QUALITY OF PRIMARY HEALTH CARE FACILITIES SUPERVISION AND IT'S ASSOCIATED FACTORS: THE CASE OF MBEYA CITY COUNCIL.

BY

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A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF PUBLIC HEALTH OF THE MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

2008

CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance of a dissertation titled "**Quality of Primary Health Care Facilities Supervision and its Associated Factors. The case of Mbeya city Council.**" in fulfillment of the requirements of the Master of Public Health Degree of Muhimbili University of Health and Allied Sciences.

Supervisor: Dr.Mughwira Mwangu.

Signature: .....

Date: 9th November 2008

DECLARATION:

I James Charles, declare solemnly that this dissertation is my own original work and that it has not been submitted to any university for a similar degree or any other degree award.

Candidate's Signature .....

James Charles

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DEDICATION:

This dissertation is dedicated to my lovely mom, wife and sons.

ABSTRACT

Despite of a growing pool of health sector reform resources channeled to the district, supervision of (PHC) Primary Health Care facilities has continually remained poor and inadequate. This has contributed to poor performance of health care providers and quality of health services, hence increasing user's dissatisfaction to the services offered. A descriptive cross sectional study involving 32 private and public PHC facilities and 7 Council Health Management Team (CHMT) members was conducted in Mbeya City Council in July, 2008 to determine the quality of CHMT supervisory visits to PHC facilities in the past 12 months. A structured questionnaire with both open and close ended question was used to interview participants. The study revealed that only 18 (56%) health facilities were supervised at least once in the past 12 month ,of these only 5 (16%) were supervised four times or more (the standard supervision guideline minimum number of visits per facility in a year), 14(88%) were not informed prior to the visit in the last visit. Furthermore it was found that supervision is not documented in table 6 of Health Management Information System ' MTUHA' Book 2 in 11 facilities (61%). Majority, 17(94%) facilities were not given written feedback report and that follow up action was developed in only 9(50%). Adherence to Supervision Guideline and staff satisfaction to last supervision was slightly higher in private facilities than government facilities. The study recommends that RHMTs should strengthen regular districts inspectorate and supportive visits, for checking CHMT on site supervision performance and that CHMT should develop and use local checklist in all facilities supervision so as to ensure consistency.

DISSEMINATION OF RESEARCH FINDINGS

Research findings will be disseminated to the following bodies:- Muhimbili University of Health and Allied Sciences, Ministry of Health and Social Welfare, Mbeya Regional Administrative Secretary and Mbeya City Council Director.

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LIST OF ABBREVIATIONS

CCHP	Comprehensive council Health Plan
CHMT	Council Health Management Team
DAS	District Administrative Secretary
DED	District Executive Director
DMO	District Medical Officer
FY	Financial year
HFs	Health Facilities
MOH	Ministry of Health
MTUHA	Mfumo Wa Taarifa za Uendeshaji Huduma za Afya.
NBS	National Bureau of statistics
PHC	Primary Health Care
PI	Principal Investigator
PO- RALG	President Office Regional Administration and Local Government.
RA	Research Assistant
RAS	Regional Administrative Secretary
RHMT	Regional Health Management Team
RHMT	Regional Health Management Team.
TSH	Tanzanian shillings
TSPA	Tanzania Service Provision Assessment survey

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND

In 1995, Tanzania embarked on the health sector reforms aiming to improve the quality of health services (MOH 1994). The goals of the health sector reforms are reflected in the Tanzania reform vision, which is to improve the health and wellbeing of all Tanzanian with the focus on those at most risk and to encourage the health system to be more responsive to the needs of the people (MOH,1999). Key objectives of the reforms were

- To improve access, quality and efficiency of primary health services (District health strategy),
- Strengthen and re orient secondary and tertiary services in support of primary health care,
- Improve capacity for policy development and analysis (development of various guidelines),
- Strengthen national support systems for personnel management, drugs and supplies, transport –Central support system,
- Implement a human resource development program to ensure adequate supply of Human Resource,
- Promote private involvement through public private partnership.

Therefore, health sector reforms which operated under decentralization gives districts the authority to undertake local planning, management of health services, allocation of resources, financing, control of finances, supervision, monitoring, and evaluation (Leighton 1996).

In order to financially support the implementation of the Programme Of Work(POW) of Health Sector Reforms, and in line with Sector Wide Approach (SWAP); several development partners decided to supplement the government budget by pooling together non-earmarked funds known as "Basket fund" , to supplement both the Ministry of Health (MOH) budget as well as the District councils. Health Basket Fund at the council level started in financial year (FY) 2000/01 under the control of district authority (Hobbs, 2001).

There is an increasing financial resource by type and amount channeled to the council for the health services. In the FY2000/01 Councils received only government subvention (basket and block grant) and programme funds whilst in FY 2006/2007 most councils received government subvention and other funds (joint rehabilitation funds for primary care health facilities, capital development grants and capacity building grants). Basket grant allocation rose from 0.5 USD per capita during 2000-2005 to 0.75USD per capita for the year 2007.This increase in financial resources is thought to increase capacity of the Council Health Management Teams (CHMTs) to perform their functions (MOH, 2007).

Also there have been significant efforts in strengthening district health system through various interventions under central support system. For example each district has been supported with at least two four wheel drive vehicles for distribution and supervision, ordering of drugs for primary care facilities from indent kit system to Integrated Logistic System and several centrally planned CHMT capacity building trainings.

Although significant progress has been made under health sector reforms, several challenges to improving District health services remain. Poor quality of health services, increasing user dissatisfaction, poorly regulated private sector, unmotivated staff, human resource crisis with more gaps in skilled personnel, poorly performing health management information system and inadequate managerial capacity of most CHMTs are some of the challenges facing Tanzania reform process (COWI 2007, MOH- HERA 2003, Munishi 2003).

Approaches to improving quality of care have usually focused on training providers and upgrading infrastructure and equipment, and better supervision of providers has often been a part of these strategies (Stinson et al 2000). Supervision provides the link between the central (district CHMT) of the health system and the health care delivery staff in the facilities within the district (Capblanch et al 2007). It is important for improving performance, controlling standards of health care and helping to motivate staff through on job transfer of knowledge(training), effective communication, problem

solving, reviewing records; observation of clinical practice (Marquiz et al 2002, Chaulet et al 1998, MOH,1999,).

There are four types of supervision recognized by the Tanzania Ministry of Health: external supervision usually done by MOH, RHMT, CHMT supervisors; internal supervision done by the facility management; peer supervision and self supervision. Under decentralized health sector reforms, external Primary Health Care Supervision is the responsibility of CHMT (MOH, 1994).

For an effective and efficient Primary Health Care supervision, the following are the essentials: a functioning health care delivery system, a functioning health management information system, availability of financial resources, monitoring and supervision tools, well functioning health transport system and human resource(knowledgeable supervisors and performing supervisee) (MOH ,1999).

Health care delivery system is a transactional process reflecting the fit between the individual, the organizational context, and the broader societal context. It entails the motivation the individuals have (supervisors), efficient and sufficient organizational resources inputs and the formal or informal feedback between the supervisor or health worker and the consumer society. For district health care system it entails commitment and performance of district authority, District Executive Director (DED), Heads of Departments, Council Health Management Team, District Health Service Board and Facility Governing Committees.

Quality of a health information system affects the quality of supervision made and on the other hand it is been affected by the quality of supervision. Preparation of supervision starts by reviewing past reports and information's of the facilities to be supervised and thereby formulating hypotheses and supervision objectives/priorities (MOH, 1999). Therefore quality preparatory stage for supervision is highly dependent on the availability and quality of storage of data and reports, and as well as its review.

Supervision tools are to guide supervisors on comprehensiveness and scope of supervision (what to be supervised).This includes, supervision guidelines, checklists and supervision matrix. Prior to supervisory visits the CHMTs should prepare supervision matrix which lists the month and dates of all supervisory visits, the routes, and the vehicles for each trip, the facilities to be visited, and the members of the supervisory team (Seattle PATH 2003).

A well-organized and adequate transportation for accessing health facilities is an important resource for an effective and efficient supervision. Adequacy of transport system can be measured on the presence of specific vehicle for supervision, availability of fuel, and reliability of the transport. On one hand, for a transport system to be efficient (organized) there needs to have the right number and types of vehicles, passable roads, and a competent transport officer/coordinator for control of vehicles and drivers

(PO-RALG, 2003). In Tanzania the integrated supervision requires that; prior to supervision visits, the CHMT should prepare a matrix listing the months and dates of all the supervisory visits; the routes and vehicles for each trip; the facilities to be visited; and the members of the supervision team. This ensures well organization of logistics and supplies needed for the visit.

1.2 PROBLEM STATEMENT

Despite of a growing pool of reform resources channeled to the districts -financial, transport, supervision tools (MOH, 2007); supervision of Primary Health Care facilities has continually become poor and inadequate (Semali et al 2005, Manongi et al 2006). It has consequently contributed to the poor performance of health care providers and quality of health services, hence increasing user's dissatisfaction to the services offered (Munishi 2003, MOH-HERA 2003).

Various studies have implicated poor supervision to resistance of CHMT to decentralization, poor functioning facility governing committee, poor interaction between CHMT and district authority, poor managerial capacity of CHMT and incomplete decentralization process (Semali et al 2005, Manongi et al 2006, HERA 2003).

