UNIVERSITY FOR DEVELOPMENT STUDIES, TAMALE

FACILITATIVE SUPERVISION IMPLEMENTATION IN GHANA: AN EXPLORATION OF ADHERENCE AND CONTRIBUTION TO PRIMARY HEALTHCARE DELIVERY IN THE UPPER WEST REGION.

BY

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DECLARATION

Student

I, Faustina Sarkpoh, hereby declare that this thesis is the product of my effort under the guidance of my supervisor and that to the best of my knowledge, it has not been presented anywhere as a whole or in part for the award of a degree, and it contains no material previously published by another person except where due acknowledgement has been made in the text.

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ABSTRACT

Given growing concerns about the quality of health care delivery in many developing countries, this thesis explores whether the introduction of Facilitative Supervision (FS) has delivered on its objective of improving the quality of primary health care. Access to basic quality health care is an important healthcare objective of the Ghana Health Service (GHS) and Sustainable Development Goals (SDGs), and in spite of the relevance of FS in this effort, its impact on the quality and uptake of primary health care is seldom explored. Drawing on the implementation of FS in primary health facilities in a municipality and districts in the Upper West region of Ghana, a qualitative approach was employed in the collection and analysis of data. Specifically, semi-structured interviews were conducted with 46 participants. Observation and document review were also employed to generate data to triangulate the results obtained through interviews. The results revealed logistical and technical challenges in the implementation of FS in some health facilities studied. These notwithstanding, adherence to FS as observed in most of the facilities studied has contributed to improvements in staff performance. There is also an increase uptake in primary healthcare services which is reflected in increases in OPD visits, maternal and child healthcare services in all of the facilities studied. In order to improve the regularity of FS for improve quality of primary health care delivery in the region, health planners and implementers ought to pay serious attention to the challenges of limited logistics and inadequate human resources ushered in by constrained funding. This would require innovation in the mobilization, distribution and effective monitoring of the use of health resources at the primary level.

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DEDICATION

To my parents, Mr. and Mrs. Alord-Donkor, my children Melvin S. A Fausters and

Leah S.A Fausters and my husband, Dr. Fauster Agbenyo.

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LIST OF ABBREVIATIONS

ADA	American Diabetes Association
CHPS	Community-based Health Planning and Service
CSC	Community Score Card
CHO	Community Health Officer
CHC	Community-based Health Center
CHMT	County Health Management Team
DHMT	District Health Management Team
FS	Facilitative Supervision
FSV	Facilitative Supervision Visit
GHS	Ghana Health Service
GAVI	Global Alliance for Vaccines and Immunization
IOM	Institute of Medicine
JICA	Japan International Cooperation Agency
MOH	Ministry of Health
M&E	Monitoring and Evaluation
NDPC	National Development Planning Commission
NASTAD	National Alliance of State and Territorial Aids Directors
NACP	National Aids Control Programme
NHMT	National Health Management Team
OPD	Out Patient Department
OED	Oxford English Dictionary
PHC	Primary Health Care
PM&E	Participatory Monitoring and Evaluation

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PRA	Participatory Rapid Appraisal
PLA	Participatory Learning and Action
PATH	Programme for Appropriate Technology in Health
RHMT	Regional Health Management Team
SS	Supportive Supervision
SARAR	Self-esteem, Association, Resourcefulness, Action Planning and Responsibility
SDHMT	Sub-District Health Management Team
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
UWR	Upper West Region
WHO	World Health Organization

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CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Primary health care (PHC) has been observed globally as the foundation upon which every health system can provide effective, quality and affordable health care to the population (ADA, 2015). In the Central and Eastern European countries, reforms in health care services remain an integral component of broader vicissitudes in the functioning and values of the society (Jemal, Murray, Ward, Samuels, Tiwari, Ghafoor, & Thun, *2005*). In Tanzania, even though the scope of health services has been increased, quality of care in these systems have been a major challenge over the years (Ministry of Health & Social Welfare, 2011-2016, 2013-2018). Some of the issues accounting for these concerns are poor hygiene and sanitation, inadequate health infrastructure, low motivation of health workers, inadequate adherence to professional and ethical standards, and gaps between what health workers know and what they actually do (Ministry of Health & Social Welfare, 2011-2016, 2013-2018).

In Ghana, the Community-Based Health Planning and Services (CHPS) programme forms an integral part of PHC services provision. CHPS is a strategy, adopted by the Government of Ghana in 1999 to bridge the gap in access to basic quality health services in rural areas by strengthening community health services (Aikins, Laar, Nonvignon, Sackey, Ikeda, Woode, & Nyonator, 2013). There are 4,700 CHPS in the country with 256 of these CHPS in the Upper West Region (GHS, 2018). To implement the CHPS policy, CHPS zones were to be created relying on already existing government structures by the year 2015. The policy serialized the milestones for the establishment of the CHPS zone which include preliminary planning, community entry,

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health compound construction (CHPS compound), procurement of essential equipment, posting of nurses and providing them with technical refresher training and recruitment of volunteer (Frimpong, 2018). Although the CHPS policy faced some implementation challenges, its benefits to the various communities have been tremendous as it brought effective, acceptable and affordable health care to the doorsteps of these communities and engendered their full participation resulting in the reduction of mortality and morbidity rates among Ghanaians (Osei & McLean, 2018).

