (for transcription, recording and note-taking of non-verbal expressions). Focus groups of the elderly people were moderated and assisted by the trained field workers.

**Procedure:**
First focus group was attended by nine persons. They are doctors from different health care centers in Damascus who are responsible for providing services to elderly people.

Second group was attended by nurses who work in elderly health clinics in the same centers.

Third group consisted of the health educators and social researchers.

The guide of the discussions with these groups included the following main components:

- Health definition, elderly health definition, elderly health needs, and elderly health program and its location in primary health care.
- Doctor, nurses, and health educator tasks in health care that are provided to elderly people, cases that may be seen in health centers, services provided, and continuity of care (practices, possibilities for increasing those practices, factors with, and factors against).
- Co-operation and coordination in the field of elderly health (the degree and practices, possibilities for increasing, factors with, and factors against).
- Health care provider satisfaction, problems and constraint, and suggestions.

4-13 groups were consisted from elderly people (chosen from clients of health centers) according to the following:
Four 50-64 age groups of males and females, and low and high socioeconomic areas. Each of them consisted of 8-10 persons.
Four 65+ age groups of males and females, low and high socioeconomic areas. Each of them consisted of 8-10 people.
Two additional groups: one of them was consisted of a seven mixed age males from a high socioeconomic area, and the other was consisted of ten 50-64 females from a low socioeconomic area.

The guide of the discussions with these groups included the following main components:
- Health definition and elderly health needs.
- Care provider (who, how to be chosen, frequency, utilization of preventive services, and continuity of care).
- Decision taking about care-provider (how and why). If not then how and why, and what is the alternative.
- Referral system (knowledge, utilization, positives, and negatives).
- Co-operation and coordination.
- Satisfaction and why, important problems, experiences, and suggestions and priorities.

The free discussions with the different stakeholders of elderly health care services were around the subjects of needs and sources of care, coordination and collaboration, and continuity of care.

**The output:**
Duration of every group was 1:30 to 2:00 hours.

The focus groups were hand-written and voice-recorded. The responses were combined together and transcribed using PC.

Two groups were excluded from the analysis because of non-meeting on the specifications.

Content approach was used to analyze the data.

**Limitations of the study:**
- While focus groups can provide very rich data, the results are not statistically representative in the way that data from a probability survey are, because sample size is relatively small, and the participants are drawn purposively.
- Rather than being representative, focus group participants reflect selected characteristics of a given population, which enable this research to yield descriptive but not definitive data.
- Limitations in communication with principal investigators and Limited time that was available for the implementation of the protocols of the study.
- Three-days training course on focus group is a short period.
- Three groups only were selected from professionals because no other health workers in elderly health were existed in Damascus.
• Some persons who attend focus groups did not meet inclusion criteria. The responses of those persons were excluded from the analysis.

• Informed consents were obtained immediately before focus groups due to many difficulties in the local situation.

• No sufficient time was available for modification of the guides, and training on their using.

• No pilot focus groups were conducted to test the modified guides because of limitations in time (the guides were tested before?)

• Competencies of the field workers were not so high.

• Place of the focus groups were in health centers due to local difficulties.

Summary of the Findings

The main findings of the study can be presented according to the following main items:

Needs and sources of care

• Health-related needs of 50 yr+ PHC users.

According to health care personnel, health needs of the elderly people are mainly medical service, good relations with the personnel of health care centers, and drugs. They also, at a lower importance and weight, mentioned that elderly people need health care and rehabilitation, medical equipments, nutrition, physical activity, health education, near health center, and psychosocial support. Doctors concentrated on the need for good physical examination, investigations, and treatment. Nurses and other health care personnel mentioned mainly the need for good relations with elderly people, and drugs.

According to the beneficiaries, the main need was drugs. All of them in all groups have mentioned this need. Other needs were good relationships with the personnel working in health centers, respect by the community, blood pressure monitoring, periodical examination, nutrition, education, and physical and mental rest. Some of those from high socioeconomic area, six males and two females, concentrated mainly on the need for good relations with health care personnel, while all those from low socioeconomic area concentrated on the drug and financial needs.

According to the representatives of other elderly health care sectors, needs are place for care, health insurance, dignity protection, nutrition, community education, trained health care personnel specially nurses, home visits, recreation, psychological support, filling leisure time, and physical activity.

• Different sources of care potentially available to them.

Doctors saw the role of doctors and elderly health program of the Ministry of Health as a source of care. Nurses' opinion is that the main role is the role of the
nurses, especially those who are properly educated and trained. One nurse only saw that the role of the nurse is not essential in the care provided to elderly people. Other health care personnel believe that there are roles for health educator and elderly homes. They believe also that the current situation is in need for good qualification and training of the educators and adequate equipment that may facilitate the process of health education.

The main sources of care according to beneficiaries from the two socioeconomic areas, and the two genders, are Doctors of the health care centers, specialized clinics of the Ministry of Health, and hospitals of the Ministry of Health and the Ministry of Higher Education. Some of those from high socioeconomic area mentioned the private sector as being the main source.

Other sources are doctors of the private sector, private hospitals, private laboratory, pharmacy, Al-Afieh fund, self care, elderly homes, and subsidized workers health centers. They use these sources only when necessary due to their financial circumstances.