In Tanzania, adequacy and quality of supervision has only been studied qualitatively and none of the study has shown the magnitude of supervision frequency, proportion of supervision feedback, follow up action, and adherence to supervision guidelines.

This study therefore aimed at providing quantitative data on quality of Primary Health Care Supervision and its associated factors.

1.3 RATIONALE OF THE STUDY.

The study aimed at obtaining information from facility in charges on the quality of supervision done in the last 12 months. Its findings expand the understanding on quality of supervision in different types and managing authorities of PHC facilities. It also underscores issues of uniformity of supervisory visits as a standard regulatory mechanism between the private and public facility.

The findings can be used to enable regions and districts to develop interventions for improving supervision and hence quality of health services.

1.4 RESEARCH QUESTIONS

The study aimed at answering the following research questions.

1. Is supervision done in accordance to the 1999 Tanzania Ministry of Health National Supervision Guideline (is it done right)?
2. Are there differences in frequency and quality of supervision between private and public facilities (dispensaries and health centers)?
3. Are the supervisees (health facilities) satisfied with the current supervision?
4. Are there differences in quality of a facility between 'supervised and non supervised facilities?

1.5 HYPOTHESIS OF THE STUDY

1. Quality of supervision (CHMT) is a critical component in effective supervision.
2. The quantity and quality of supervision received by health workers has a direct and indirect influence on the quality of health services of a facility especially facility management.

1.6 RESEARCH OBJECTIVES

1.6.1 BROAD OBJECTIVE

To determine quality of CHMTs PHC facilities supervision and its associated factors in Mbeya City Council for the past 12 months.

1.6.2 SPECIFIC OBJECTIVES

1. To determine the number of CHMT supervisory visits to the PHC facilities for the last 12 months by type and ownership of the facility.
2. To assess the extent of CHMT adherence to 1999 National Supervision Guideline processes in the last supervisory visit by type and ownership of health facility.
3. To assess staff satisfaction to the last CHMT supervisory visit by managing authority of health facility.
4. To determine the association between number of supervision done to the health facility in the last 12 months with quality of some items (cleanliness ,presence of sanitation facilities, presence of functioning facility governing committee and written job description of each health worker).

1.7 Conceptual framework of PHC supportive supervision

Quality of supervision in this study was assessed basing on the framework of 1999 Tanzania National PHC Supervision Guideline and Kadushin's model of supervision (1992). The 1999 National Supervision Guideline stress on quality pre supervision preparation, interactive problem identification and solving, constant follow up action and feedback. This is also similar to the Kadushin's model which stressed on the following three key functions of supervision

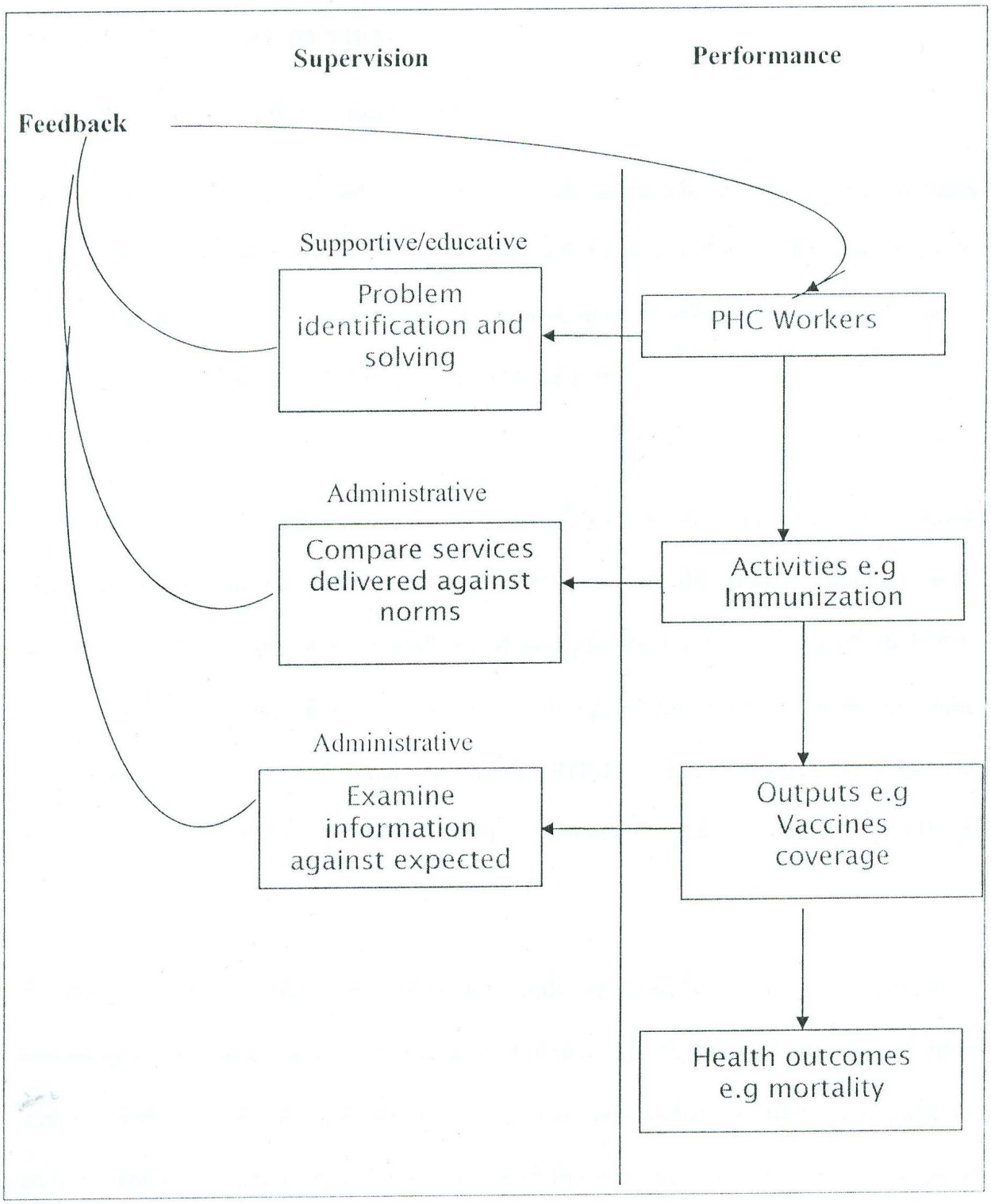
Administrative - the promotion and maintenance of good standards of work, co-ordination of practice with policies of administration, the assurance of an efficient and smooth-running office;

Educational - the educational development of each individual worker or the staff in a manner calculated to evoke her fully to realize her possibilities of usefulness; and

Supportive - the maintenance of harmonious working relationships, the cultivation of esprit de corps.

All these components are illustrated in the diagram below of the conceptual framework of PHC supervision as conceptualized by Capblanch and Garner (2008).

Conceptual framework of PHC supportive supervision using Kadushin model



Source: Garner and Capblanch (2008

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CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Number of facilities supervision

Districts are required to include supervision in the annual health plans. This includes routine and focus supervision (MOH ,2007b).Each facility in the district is supposed to be supervised by CHMT at least once every three months, which makes a minimum of four supervisory visits per facility annually (MOH,1999).

The survey done in Tanzania showed that, overall 86 percent of facilities have routine external supervision (at least one supervisory visit in the past 6 months), with government (89 percent) faith based (82%) and private for profit 79% (NBS,TSPA, 2006). It is however not indicated if the external supervision was the supervision done by CHMT or any other external supervisor (RHMT, Church leaders, management authority of the private firm outside the private facility).

Contrary to this was the findings of the study done in Tanzania rural districts on stakeholders response to decentralization of expanded programme of immunization which noted a decline in supervision by 22 percent and that the visits were inadequate and unscheduled (Semali et al 2005).The same findings were also noted in qualitative study done in Kilimanjaro Region to explore experiences of health workers working in the primary health care facilities, in terms of their motivation to work, satisfaction and

frustration, where health workers reported to receive irregular ,inadequate and unscheduled visit which de-motivated and frustrated workers (Manongi et al 2006).

2.2 CHMT adherence to 1999 National Supervision Guideline

The main indication of the efficiency of supervision is the detection and solution of problems and a gradual improvement in the indicators of health services quality (Chaulet p et al 1998).

The 1999 Tanzania National PHC Supervision Guideline lays down important supervision process quality indicators of any CHMT supervisory visit which has three stages; preparation of supervision, the actual supervisory visit and the immediate feedback. Quality of preparation of supervision means including supervision in the annual health plan, identifying priority issues for supervision and preparation for supervision logistics including informing the facilities which will be supervised prior to visits. Quality indicators during the supervisory visit are; ability to identify performance gaps and problems including their causes, degree of support provided to supervisee by the supervisor and problem solving through sonic dialogue with supervisee. Immediate feedback stage qualities is measured on the quality of discussion between supervisors and supervisees in areas which health workers have performed well and areas of weakness and hence develop a follow up action for improvements (MOH,1999).

The qualitative study done in Kilimanjaro on motivation of primary care health workers found that external supervision from CHMT is not done according to schedule, it adds frustrations instead of supporting health workers and also was deficient in giving feedback. This is contrary to the survey done in 2006 which reported that most child health service providers (90%,82%,60%,and 78% of government, private-for profit, parastatal and faith based respectively) received routine personal supervision, and 81% service providers were given supervision feedback (NBS,TSPA, 2006).

