World Health Organization

Concept Paper proposed by WHO Tanzania:

Strengthening of Integrated Support and Supervision in Tanzania

Introduction:

Integrated support and supervision is one of the important undertakings towards improvement of the quality of health services. Recognizing this, the Health Sector Strategic Plan (HSSP III) July 2009-June 2015 gave prominence to it in its contribution towards improving quality of health services. The Performance Audit Report of the Controller and Auditor General for Financial Year 2008/09 pointed to some inadequacies in the service provision and emphasized the need for undertaking support and supervision. Furthermore the need for support and supervision is even more crucial given the shortage of staff in health facilities.

To move forward implementation of the integrated support and supervision, the Ministry of Health and Social Welfare has developed the National Supervision Guidelines for Quality Health Care Services to guide Managers and staff. The supervision is supposed to be carried at all levels; starting from the National level i.e. Ministry of Health and Social welfare staff, supervising health staff at the regional levels, the Regional health staff in the Region including in health staff at Local Government authorities, and Local Government Authorities health staff supervising those working in the health centers and dispensaries. Also, given the government plan to expand delivery of health services to cover all villages with a dispensary as outlined in the Primary Health Services Development Programme (MMAM) 2008-2017, the importance of supervision cannot be overemphasized.

Statement of the Problem:

Currently, there are activities taking place related to support and supervision. However, some of these are not well coordinated and hence ineffective, as they are undertaken by different health programmes and are not well linked and coordinated at the central level for proper harmonization and sharing of experiences that can be helpful in improving health services delivery. Also noted is that the health services delivery has been de-concentrated and devolved to the Regional Administration and Local Government Authorities respectively; however, these levels of Authorities are not sufficiently used to implement the recommendations of the supervision reports. In some of these supervision reports the progress is noted on the number of visits rather than improvements in attending patients and clients of health services.

The difference between administrative and technical support and supervision also poses operational challenges in terms of organizing supervision visits that are adequate to suit the interests of both. This is because with administrative supervision, (which occurs between managers and health facility staff covering issues including adherence to financial rules and regulations, management of operational resources and logistics; and staff welfare to ensure promotion of good standard of work, operational effectiveness and performance) done mostly by managers and administrators, might not be as frequent and intense as technical supervision

(which is focused on technical interaction which occurs between supervisors and technical staff of health facilities by fostering improvement in procedures, adherence to diagnostic and treatment procedures to ensure quality services are provided). In practice, technical supervision can be of "general nature", for example a District Medical Officer can undertake a broad range supervisory visit covering a range of technical issues as opposed to a "focused/technical visit e.g undertaken by for example a pharmacist covering identified thematic issues at a facility.

In many instances the composition of health staff at National, Regional, Council, Health centers and dispensaries may not necessarily suit the requirement of existing health programmes. This is compounded by planned supervision routes at National, Regional and Council level, which seem to favour more on administrative supervision than on technical supervision.
The other challenge is the availability of resources to undertake supervision, this includes availability of staff at all levels in particular at the National level where staff are faced with other competing priorities such as meetings, conferences and external travels resulting into assigning low priority to supervision. In view of the increasing number of health facilities and decreasing number of staff to undertake supervision and other regular activities in the health facilities, the time allocated for supervision for each health facility is also not satisfactory.

Adequate financial resources and vehicles for supervision are also cited as contributing factors in hindering effective supervision. At the district level vehicles which were under the direct control of the Department of Health have now been transferred to the Local Government Authority pool. Inefficiencies in prioritization, vehicle maintenance and planning route schedules affect directly supervision of health services.

Proposed way forward:

To address the issues raised, we see several possible practical ways of addressing them given the different needs and expectations of the MoHSW top leadership, program managers, Regional, District and Health facility staff.

The first step proposed is the finalization of the guidelines for support and supervision, taking into consideration some of the ideas presented above. This is important since it is recognized that there can be no single guideline to respond to all the needs and expectations at various levels of the health system. Hence the support and supervision framework could apply at several different levels as described below.