The representatives of other sectors concentrated on the voluntary work and volunteers as a source of care. They also stressed on the role of the nurse and home visits, and the need to qualify nurses who will be able to do that task efficiently.

**Collaboration/ Co-ordination**

- **The current degree of collaboration and co-ordination between the various components of PHC and their interface with other areas of care provisions (secondary and tertiary care; LTC; social welfare; NGO sector).**

For some doctors, nurses, and other health personnel, the collaboration and co-ordination depends on referral system. Doctors see that referred people do not find the expected care. Two of them believe that the care provided at the referral place depends on individual relations and not on an official system, and the patient may need to pay some illegal money, if he or she doesn’t know anybody there, to get the demanded service. On reverse nurses see that referral is good for primary health care users. Other health workers see that the referral system was existed in the early stages of the application of the elderly health program, but now it is not.

Some doctors see the role of other sectors like Ministry of Information, but they said that there is no role for them in actual situation.

Primary health care users experienced referral and most of them believe that it is not useful. They are not satisfied by the quality of care. Few of them (two only) saw it good because of their financial problems and their inability to pay.
Representatives of other sectors believe that all persons are ready to co-operate and coordinate, but in reality there is nothing done in these fields. Representative of the Ministry of Social Affairs and the Ministry of Information saw that the co-operation is partial and takes place in some occasions only like the activities that are implemented in the elderly day once a year.

**The potential for increased collaboration/co-ordination.**

Doctors see that collaboration/co-ordination can be improved by increasing equipments in health centers, establishing elderly health clinic inside the hospital, planning for training courses for doctors on geriatric health, allocating special vehicles for elderly people transportation, and preparing a comprehensive strict plan for coordination with other sectors. The other personnel of the health centers see the improvement of collaboration/co-ordination in training courses that can be provided to the personnel of other sectors.

Representatives of other sectors believe that the main thing in improving collaboration/co-ordination is the need for establishing the national team and involving all other sectors. This national team may be responsible for planning for the future strategy, planning for mechanisms of connecting all sectors together, and follow-up. They also motivate the individual initiatives. The potential for all of those procedures to be successful is the enthusiasm that all of them have.

**The factors which facilitate collaboration/co-ordination.**

Doctors believe that improving general socioeconomic status of the population may facilitate collaboration and co-ordination. Also the effect of the conscience, providing health centers with social workers, and financial incentives can do that. They decided that this depends on legislations and not on personal attitudes.

Primary health care users see the solution of the collaboration and co-ordination problem in setting good procedures for social classification and social insurance. They depends also on the co-operation between the Ministry of Social Affairs and the Ministry of Health, and providing good health care at elderly homes, and raising Islam awareness and following its rules.

Representatives of other sectors find that working as a team, with the same importance of every member, is a good facilitator of collaboration and co-ordination.

**The factors which act as barriers to collaboration/co-ordination.**
The barriers in the opinions of primary health care users are:

- Two mentioned the existence of waiting list, and five mentioned the large numbers of clients.
- Many of them mentioned the need to know someone in the referral level in order to facilitate the affairs of the referred person.
- Two of them mentioned the slow procedures, and the short doctor time in the clinic.
- One of them mentioned the need for companionship when referred.
- One of them mentioned drawing the patient to private clinic.
- Two of them mentioned paying illegal additional fees.
- Three of them mentioned the accessibility problems.

Representatives of other sectors see the barrier as been the individualism in work (not group or team work).

**Continuity of care**

- **Current practices that ensure continuity of care.**

  **Doctors:**
  - No home visits.
  - No periodical examination.
  - No administrative monitoring of the elderly health program.

  **Nurses:**
  - One only: connecting elderly people to health center by sport day at the center.

  **Users:**
  - One of them sees that Social co-operation is the solution for their problems.
  - Another one follows frequent visits to health center.
  - Few of elderly people have periodical follow-ups.

- **The potential for increased continuity of care.**

  **Doctors:**
  - Training courses.

  **Nurses:**
  - Elderly gardens.
  - Elderly journeys.
  - Elderly meetings.

  **Users:**
  - Good care in all places.
  - Psychological care.
  - Special clinic.

  **Other sectors:**
  - Raising family awareness.
  - Financial support of the family.
• Training the personnel.
  o Volunteers, how can we create this? By advertising, the role of health centers, and the role of NGOs.

• **The factors which facilitate continuity of care.**

  Doctors:
  o Good relations with elderly people.
  o The existence of drugs.
  o BP monitoring.

  Nurses:
  o The existence of drugs.
  o Good relations with elderly people.
  o Raising awareness of the patient.
  o Care for psychological status of elderly people.
  o The existence of all specialties in health center.

  Other personnel:
  o The existence of drugs.
  o Good relations with elderly people.

  Users:
  o Insulin distribution.
  o Good dealings with health personnel.

• **The factors which act as barriers to continuity of care.**

  Doctors:
  o The personality of the doctor that cannot be changed.

  Users:
  o No drugs.
  o Weakness of the experience of health personnel.
  o Bad dealings with health personnel.
  o No care and insurance after retirement.