2.3 Staff satisfaction to supervision done

Health care providers in developing countries struggle daily with problems arising from a poor infrastructure, lack of funds and supplies, and bureaucratic barriers.

While many approaches have been proposed to improve the quality of health services (for example, quality assurance, continuous quality improvement, client-centered services, district team problem-solving, fully functional service delivery points), the supportive supervision approach improves services by focusing on meeting staff needs for management support, logistics, and training and continuing education (Rohde J, 2006).

Gibson &McClelland viewed supervision as an important tool needed to ensure quality health care and described six components of an effective supportive supervision for satisfying clients and staffs. These components are; effective communication, assessing

performance, follow up training, observation of a health facility and staffs ,provision of feedback, and regular follow up actions on the weakness identified in previous visits(Gibson P, 1990). In reviewing effect of supervision outreach to improve quality of primary care services in low and middle income countries, Garner and Caplanch noted that improvement of performance of service provision requires a supervisory visit with problem solving approach which involves a provider in problem identification, developing a follow up action and giving a written supervision feedback report for reference and administrative call of action (Capblach and Garner 2007).

2.4 Supervision and quality of health care facilities

Several studies have shown that supervision quality is important tool for strengthening quality of health care services at the primary health care facilities (Stinson et al 2000, Marquiz et al2002, chaulet p et al 1998). Though supervision is a complex intervention and implemented in different ways there are evidences of benefit on increasing health care performance in primary health care in most developing countries (Capblach and Garner 2008)

The prospective study done in Senegal noted a significant increase in quality of reproductive health services and community involvements after two rounds of supervision (Suh et al 2006). A checklist was used to assess changes in four areas of service delivery; infrastructure, staff and service management, record keeping and

technical competence, community involvement. Results showed that after two rounds of follow up supervision there was a significant increase in technical competence in infection prevention, counseling, prenatal care, and family planning by 30%,26%,16% ,and 10%respectively. Logistics management improved by 29%, Management of staff and services improved by 20%, record keeping by 56%, while infrastructure improved by 4%. How ever it seems the follow up was short lived and no documentation on sustainability of the improvements was made.

External Supervision especially by CHMT ensures that system wide standards and protocols are followed at the facility, and promote an organizational culture that expects such standards and protocol to be implemented (MOH, 2008).

2.5 Supervision in the Private Medical Sector

Since the re-introduction of private for profit practice in Tanzania in 1991, private medical sector has registered tremendous growth, providing care to those who can afford it. Up to the year 2000 there were 1340 registered private dispensaries (561 are private for profit and 250 belong to Parastatal organizations), 126 registered health centers (50 private for profit) (MOH, 2000).

While acknowledging the advantage of an optimal mix of private and public delivery of medical care it is well understood that commercialization in private for profit health facilities pose greater dangers in adherence to standards of service and care of health services (Kumaranayake, 1997). According to Kadushin model of supervision,

supervision has an administrative function of promotion and maintenance of good standards of work, co-ordination of practice with policies of administration (Kadushin A.1992) .Therefore Private facilities receiving high frequency external supervision from CHMT are likely to be operating in accordance to national standards of care.

Service provision assessment done in 2006, generally found that, management practices supporting quality services (family planning, child care and infection prevention) was poor in private for profit and parastatal facility as compared to government facility. External supervision of service provider was 20 to 40 percent low compared to government facility (NBS,TSPA, 2006) .

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study design

A descriptive cross section study was conducted in Mbeya City Council.

3.2 Study area

Mbeya City Council is one of the 8 Councils of Mbeya Region. It lies between latitudes 8°50 - 8°57' East of Greenwich and longitude 33°30' - 35° 35' and is surrounded by Mbeya District Council in all directions. It has a total area of 214 sq km. It is divided into two divisions namely Sisimba and Iyunga and has 36 wards with 180 hamlets. The City has 4 hospitals, 6 Health centers and 32 Dispensaries with distribution shown in the table below. It was chosen because of heterogeneous mixture of PHC facilities ownership.

Table Distribution of health care facilities in Mbeya City by type and ownership.

Category	**Type of facility**			**Total**
	Hospital	**Health centre**	**Dispensary**	
Government	2	4	8	14
Faith based(voluntary)	0	2	3	5
Parastal	0	0	3	3
Private	2	0	18	20
Total	**4**	**6**	**32**	**42**

Source: Mbeya City CCHP (20072008).

3.3 Study Populations

All PHC facilities in Mbeya City Council.

3.3.1 Target Population

Two study units, health facility and CHMT were targeted.

A Health facility unit of study included Dispensaries and Health Centers both government and Non governmental. Health facility in charge was the main respondent of the facility interview.

A CHMT unit comprised of one key informant who is the custodian of supervision reports and other 6 randomly selected members including co opted members.

3.3.2 Inclusion Criteria.

- Registered facility actively providing services.
- In charge of the facility or any health worker involved in facility supervision.

3.3.3 Exclusion criteria.

Unregistered facility or dormant (closed) facility

3.4 Sample size

The Minimum sample size of facilities to be included in the study was calculated by EPI TABLE calculator of EPI 6 Version 6.04d of 2001 for calculating sample size using single proportion. Inputs for the calculator were;

- Size of the population –in this study it was the number of all Primary Health Care facilities in Mbeya City Council, both private and public
- Expected prevalence –in this study is the percent of facility reporting to receive regular supervision from the district (at least one supervision in the period of 6 months).
- Desired precision.
- Design effect.

Tanzania Service Provision Assessment survey showed that; the proportion of facilities where Family planning providers reported being regularly supervised was ranging from 80% to 90% (NBS 2007)

Assuming the proportion of health workers reported being regularly supervised is equal to the proportion of facility receiving regular CHMT supervisory visits, then

Inputs for EPITABLE calculator were.

- Size of the population is 38 (2007/2008 Mbeya city CCHP)
- Expected prevalence is 85%
- Desired precision. Is 5 %(85% ±5%)
- Design effect is 1.

Substituting the inputs in EPITABLE calculator gives the minimum sample size of facilities to be included in the study to be 32 (84% of all PHC facilities in the city). This sample size is congruent with the protocols for rapid data analysis which requires covering at least 30-50% of health institution to get a geographical representation and subsequent generalization.

3.5 Sampling technique

A proportionate stratified sampling technique was used to select 32 facilities. All Primary Health Care facilities meeting the inclusion criteria were listed according to their type and managing authority.

Based on the proportion of facilities according to its type, Five (5) out of six (6) Health centers and 27 out of 32 dispensaries were randomly selected. Also based on the proportion of facility according to their ownership (managing authority); government owned(public) 3 heath centers out of 4, 7 dispensaries out of 8; and 14 out of 18 private dispensaries were randomly selected. Also all five (5) faith based facilities (2 health centers and 3 dispensaries) and all 3 parastatal dispensaries were included.

3:6 Data collection

3.6.1 Recruitment and Training

Three research assistant with some knowledge on District health supervision and research background were involved in data collection. They were given orientation

on the study, and made competent with research questionnaire. Logistic arrangements were also made for them including per diem, and transport allowance.

3.6.2 Data collection Tools and Technique

i) Structured questionnaire with both open and close ended question was used to interview health facility participants and CHMTs. Both Swahili and English version questionnaire were prepared, however only Swahili version questionnaire was used.

iii) A checklist was used to assess quality of a health facility-facility cleanliness, availability of sanitation facilities, status of important equipments and management functioning.

iv) Document review from registers, MTUHA book 2, supervision reports and supervision matrix were used to verify number of supervision visits and adherence to supervision guideline and schedule.

3.6.3 Data collection procedure

Data were collected by principal investigator and the research assistants. Explanation on the objectives and what the study is in general was given to each participant and thereafter he/she was asked to give his /her consent to be interviewed. The responses were being recorded on the questionnaire by the Principal investigator or research assistant.

3.6.4 Pre testing

Questionnaire was pre tested in Kibaha district to check if the questionnaire is well understood, if sequence of the questions is logical, and if there is a need for any modification in terms of structuring or rephrasing the question.

3.7 Study Variables

Dependent variable-

Number of supervision, satisfaction with supervision, number Supervision visits with feedback report, number of supervision visits with supervisor- supervisee agreed follow-up action, availability of treatment protocol

Independent variables- type of health facility, ownership of health facility

3:8 Data management and Quality control

Data were collected from June to July by the research assistant and Principal Investigator. In the course of data collection (field work) the principle investigator was also responsible for guiding and supervising the filling of the questionnaires and checking of all interviews to ensure correctness. Any detected error was brought to the attention of the respective interviewer for correction. Completed questionnaires were re-checked and coded by principle investigator. Thereafter codes were assigned to all open ended questions.

3:9 Data entry and analysis

Data entry, cleaning and validation were done using Epi Info 6 version and analysis done by SPSS programme version 13. Explorative analysis was carried out using frequency distribution. Proportions were compared by Chi-squre test at significance level of less than 0.05.

3:10 Ethical issues

Before the study was undertaken, ethical approval was obtained from the Research and Publication Committee of the Muhimbili University of Health and Allied Sciences. The permission to conduct the study in the study area was sought from Regional Administrative Secretary of Mbeya Region, Mbeya City Director though City Medical officer of Health.