At the level of the PS, CMO and other top Government officials, support and supervision is designed to check on implementation of government policy, compliance with specific instructions, assessment of and addressing human resources needs, assessment of status of health infrastructure including equipment and supplies, responding to specific political

instructions or expectations among others. These visits could be to any level of the health care structure, would tend to be generic and cover all areas. However, it is important that a regular schedule be prepared so that Regions for example know that they expect one such high profile visit per year or every so often. Field staff value such support and this is an important morale booster. It is important also for MOHSW senior officials to play their role, in this context, of overseeing the operations of private health care providers.

At the level of program staff which includes Directors, Assistant Directors and their staff, they are expected to undertake more structured and regular visits to the field to assess implementation of relevant policy in their program specific areas. They would particularly want to check on compliance with agreed standards and norms set by MoHSW for implementation of specific health interventions. They may require program guidelines and checklists for their support and supervision visits. They would also use opportunity of support visits for capacity building in areas identified as requiring improvement. These visits could be to Regional level, District level, health facility level and in some cases down to community level.

Regional Health Team staff would use the guidance provided from program staff to develop their own support and supervision guidelines which would tend to combine several or all health programs. These visits need to be regular to districts where within the district they can visit any level of the health care structures including the community.

The District health team requires a clearly structured schedule to visit each health facility perhaps monthly. There would be need to use a guide or checklist which any member of the team can use when they visit. This should cover technical program areas as well as administrative areas. This should assist in checking compliance with national guidelines, identification of problems and provision of solutions including addressing key operational and personnel welfare issues. Reports should be prepared and submitted to the Regional level for necessary follow-up.

Two key elements of the whole process are the systematic recording of information collected from the support and supervision, and the regular feedback and dissemination of these findings both back to those being supervised and upwards to other levels in the system. There is also need for a way of capturing this information, transmitting it, and using it as the basis for the next supervision, so that the supervisor does not start with a blank slate each time. There are relatively inexpensive information technology approaches, such as PDA's, which can be used for these purposes, and should be explored. This will go a long way to help justify the substantial resources currently being provided through the Basket Fund for example and any additional

funds that may be mobilize to support this initiative. Support for this initiative should be made "performance based" so that payments are linked to support and supervision undertaken.

The MOHSW and PMORALG have shared responsibility for undertaking support and supervision in health hence the need to agree and outline how each can best carry out its responsibility. The MOHSW is clearly expected to take the lead on health technical matters and PMORALG on administrative issues during such visits. Senior MoHSW officials report that this process has already started. However there is need to facilitate free movement of staff to undertake support and supervision within health institutions.

Mobilization of adequate financial and other resources is required to successfully implement this initiative. Currently a lot of money is used for undertaking workshops and not well structured support and supervision. Given that some of the workshops undertaken are organized to address problems that would otherwise have not occurred were effective support and supervision been undertaken, such funds could now be reprogrammed.

We call upon government and partners to agree to this approach and better channel resources required to support undertaking effective support and supervision. Also, additional resources are required to be mobilized to cater for critical needs including logistics, documentation and communication.

Additionally, in view of the shortage of staff both at Regional and district levels, the regions and districts should arrange supervision visits in such a way that time used for support and supervision is optimized. Adequate time should be spent for each health facility to ensure productive interactions, observations and feedback to facility managers and their team. Moreover, facilities that are found with weaknesses should be visited more frequently than those with fewer problems. Again the frequency of these visits needs to be decided by MOHSW in collaboration with the PMORALG, Regions and districts health managers. It is recommended if possible each health facility should be visited at least once each month by trained and experienced teams using concise and well structured checklists.

Conclusion:

The ideas expressed in this concept paper recognize the different support supervision scenarios and discuss key problems hindering its achievement. Based on the current health decentralization mandates and responsibilities, we advocate for stronger institutional partnership between the MOHSW, PMORALG and districts. In addition, there is need to fast track completion of the supervision guidelines and checklists, mobilization of adequate funds and resources and partnership arrangements to enhance coordination and harmonization of supervision in the health sector. Partners in the health sector are requested to provide support to the MOHSW, PMORALG, in elaborating further strengthening of supervision along this conceptual framework.