All the participants were asked for their consent and told the purpose of the study before they were asked to participate in the study. They were also assured of their right to withdraw from the study at any time of interview. The participants were also assured the fact that in no way their names would be used and that information provided by them will be used for research purpose only.

3:11 Study limitations

Information bias; since the facilities interview dwelt much on perception of the participants in judging quality of the last supervisory visit, then it is likely to have missed other important factors which needs observational methods/strategies. However this limitation has little effect on validity of the findings as it was further

explored from CHMT perspective objectively on parameters of quality supervisory visits such as number of supervision reports and supervisory meeting minutes.

3:12 Definitions of terms

Quality of supervision

Quality simply means how good something is or the achievement of the desired objectives in the most efficient and effective manner, with emphasis on satisfying the client or user. In this study quality of supervision means ability to satisfy staffs (supervisee), feedback given, ability to support staff in solving problems and giving update training or information.

Standard

A standard is a statement of the "desired achievable" (rather than observed) performance or value with regard with a given parameter. Standards are statements of expectations for inputs, processes and outcomes of a system necessary to ensure quality healthcare. In this study standard will be measured on the adherence to Tanzania national PHC supportive supervision.

Supportive supervision

This is a supervision approach that seeks to prevent the development of potentially stressful situations, removes the worker from stress, reduces stress impinging on the worker, and helps her/her adjust to stress. The supervisor is available and approachable, communicates confidence in the worker, provides perspective,

excuses failure when appropriate, sanctions and shares responsibility for different decisions, provides opportunities for independent functioning and for probable success in task achievement. (Kadushin 1992)

CHAPTER FOUR

RESULTS

4.1 Description of study population

The study population consisted of thirty two (32) Primary care health facilities, where the in charge of a facility was the main respondent. Of these 28(88%) were Dispensaries as shown in table 1 below. The distribution of facilities under study by their managing authority was Private 38%, Government 31 %, Voluntary agency 23% and Parastatal 9%

.

Table 1. Distribution of primary health care facilities according to type and managing authority (owner)

MANAGING AUTHORITY	TYPE OF FACILITY					
	Health Centre		Dispensaries		Total	
	Number	(%)	Number	(%)	No.	%
Government	2	20.0	8	80.0	10	31.3
Voluntary Agency	2	28.6	5	71.4	7	21.9
Parastatal	0	0	3	100.0	3	9.4
Private	0	0	12	100.0	12	37.5
Total	**4**	**12.5**	**28**	**87.5**	**32**	**100.0**

4.2 Number of CHMT facilities supervisory visits

The facility in charge were asked the number of times the facility has been supervised by district CHMT in the last 12 months (from July 2007 to June 2008) by looking into the visitors record book. Overall 18 (56%) health facilities reported to be supervised at least once in the past 12 months as shown in table 2 below. Though there was clear difference between percentages of heath centers that were supervised as compared to dispensaries 4 out of 4 (100%) supervised health centers compared to 14 out of 28(50%) supervised dispensaries, the difference is not statistically significant (P value≥ 0.05).

Table 2: Percentage of facilities which had ever been supervised (supervised at least once in the past 12 months) by type of a facility

FACILITY TYPE	SUPERVISION STATUS					
	Supervised		Not Supervised		**Total**	
	Number	(%)	Number	(%)	**Number**	**%**
Health Centers	4	100.0	0	.0	**4**	**12.5**
Dispensaries	14	50 .0	14	50.0	**28**	**87.5**
Total	**18**	**56.3**	**14**	**43.8**	**32**	**100.0**

P value 0.113 (fisher exact)

Table 3.Distribution of facilities that had ever been supervised in the last 12 months by managing authority

MANAGING AUTHORITY	SUPERVISION STATUS					
	Supervised Number	(%)	Not Supervised Number	(%)	**Total No.**	**%**
Government	8	80.0	2	20.0	**10**	**31.3**
Voluntary Agency	3	42.9	4	57.1	**7**	**21.9**
Parastatal	0	0	3	100	**3**	**9.4**
Private	7	58.3	5	41.7	**12**	**37.5**
Total	**18**	**56.3**	**14**	**43.8**	**32**	**100.0**

P value 0.09

As shown in table 3 above, majority of government facilities were supervised 8 out of 10 (80%), compared to other facilities (58%, 43%, and 0% for private for profit, voluntary agency and parastatal respectively). However there was no significant association between supervision and managing authority of a facility (P value≥ 0.05).

4.3 Adherence to Tanzania National Supervision Guideline.

As shown in table 4 below, 14 (44%) facilities were never supervised in the last 12 months (from July 2007 to June 2008), and that 5 (16%) received adequate supervision, that is four or more supervisory visits per facility annualy.

Table 4.Number of CHMT supervision to the facility in the last 12 months by type of facility

NUMBER OF SUPERVISION	TYPE OF FACILITY					
	Health Centers		Dispensaries			
	Number	(%)	Number	(%)	**Total Number**	**%**
≥4 times	2	50.0	3	10.7	**5**	**15.6**
2-3	1	25.0	3	10.7	**4**	**12.5**
1	1	25.0	8	28.6	**9**	**28.1**
0	0	0	14	50.0	**14**	**43.8**
Total	**4**	**12.5**	**28**	**87.5**	**32**	**100.0**

We further explored the adherence to supervisory guideline by asking facilities in charge (of the facilities reported to be supervised in last 12 months), on whether the supervisor did or didn't do /observe parameters of a good and effective supervisory visit according to guideline as shown it table 5 below

Table 5.Percentage of last supervisory visits that adhered to national supervision guideline by managing authority of facility

	PERCENT OF FACILITIES REPORTED GOOD ADHERENCE						Total	
	GOVT n=8		VA n=3		PRIV n=7		N=18	
ADHERENCE CRITERIA	N0.	%	No.	%	No	%	**No**	**%**
Supervisees are informed on the supervisory visit	2	25.0	0	.0	2	28.6	**4**	**22.2**
Supervisors talked to clients	5	62.5	1	33.3	3	42.9	**9**	**50.0**
Had immediate supervision feedback meeting	7	87.5	2	66.7	7	100	**16**	**88.9**
Jointly developed problem follow up action	4	50.0	1	33.3	4	57.1	**9**	**50.0**
Planned together next supervision	1	12.5	1	33.3	0	.0	**2**	**11.1**
Observed cleanliness of the facility	7	87.5	3	100	7	100	**17**	**94.4**
Observed status of drugs and equipments	3	37.5	3	100	7	100	**13**	**72.2**
Observed records (HMIS registers/forms)/ minutes of facilities minutes.	2	25	2	66.7	3	42.9	**7**	**38.9**
Observed how services are provided to clients	4	50.0	1	33.3	4	57.1	**9**	**56**
At least one supervision visit recorded in MTUHA book 2	5	62.5	0	0	2	28.6	**7**	**38.9**
Given written supervision feedback report	0	0	0	0	1	14	**1**	**5.6**

GOVT; Government, VA: Voluntary agency PRIV: Private

According to table 5 above, Communication between CHMT and facilities is poor (only 22% of facilities were informed on the day and date of supervision and 6% were given written feedback report of supervisions done).

During supervision, most supervisors observed cleanliness of the facility (94%), and status of equipment and drugs (72%). Client's opinion on the quality of services they receive in a facility was sought in 9(50%) supervision visits and facility information/ records observed in 7(39%) visits.

Though immediate feedback meeting is done in most facilities after supervision (89%), interaction and involvement of supervisee is not satisfactory (only 11% facilities were involved in planning next visit, and 50% developed jointly a problem follow up action).

There is no statistically significant difference in CHMT adherence to guideline when supervising government facilities and when supervising other facilities (voluntary agency, parastatal and private) p value >0.05 in all table 5 satisfaction parameters

4.4 Staff satisfaction to supervision

Facility in charges of all 18 facilities reported to be supervised in the last 12 months, were asked to rate their satisfaction with the last supervision visits. Table 6 shows percentage of facilities reported to be strongly satisfied with last supervision according to their managing authority.

Table 6. Last supervisory visit, facilities satisfaction ratings.

ITEM/SATISFACTION CRITERIA	PERCENT OF FACILITIES REPORTED TO BE SATISFIED N=18 Strongly satisfied		Satisfied		Not satisfied		Strongly dissatisfied	
	N0.	%	No.	%	No	%	No	%
Meeting training needs	6	33.3	9	50	2	11.1	1	5.6
Getting information	6	33.3	8	44.4	3	16.7	1	5.6
Respecting staff time and recognition of their work	9	50	5	27.8	3	16.7	1	5.6
Staffs encouragement and guidance on work challenges	10	56	5	27.8	2	11.1	1	5.6
Getting a platform for expressing opinion about work and work environment	6	33.3	7	38.9	4	22.2	1	5.6
Meeting supplies requirements	5	27.8	9	50	3	16.7	1	5.6
Involvement in problem identification and solving	4	22.2	7	38.9	5	27.8	2	11.1
Interaction (friendliness) with supervisors	6	33.3	9	50	2	11.1	1	5.6
Average satisfaction	**36%**		**42%**		**16%**		**6%**	

On average 36% of facilities reported to be strongly satisfied with last supervision visit, 42% were satisfied, 16%were not satisfied and 6% were strongly dissatisfied.

Table 7; Percentage of facility in charge who reported to be strongly satisfied with the last supervision visit by managing authority

	PERCENT OF FACILITIES REPORTED TO BE STRONGLY SATISFIED						Total	
	GOVT n=8		VA n=3		PRIV n=7		N=18	
ITEM/SATISFACTION CRITERIA	N0.	%	No.	%	No	%	No	%
Meeting training needs	3	37.5	0	0	3	42.9	6	33.3
Getting information	3	37.5	0	0	3	42.9	6	33.3
Respecting staff time and recognition of their work	5	62.5	1	33.3	3	42.9	9	50
Staffs encouragement and guidance on work challenges	4	50	1	33.3	5	71.4	10	55.6
Getting a platform for expressing opinion about work and work environment	2	25	0	0	4	57.1	6	33.3
Meeting supplies requirements	2	25	1	33.3	2	28.6	5	27.8
Involvement in problem identification and solving	1	12.5	0	0	3	42.9	4	22.2
Interaction (friendliness) with supervisors	3	37.5	0	0	3	42.9	6	33.3
Average satisfaction	**32%**		**12.5%**		**46%**		**36%**	

GOVT; Government VA: Voluntary Agency PRIV: Private

As table 7 shows, there is strong satisfaction with last supervisory visit in private facilities compared to government facilities (on average 46% for private and 32% for government facilities). Fifty six percent (56%) of facilities reported to be strongly

Table 8.Association between supervision and quality of certain items in a health facility

ITEM	SUPERVISION STATUS	QUALITY STATUS Good Number	%	Poor Number	%	Total	Chi square... P value...
Cleanliness of facility	Supervised	18	100	0	0	18	56.3
	Not supervised	12	85.7	2	14.3	14	43.8
	Total	**30**	**93.8**	**2**	**6.3**	**32**	**100**
						P value	**0.18**
Sanitation facilities	Supervised	13	72.2	5	27.8	18	56.3
	Not supervised	5	35.7	9	64.3	14	43.8
	Total	**18**	**56.3**	**14**	**43.8**	**32**	**100**
						P value	**0.039**
Written job description of health workers	Supervised	1	5.6	17	94.4	18	56.3
	Not supervised	1	7.1	13	92.9	14	43.8
	Total	**2**	**6.3**	**30**	**93.8**	**32**	**100**
						P value	**1.00**
Presence of functioning facility governing committee	Supervised	9	50	9	50	18	56.3
	Not supervised	2	14.3	12	85.7	14	43.8
	Total	**11**	**34.4**	**21**	**65.6**	**32**	**100**
						P value	**0.061**
Presence of diarrhea treatment protocol	Supervised	5	5.6	13	72.2	18	56.3
	Not supervised	1	7.1	13	92.9	14	43.8
	Total	**6**	**18.8**	**26**	**81.6**	**32**	**100**
						P value	**1.96**

Table 9. Reasons for non adherence to 1999 supervision guideline, CHMT perspective

Problems with Current Supervision	**No. of CHMT Identified this Problem (N = 7)**
Lack of trained and motivated supervisors	4 (57%)
Lack of transportation and logistics	7(100%)
Irregularity of supervision and lack of serious preparation	4(57%)
Inappropriate communication and behaviors during Supervision.	3(43%)
Supervisors don't share supervision findings/reports (no meeting to discuss supervision)	2(29%)
Self reported reasons for not conducting supervision according to schedule	**No. of CHMT Identified this Problem (N = 7)**
Unaware of the schedule (poor communication among members of supervising team)	5(71%)
Lack of top management commitment (City directors office don't view it as an important activity)	2(29%)
Supervision transport being put in pool system which is not in favor of health activities.	6(86%)
No involvement of all members in planning a monthly supervision schedule	4(57%)
Lack of follow-up from top management (City medical officer ,transport/supervision coordinator)	2(29%)
Adherence to 1999 CHMT supervision quality indicators	**Indicator**
Proportion of planned supervision done from July 2007 to June 2008	42/168 (0.25)
Proportion of supervision done with written report i.e. number of supervision with written report/total number of supervision done from July 2007 to June 2008	9/42 (0.21)

specifically looked at CHMT supervision visits in one district which makes it difficult to generalize its findings. Given a few number of parastatal primary heath care facilities, a broader study is needed to assess the status of CHMT supervision in parastatal facilities.

The findings of this study however agrees with findings of Tanzania service provision assessment of 2006 that supervisory visits are relatively more common in government heath facilities as compared to other private facilities though the difference noted in this study was not statistically significant (NBS, TSPA 2006).

5.2 Adherence to National Primary Health Care Supervision Guideline

Tanzania, National Primary Health Care Supervision Guideline set the minimum number of supervisory visit to each facility to be once every three months, that means each facility will be supervised at least four times annually minimally. In this study only 16% facilities reported to receive four or more CHMT supervisory visits indicating that supervision in primary care facilities is inadequate. This finding agrees with the findings of a qualitative study done to health care providers of Kilimanjaro who reported to receive inadequate supervisions (Manongi et al 2006).

For an effective supervision and in order to avoid logistical problems including lack of transport and time constraints of supervisors and supervisee, a supervisory visit need to be well scheduled and supervisee should have a prior information of date and time of supervision. This study found that eighty eight percent (88%) of all health facility

reported to be supervised had no prior information of the last visit. This finding concur with the findings that most of CHMT supervision visits are unscheduled and done at inappropriate time to health care providers thus adding frustration to staffs (Manongi et al 2006) .

Improvement of performance of service provision requires a supervisory visit with problem solving approach which involves a provider in problem identification, developing a follow up action and giving a written supervision feedback report for reference and administrative call of action (Capblach and Garner, 2007).Tanzania quality standards requires that problems identified during a supervisory visit should be filled in table 6 of MTUHA (Health Information Management System) Book two, together with its agreed follow up action. Further each supervision visit should have a report written aiming at informing the supervised health workers and those who have authority to make decisions (MOH 1999).This study found that supervision is not regularly documented in Table 6 of MTUHA Book 2 (only 39% documented) and that facilities don't receive written feedback report (only 6% received report).Follow up action was not developed in 50% of last supervisory visit done to a health facility.

These findings concur with the findings of the review to see the benefits and harms of supervision of primary care facilities in low and middle income countries which noted that supervisions have more harms than benefits. To quote the conclusion "Though supervision is costly, in average can cost up to 40% of cost of community health worker, and that the official theory encouraging supervision collides with the fact that

supervision is implicitly seen as a means of earning extra allowance to supervisors as oftenly lack documentation of the improvements in service delivery noted and its harms outweigh the benefits" (Capblach and Garner, 2007). This also agrees with the findings of the qualitative study done in Kilimanjaro Region where many health workers complained that they never received any written or oral feedback from supervisors. To quote the findings:" When the re-supervision is done for the second time, there should be feedback from the first supervision so that we can recognize where we went wrong and correct our mistakes. There should also be feedback of the problems identified from the previous supervision. It is not easy to think the supervisors are useful when reported problems remain and no feedback is given" (Manongi et al 2006).

Generally this study also found a slightly higher percentage of supervisor's adherence to National Supervision Guideline when supervising private facilities than when supervising government facilities (in average 52% for private compared to 45% for government facilities). Though its magnitude and significance requires more research but generally it may imply that CHMT do not pay much attention to standard protocol in government facilities and this might cause a gap of quality of health facilities between government and private facilities.

5.3 Staff satisfaction to supervision

This study has shown that, Private facilities though infrequently supervised compared to government facilities (56% supervised private facilities compared to 80% government

facilities), they were relatively more strongly satisfied with supervision done compared to government facilities (46% private facilities compared to 32% government facilities). Supervision parameters which they were more satisfied with compared to government facilities were: involvement in problem identification and solving, gaining encouragement and guidance on work challenges. These findings might be explained by the fact that supervisors generally were seen to adhere more to National Supervision Guideline when supervising private facilities than when supervising government facilities. Parameters of good adherence to supervision guideline which are relatively higher in private facilities compared to government facilities are: having immediate feedback meeting, observing status of drugs and equipment and also jointly developing a problem follow up action. These findings concur with the findings of Paul and Garner that staffs are more satisfied when supervisions helps them to solve work problems and when they are given feedback reports where they did well and their weaknesses.

5.4 Supervision and quality of some items in a health facility.

According to National Supervision Guideline standards, the objectives of supervision are: to provide refresher training, improve working conditions and motivate and support health workers. Supervisors expected to evaluate the job descriptions of various categories of providers, cleanliness of the facility, presence and status of essential equipments and the functioning of facility management. Presumably this means that there would be a difference between supervised and non supervised facilities in presence of job descriptions, cleanliness of facility ,presence of functioning equipments and

improvement of facility management if supervision had is making an impact in health service This study found difference between supervised and not supervised facilities on issues of facility cleanliness, presence of a written job description, functioning facility governing committee and diarrhea treatment protocol. This findings agrees with the findings of the study done in Senegal which concluded that "when supervisory visit are infrequent and don't adhere to standards its capacity to improve services is limited" (Suh et al 2007). However the impacts of supervision in health service provision in Tanzania need to be explored broadly.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATION

6.1 Conclusion

The following can be concluded from this study.

- Supervision to Primary Health Care facilities is inadequate, more so in parastatal facilities.
- Quality of CHMT Primary Health Care supervision measured on adherence to supervision guideline is poor, characterized by poor communication between CHMT and facilities, non adherence to supervision schedule, unsatisfactory involvement of supervisees in problem identification and solving, lack of follow up action and not giving written supervision reports.
- Supervisor's adherence to National Supervision Guideline is high when supervising private facilities than when supervising government facilities.
- Private facilities are more satisfied with supervision done than government facilities.

6.2 Recommendation.

This study recommends that.

- RHMT should strengthen regular district inspectorate and supportive visits, for checking CHMT on site supervision performance so as to increase CHMT adherence to National Supervision Guideline.
- CHMTs should develop and use local supervision checklist which will be used in all facilities supervision so as to ensure consistency in their supervision and remove the emanating gap in adherence to Supervision Guideline and staff satisfaction to supervision observed between private and government facilities.
- Given the ongoing debate on the controversy of cost benefit of districts supervision visits compared to other modalities of improving workers performance, the Ministry of Health needs to re examine the impact of current supervision process taking into account cost and benefits and the alternative options.

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APPENDICES

APPENDIX 1 : QUETIONAIRRE – (English version)

General instructions:

1. Any information collected will be strictly confidential.
2. Do not write names of interviewee or of the health facility ... ... questionnaire
3. Circle or tick number of the answer corresponding to the response.
4. Select circled or ticked numbers and write it on the box provided on the right hand side.
5. Write fully given responses in the spaces provided for the open ended questions and on "others"

Quality of Primary Health Care Supervision and its associated factors: the case of Mbeya City Council.

QUESTIONNAIRE 1. HEALTH FACILITY QUESTIONNAIRE. [To be administered to the in charge of the health facility].

PART 1: Background information

1. Questionnaire number_____
2. Name of interviewer_____
3. Date of interview_____
4. Facility code_____

PART II. Basic Facility information.

1. Type of facility ☐

   1= Health centre

   2= Dispensary

2. What is the managing authority of this facility (owner)?

   1= Public 2= Voluntary agency ☐

   3= Parastatal 4= Private

PART III: Number of CHMT supervisory visits

3. How many supervisory visits were made by CHMT in the last 12 months from your visitor's records?

   1=Four or more times (≥ 4 times)

   2= two to three (2-3) times ☐

   3= once 1 4= none-0 **If none go to Q13**

When was the last time a supervisor from the district (CHMT) came here for supervision?

1=within the past 6 months

2= More than 6 months ago. ☐

3= Never supervised.

PART IV: Adherence to 1999 national supervision guideline.

4. How many CHMT supervisory visits made in the last 12 months were recorded in MTUHA book 2? _____number of visits (check from your records MTUHA book 2/register) ☐

5. Were the following done in the last supervision visit?

   a. Informed of the day/date and time of supervision before their visit.

   1=Yes 2=No ☐

   b. Supervisor talked to your clients about their satisfaction to services of this facility? ☐

   1=Yes 2=no

   c. Had immediate feedback meeting with you? ☐

   1=Yes 2=no

   d. Developed jointly with you a follow up action plan of the deficiencies/problems identified. ☐

   1= Yes 2=no

   e. Planned with you on when will be the next supervision visit (date/month) ☐

   1=Yes 2=No

6. In the last supervision visit, did the supervisor observed the following

   a. The cleanliness and adequacy of surroundings, buildings (room, toilets) ☐

   1= yes 2=no

   b) How you provide service to your clients/perform your duties ☐

   1= Yes 2=No

   c) The status and/or adequacy of the essential equipments/drugs.

1=Yes 2=no ☐

d) Your records (HIMS registers /forms)/minutes of facility meetings.

1= Yes 2=no ☐

7. Are you regularly given written feedback reports by CHMT supervising team for supervisions done? ☐

1= Yes 2= Sometimes

3= No **If no go to Q 10**

8. IF yes/sometimes; can you show the reports? ---number of reports in the last 12months(calculate the percentage of number of supervision done with written feedback report i.e. number of supervision with written feedback report/total number of supervision in visitors book x 100)

1= >75% 2=50%-75% ☐

3=<50%

9. Observe from MTUHA book 2 number of supervision in the past 12 months with a follow up action plan. _____ number of supervision with follow up action plan. (Calculate the percentage, number of supervision with follow up action written/total number of supervision made from visitor's book x100).

1= >75% 2=50%-75%

3=<50% ☐

PART V. Staff satisfaction to CHMT supervisory visits.

10. How do you rate your satisfaction with supervision made by CHMT in the last supervisory visit? Use the following rating scale.

5=Excellent 4= Good 3= Satisfactory 2= Poor 1= Insufficient

Statement	**Rating**	
a) Meeting your training needs	1 2 3 4 5	☐
b) Getting information regarding your job	1 2 3 4 5	☐
c) Respect of your time and recognition of your work	1 2 3 4 5	☐
d) Encouragement and guidance on the difficulties in your work	1 2 3 4 5	☐
e) Platform for expressing your opinion about your work and work environment	1 2 3 4 5	☐
f) Meeting your supplies requirements	1 2 3 4 5	☐
g) Your involvement in problem identification and solving.	1 2 3 4 5	☐

11. How do you rate the quality of interaction (friendliness) with supervisors in the last supervision visit?

1=Very friendly 2= Friendly 3=somewhat friendly ☐

4= Not friendly 5= Very unfriendly

12. How do you rate usefulness of supervision in improving your career performance?

1 =Very useful 2= Useful 3= somewhat useful

4= Not useful 5= Useless. ☐

PART VI. Quality of a health facility

Observe the following 1=good 2= poor

13. Cleanliness of facility

Good; facility floor swept, tidy, no uncut grasses, sharp boxes present and used.

Poor: 3 out of 4 problems available. ☐

14. Sanitation facilities

Good: latrine -present, in good condition, disinfected and clean, placenta pit or incinerator-present, used .

Poor: absence of latrine or placenta pit/incinerator; and or 3 out of 5 problems available. ☐

15. Are the following equipments present and functioning (use the following rating scale:

1=present and functioning, 2=present but not functioning, 3=Not present)

	1	2	3	
a) Stethoscope	[ ]	[ ]	[ ]	☐
b) Thermometer	[ ]	[ ]	[ ]	☐

c) Weighing scales [ ] [ ] [ ] ☐

d) Bp machine [ ] [ ] [ ] ☐

e) Examination bed [ ] [ ] [ ] ☐

f) Fetal scope [ ] [ ] [ ] ☐

Management

16. Are the following present.

1= Yes 2= No

a). Written job description of health workers [ ] [ ] ☐

b) Facility governing committee (FGC) [ ] [ ] ☐

c) Minutes of the past FGC meeting [ ] [ ] ☐

d) Annual facility health plan [ ] [ ] ☐

e) Diarrhea treatment protocol/guideline [ ] [ ] ☐

QUESTIONNAIRE 2. CHMT QUESTIONNAIRE (To be administered to the key informants (DMO, DRCHCO, HMIS coordinator or transport coordinator)

PART 1: Background information

1. Questionnaire number_____

2. Name of interviewer_____

3. Date of interview_____

PART II: Number of CHMT supervisory visits

1. How many supervisory visits did you plan to conduct in primary health care facilities From July 2007 to June 2008? (Ask DMO or HIMS, coordinator, CCHP may be important reference)_____ number of visits. ☐

2. How many supervisory visits have you made to primary health care facilities in the period of July 2007 to June 2008? (Ask DMO or HIMS coordinator. Quarterly HIMS reports may be useful reference) ☐

3. Specifically, how many supervisory visits were done in the following primary health care facilities?

   a) Public (government owned) facilities ☐

   b) Faith based facilities ☐

   c) Parastatal facilities ☐

   d) Private for profit facilities. ☐

PART III: Adherence to 1999 national supervision guideline.

4. Do you regularly write reports of all supervisions you have made?

   1=Yes ☐

   2=Some

   3=No **If no go to Q.7**

5. Do you have written reports of all these supervisions you have made?

   1=Yes

   2=Some ☐

   3=No if no go to Q7

6. IF yes/sometimes; can you show the reports? ---number of reports in the last 12months (calculate the percentage of number of supervision done with written report i.e. number of supervision with written report/total number of supervision done according to Q2x 100)

   1= >75% ☐

   2=50%-75%

   3=<50%

7. Do you have the following? 1=Yes 2=No

   a) A trained health department transport coordinator [ ] [ ] ☐

   b) A 1999 National PHC Supervision Guideline [ ] [ ][ ] ☐

c) A locally prepared supervision checklist [ ] [ ][ ] ☐

d) Monthly or quarterly supervision matrix [ ][ ][ ] ☐

(Note tick yes for a-d if the document is available and you have seen it).

8. Do you regularly conduct supervision preparatory meetings?

1= Yes always.

2=Sometimes (occasionally) ☐

3=No

9. If yes, do you have minutes of these meetings? ____minutes seen.

1= Yes mostly (>50%)

2=Yes, few. (<50%) ☐

3= No (0%)

(Calculate the percentage of number of supervision done with written pre supervision preparatory meeting minutes/total number of supervision done according to Q2x 100)

10. How many scheduled supervision last quarter (3 months) were not done according to the schedule----- (establish the number from supervision matrix and supervision reports) ☐

11. In facilities.....(names of facilities and dates) supervisions were not done as shown in your supervision schedule/ matrix. What were the reasons for not doing these supervisions? ☐

1= No transport.

2= Coincided with other important activities.

3=Supervisors were not aware of their schedule.

4=other reasons specify

i).....ii).....iii).....iv).....

.....

12. How do you rate supervision performance of CHMTs with respect to the following (from selected 4 CHMT members i.e DMO,DRCHCO,HIMS coordinator and Transport cordinator)?

1=Good

2= acceptable

3= bad

a) Proportion of supervisors who are aware of their [ ][ ][ ] ☐
Supervision schedule (date and facilities to supervise).>75% 50-75% <50%

b) Involvement of all supervisors in developing local [ ][ ][ ] ☐
checklists, supervision schedule or evaluation. >75% 50-75% <50%

c) Availability of supervision tools (checklist, guidelines) [ ][ ][ ] ☐
>75% 50-75% <50%

d) Availability of supervision transport [[ ] [ ] ☐

>75% 50-75% <50%

e) Proportion of supervisors trained on supervision, [ ] [ ] [ ]

performance planning >75% 50-75% <50% ☐

13. Do you have any comment for improving supervision in both public and private primary care facilities?

a) _____

b) _____

c) _____

Thank you for your cooperation.

APPENDIX 2: Swahili version Questionnaire.

Utafiti kuhusu sababu zinazohusiana na ubora wa ziara za usimamizi wa vituo vya huduma za msingi

Maelezo ya Jumla;

1.Maelezo yoyote yatakayokusanywa yatatunzwa kwa siri.

2.Jina la msailiwa na la kituo lisiandikwe kwenye dodoso hili.

3Zungusha alama ya mduara au weka alama ya vema katika namba yenye maelezo yanayoshabihiana na jibu lililotolewa.

4.Chagua namba zilizowekewa vema au mduara na ziandikwe kwenye visanduku vilivyopo kulia mwa swali.

5.Andika majibu kamili kwa maswali yaliyoachwa wazi bila majibu yaliyopendekezwa na yale yanayokutaka kujaza

DODOSO NAMBA 1. **DODOSO LA KITUO CHA KUTOLEA HUDUMA(Litolewe kwa mfawidhi wa kituo)**

SEHEMU YA I. TAARIFA ZA AWALI

1. Namba ya Dodoso.....
2. Jina la mdahili------
3. Tarehe ya udahili----------
4. namba ya kituo------

SEHEMU YA II. Taarifa za kituo.

17. Aina ya kituo. ☐

1= Kituo cha Afya 2= Zahanati

18. Mwendeshaji (Mmiliki) wa kituo?

1= Serikali 2= Shirika la ya dini

3= Taasisi 4= Binafsi ☐

SEHEMU YA III: Idadi ya Ziara za usimamizi.

3. Katika kipindi cha miezi 12 iliyopita wasimamizi wa huduma za afya za wilaya wamefanya ziara ngapi za usimamizi katika kituo chako?.------idadi ya ziara (angalia kutoka katika kitabu cha wageni).

1=Mara nne au zaidi (≥ 4) 2= Mara mbili au tatu (2-3) ☐

3= Mara moja (1) 4= Hakuna (0) **kama hakuna nenda swali la 13**

4. Mara ya mwisho timu ya uendeshaji wa huduma za afya wilaya kufanya ziara ya usimamizi/ukaguzi katika kituo hiki ilikuwa lini? ☐

1=ndani ya miezi 6 iliyopita 2= zaidi ya miezi 6 iliyopita.

3= haijawahi kabisa.

SEHEMU YA IV: Uzingatiaji wa muongozo wa mwaka 1999 wa ziara za usimamizi.

5. Ziara ngapi za usimamizi zilizofanyika katika kipindi cha miezi 12 zilijazwa kwenye kitabu namba 2 cha MTUHA? ☐

. …idadi ya ziara (angalia kitabu cha MTUHA namba 2)

6.Je katika ziara ya mwisho ya usimamizi, wasimaimizi walifanya mambo yafuatayo?

a)Kukujulisha siku au tarehe na saa watakayofanya ziara kabla ya kuja. ☐

1=Ndio 2=Hapana

b) walizungumza na wagonjwa kuhusu huduma wanazopata hapa kituoni?

1=Ndio 2=hapana ☐

c) kufanya kikao cha mrejesho 'feedback meeting' mara baada ya kumaliza ziara ?

1=Ndio 2=Hapana ☐

d)walitengeza mpango wa ufumbuzi wa matatizo/mapungufu yaliyoonekana kwa kushirikiana nanyi?. ☐

1= Ndio 2=Hapana

e)Mlipanga pamoja kwa kushirikiana tarehe/siku ya ziara inayofuata.

1=Ndiyo 2=Hapana ☐

7. Je katika ziara ya mwisho wasimamizi waliangalia mambo yafuatayo?

a) Usafi wa mazingira,majengo na vyoo. ☐

1= ndiyo 2=hapana

b) Jinsi mnavyotoa huduma kwa wagonjwa ☐

1=Ndiyo 2=hapana

c) hali ya vifaa muhimu vya huduma na madawa (ubora,upungufu) .

1=Ndiyo 2=hapana ☐

d)Taarifa muhimu za kituo (MTUHA) pamoja na kumbukumbu'minutes' za vikao vya kituo. ☐

1=Ndio

2=hapana.

8. Kwa kawaida huwa unapewa ripoti ya mrejesho "feedbak' kutoka wilayani kuhusu ziara zilizokwishafanyika kituoni kwako?

1= ndiyo tunapewa kila mara ☐

2= ndiyo baadhi ya ripoti

3= hapana **kama hapana nenda swali la 10**

9.Kama ndiyo au baadhi,onyesha ripoti za ziara zilizofanywa na CHMT katika kipindi cha miezi 12 (toka julai 2007 hadi juni 2008)?--------namba ya ripoti zilizoonekana.(gawanya idadi ya ripoti zilizoonekana kwa idadi ya ziara kutoka kitabu cha wageni x 100 ili upate asilimia ya ziara zenye ripoti ya mrejesho).

1= >75%

2=50%-75% ☐

3=<50%

10. Angalia kutoka katika kitabu cha MTUHA namba 2, idadi ya ziara za usimamizi zenye mpango wa ufuatiliaji na ufumbuzi wa matatizo yaliyoonekana 'follow up action plan" katika kipindi cha miezi 12 iliyopita(julai 2007-juni 2008).....idadi ya ziara . (Kokotoa asilimia ya ziara zenye mpango wa ufuatiliaji na ufumbuzi wa matatizo kwa kuchukua idadi iliyojazwa hapo juu gawanya kwa jumla ya ziara za CHMT zilizojazwa kwenye kitabu cha wageni x 100).

1= >75% 2=50%-75% ☐

3=<50%

SEHEMU YA V. Uridhikaji wa wafanyakazi na ziara za usimamizi za CHMT.

11.Tumia (vipimo) vigezo vifuatavyo kupima jinsi ulivyoridhika na ziara ya mwisho ya usimamizi iliyofanywa na CHMT.

5=Niliridhika sana 4= niliridhika 3=niliridhika kiasi2= sikuridhika 1=sikuridhika kabisa.

Maelezo	**Kipimo**				
a) Kufikia mahitaji yako ya kujifunza	1	2	3	4	5 ☐
b) Kupata taarifa zinazohusiana na kazi yako	1	2	3	4	5 ☐
c) Kuthamini muda wako na kutambua kazi yako.	1	2	3	4	5 ☐
d) Kutia moyo na kutoa mwongozo katika mambo yanayokutatiza ya kikazi	1	2	3	4	5 ☐
e) Kupata nafasi ya kuzungumzia mawazo yako kuhusu kazi yako na mazingira ya kazi	1	2	3	4	5 ☐
f) Kupata mahitaji yako ya vifaa muhimu vya kazi.	1	2	3	4	5 ☐
g) Kushirikishwa katika kupatia ufumbuzi matatizo au mapungufu yaliyojitokeza.	1	2	3	4	5 ☐

12.Unaonaje kuhusu ubora wa mahusiano (urafiki) yaliyokuwepo kati yako na msimamizi katika ziara ya mwisho?

1= ulikuwa wa kirafiki sana 2= ulikuwa wa kirafiki

3=kwa kiasi ulikuwa wa kirafiki 4= haukuwa wa kirafiki

5=haukuwa wa kirafiki kabisa. ☐

13. Ziara za usimamizi za CHMT ni za manufaa kwa kiasi gani katika kuboresha kazi yako? Pima umuhimu kwa kutumia viwango vifuatavyo

1= ya manufaa sana 2= ya manufaa ☐

3= ya manufaa kiasi 4= isiyo na manufaa

5= isiyo na manufaa kabisa.

SEHEMU YA VI: Ubora wa kituo cha kutolea huduma

Angalia vitu vifuatavyo.

<u>Majengo na vifaa.</u>

Angalia mambo yafuatayo 1= inaridhisha 2= hairidhishi

14. usafi wa kituo [ ] [ ] ☐

inaridhisha; sakafu safi,mazingira masafi, majani yamefyekwa,maboksi ya kutupia sindano yapo na yanatumika. Hairidhishi: mapungufu matatu 3 kati ya vigezo 4 hapo juu.

15. Huduma ya taka zenye madhara [ ] [ ] ☐

inaridhisha: choo-kipo,kina hali nzuri,kisafi; shimo la kutupia kondo au "incinerate" ipo na iantumika.Hairidhishi kutokuwpo kabisa kwa choo au shimo la kutupia kondo la nyuma/incinerate AU mapungufu matatu kati ya vigezo 5 vya choo.

16.Angalia kama vifaa muhimu vifuatavyo vipo na vinafanya kazi.

	1=ndiyo	2=hapana	
a) Thermometer	[ ]	[ ]	☐
b) Weighing scales	[ ]	[ ]	☐
c) Bp machine	[ ]	[ ]	☐
d) Examination bed	[ ]	[ ]	☐
e) Fetal scope	[ ]	[ ]	☐

Menejimenti

17. Je mambo yafuatayo yapo.	Ndio	Hapana.	
a)Maandishi yanayoonyesha majukumu ya kazi ya kila mtumishi "job description"	[ ]	[ ]	☐
b)Kamati ya kituo ya usimamizi wa huduma	[ ]	[ ]	☐
c)Miniti za kikao cha mwisho cha kamati ya kituo	[ ]	[ ]	☐
d)Mpango wa mwaka wa kituo	[ ]	[ ]	☐
e) Mwongozo wa matibabu wa magonjwa ya kuhara	[ ]	[ ]	☐

DODOSO NAMBA 2; TIMU YA UENDESHAJI YA WILAYA –CHMT (Litolewe kwa wadahiliwa maalumu –DMO/DRCHCO,Mratibu wa MTUHA au Mratibu wa Usafiri).

SEHEMU YA I. TAARIFA ZA AWALI

1.Namba ya Dodoso.....

2. Jina la mdahili------

3.Tarehe ya udahili----------

SEHEMU YA II: Idadi ya Ziara za usimamizi.

1.Ni Ziara ngapi za usimamizi katika vituo vya huduma za msingi(dispensari na vituo vya afya) **mlipanga** kuzifanya katika mpango wenu wa CCHP kuanzia Julai 2007 hadi Juni 2008.(Uliza swali hili kwa DMO au Mratibu wa MTUHA.Mpango wa afya wa wilaya unaweza ukasidia kujibu swali hili).----------idadi ya ziara ☐

2. Ni ziara ngapi za usimamizi mmekwishakuzifanya katika vituo vya huduma za msingi(zahanati na vituo cha afya) katika kipindi cha Julai 2007 hadi Juni 2008.(Uliza swali hili kwa DMO au Mratibu wa MTUHA.Taarifa za MTUHA zinaweza kusaidia kujibu swali hili).....idadi ya ziara. ☐

3.Ni ziara ngapi za usimamizi zimekwishafanywa katika vituo vifuatavyo ?

a) Vituo vya serikali. ☐

b) Vituo vya mashirika ya dini. ☐

c) Vituo vya taasisi. ☐

d) Binafsi. ☐

SEHEMU YA IV: Uzingatiaji wa muongozo wa mwaka 1999 wa ziara za usimamizi.

4. Je, kwa kawaida huwa mnaandika taarifa ya kila ziara ya usimamizi mliyofanya?

1=Ndiyo ☐

2=Baadhi

3=Hapana. **Kama hapana nenda swali la 7 .**

5. Je unazo taarifa za ziara hizi zilizokwishafanyika?

1=Ndiyo ☐

2=Baadhi.

3=Hapana **kama hapana nenda swali la 7**

6. Kama ndiyo/baadhi unaweza ukanionyesha taarifa hizo? –idadi ya taarifa katika kipindi cha miezi 12.(jualai 2007 hadi Juni 2008. (Tafuta asilimia ya ziara ambazo taarifa zake za ziara zimepatikana kwa uthibitisho kwa kugawanya idadi ya ziara ambazo taarifa zake zimeonekana kwa jumla ya idadi ya ziara zote zilizofanyika katika swali la 2 hapo juu x100) ☐

1= >75%

2=50%-75%

3=<50%

7. Je unavyo vitu vifuatavyo?	1= Ndiyo	2= Hapana	
a. Mratibu wa usafiri aliyepatiwa mafunzo	[ ]	[ ]	☐
b.Mwongozo wa kitaifa wa ziara za usimamizi wa mwaka 1999	[ ]	[ ]	☐

c. "supervision checklist " ya wilaya [ ] [ ] ☐

d. 'Matrix' ya ziara za usimamizi ya mwezi au robo mwaka [ ] [ ] ☐

(**Angalizo;**Weka tiki kwenye ndiyo iwapo tu utaonyeshwa vitu hivyo kwa uthibitisho)

8. Je mnafanya vikao vya mara kwa mara vya maandalizi vya ziara ya usimamizi?

1=Ndiyo kila wakati. ☐

2= Baadhi ya ziara.

3=Hapana

9. Kama ndiyo ,je unaweza ukanionyesha kumbukumbu za vikao hivi kwa miezi12 ilyopita? ----idadi ya kumbukumbu zilizoonekana ☐

1= ndiyo asilimia zaidi ya 75% ya ripoti zimeonekana.

2= ndiyo, asilimia chini ya .75% ya ripoti zimeonekana.

3=Hapana hakuna ripoti (0%)

Tafuta asilimia ya ziara ambazokumbukumbu za vikao vya maandalizi ya ziara zimepatikana.(ie.idadi ya ziara zenye kumbukumbu za vikao vya maandalizi/jumla ya ziara zilizo kwisahfanyika x100)

10. Je ni ziara ngapi za usimamizi zilizopangwa kufanyika katika kipindi cha miezi 3 iliyopita hazikufanyika kabisa kulingana na ratiba.----- (linganisha ratiba ya ziara na ripoti za usimamizi zilizopo) ☐

11.Katika kituo.....(taja jina la vituo 3 na tarehe) ziara za usimamizi hazikufanyika kama ratiba inavyoonyesha.Je ni sababu zipi zinazozuia kufanyika kwa ziara hizo kama ilivyopangwa? ☐

1= Kukosekana kwa usafiri.

2= Mwingiliano na kazi nyingine muhimu.

3= Wasimamizi hawakuwa na taarifa za zamu ya kufanya ziara.

4=Sababu nyingine. taja

i).....ii).....iii).....iv).....

12. Je unaelezeaje utendaji wa timu ya usimamizi (CHMTs) katika kufanya ziara za usimamizi (uliza maswali haya kwa wasimamizi wanne waliochaguliwa (DMO,DRCHCO,DCCO, na MTUHA coordinator)

1=nzuri 2= kiasi 3=mbaya

a) Idadi ya wasimamizi wanaojua siku ya ratiba yao ya kufanya usimamizi(tarehe na vituo) [ ] [ ] [ ]

>75% 50-75% <50% ☐

b)Ushiriki wa wasimamizi katika kuandaa ratiba ya ziara na kutathmini ziara zilizofanyiaka [ ] [ ] [ ]

>75% 50-75 <50% ☐

c) Upatikanaji wa vifaa muhimu vya kufanyia ziara za usimamizi 'supervision tool' (miongozo ,na checklist) [ ] [ ] [ ] ☐

>75% 50-75 % 50%

d) Upatikanaji wa usafiri kwa ajili ya ziara za usimamizi [ ] [ ] [ ]

>75% 50-75% 50%

e) Idadi ya wasimamizi waliopata mafunzo ya namna ya kufanya usimamizi shirikishi [ ] [ ] [ ]

>75% 50-75% 50%

13. Je una maoni yoyote ya kuimarisha ziara za usimamizi kwa vituo vya afya vya msingi ?

a)----------

b).....

c).....

Asante kwa ushirikiano..

APPENDIX 3

Informed Consent Form, English Version

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

DIRECTORATE OF RESEARCH AND PUBLICATIONS, MUHAS

CONSENT FORM

ID-NO ☐☐☐

Consent to participate in study.....

Greetings! My name is ....., I am a doing research on **QUALITY OF PRIMARY HEALTH CARE FACILITIES SUPERVISION AND ITS ASSOCIATED FACTORS .A CASE STUDY OF MBEYA RURAL DISTRICT.**

Purpose of the study

To find out quality of supervision done by CHMT and its associated factors (causes and effects)

What Participation Involves

If you agree to join this study, you will be required to answer a series of question that have been prepared for the study ,through interview in order to obtain the intended information regarding breastfeeding issues.

Confidentiality

All collected information will be kept confidential and will only be used for study purposes. Identification numbers will be used instead of names.

Risks

We do not expect any harm to happen to you because of participating in this study.

Rights to Withdraw and Alternatives

To participate in this study is completely voluntary. You can freely choose not to participate in this study, and even if you have already accepted to participate in the study you can quit at any time if you feel so. No penalty or loss of any benefits upon refusal to participate or withdrawal from the study.

Benefits

If you agree to take part in this study, we hope that the information we gather from this study will be beneficial to you and other health care providers/stakeholders in the district and other places in the country.

In Case of Injury

We do not anticipate that any harm will occur to you or your staffs as a result of participating in this study. There will be no compensations to you or your facility.

Who to contact

If you ever have questions about this study, you should contact the study Coordinator or the Principal Investigator **DR.JAMES CHARLES**. Muhimbili University of Health and Allied Sciences, P.O.Box 65001,Dar es Salaam.

If you have questions which need further clarification, as a participant you have a right to call **Prof. E .F .LYAMUYA**, Chairman of the College Research and Publications Committee, P.O.Box 65001, Dar es Salaam. Tel: 2150302-6.

Signature:

Do you agree?

Participant agrees..... Participant does not agree .....

I _____ have read the contents in this form.

My questions have been answered. I agree to participate in this study.

Signature of Participant _____

Signature of Research Assistant _____

Date of signed consent _____