As part of efforts to improve quality health care delivery in the Upper West Region, facilitative supervision also known as supportive supervision, which is a strand of participatory monitoring and evaluation (PM&E) was introduced in to the CHPS programme (Aikins *et al.,* 2013). According to Engenderhealth (2001), facilitative supervision is an approach to supervision which focuses attention on mentoring, joint-problem solving and two-way communication between the supervisor and supervisee. Unlike Conventional monitoring which focuses on the results of external review, inspection of the end results and heavy investment in the supervisors to monitor staff, facilitative supervision focuses on whether existing work processes are planned, designed and implemented according to plan to enable the achievement of desired results. This way facilitative supervision anticipates and prevent problems from occurring even before corrective measures are contemplated (Aikins *et al.,* 2013).

The introduction of facilitative supervision forms part of a paradigm shift where institutions, organizations and project implementers as well as donors, being aware of inherent weaknesses of conventional monitoring have formulated and/or adopted new approaches (Ofosu & Ntiamoah, 2016); including the concept of participation thereby PM&E. The literature demonstrates, PM&E began as far back as the 1970s (Estrella &Gaventa, n.d.; Howes, 1992; Feuestein, 1986; Pratt &Boyden, 1985; PRIA, 1995).

Participation in this context, is defined as "Development as a process of increasing people's capacity to determine their future means that people need to be included in the process of planning their needs and development" (Sana, 2011: 18). Again, participation has been conceptualized as a process by which stakeholders influence and share control over development initiatives and the decisions and resources which affect them (World Bank, 1996).

On the other hand, PM&E is viewed as a process by which stakeholders at various levels monitor and evaluate a particular intervention, which can be a project, programme or policy, distribute control over the content, process and the results of the Monitoring and Evaluation (M&E) exercise and take remedial measures. PM&E concerns itself with the active involvement of primary stakeholders (World Bank, 2010a). It is one of several approaches employed to ensure smooth implementation of various projects in the action plan or smaller related projects within a programme to yield the desired outcomes. As found in all M&E elements, the process and content of M&E are usually prepared as precursors to project implementation (Philip et al 2008).

1.2 Problem Statement

Facilitative supervision, as a tool for implementation management is important for health services provision and access in the form of anticipating and preventing problems from occurring even before corrective measures are contemplated (Aikins *et al.,* 2013). Other importance include reduction in routines and lower-level problems as staff learn to solve their own problems with less technical assistance needed from higher-level supervisors. More so, facilitative approach induces a paradigm shift where the focus is redirected from inspection and fault-finding assessment to a joint problem-solving approach to a continuous improvement in the quality of health care services

provision. Furthermore, the supervisor will have satisfaction of working as a team member, making staff learn and grow with improvement in quality of health leading to staff motivation and commitment (Engenderhealth, 2001). Despite these importance, very little attention has been paid to facilitative supervision in terms of scholarly work in order to establish its contribution to the PM&E literature, particularly in the Upper West Region of Ghana. The only systematic study accessible on facilitative supervision in Ghana is Aikins et al. (2013) which states that in facilitative supervision, supervisors are concerned with the needs of the staff that are under their tutelage. In trying to attend to the needs of staff to ensure their control over quality improvement management in PHC services provision, both supervisors and staff will be confronted with many challenges; however, these challenges are visibly missing in their study. More so, it has been realized that facilitative supervision has not been embraced fully at the various health facilities but treated as mere formality. A case in point is when I was on admission in a hospital in Takoradi and a dialogue ensued between a nurse in- charge and a nurse as regards the presence of a supervisor. The in-charge said:" take that thing off, the supervisors are coming", even though I did not know what the in-charge was referring to. Then, the nurse asked with a surprise on her face: why should I take it off since this is how it has always been done here ". The in-charge replied: just take it off when the supervisors are done and gone, we will put it back. What I witnessed motivated me into researching into the subject area to help me get a better understanding of the issue. This among others, therefore, necessitates a study that aims to contributing to the M&E literature, with specific focus on adherence to the guidelines of facilitative supervision in the Upper West Region of Ghana.

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1.3 Research Questions

1. How is Facilitative Supervision carried out in health facilities in the Upper West Region?

2. To what extent are staff of facilities adhering to the guidelines of facilitative supervision?

3. How has facilitative supervision contributed to uptake of primary health care in the region?

4. What are the challenges associated with adherence to facilitative supervision in the region?

4.4 Research Objectives

1. To examine how Facilitative Supervision carried out in health facilities in the Upper West Region.

2. To assess how staff of facilities adhere to guidelines of facilitative supervision.

3. To assess how facilitative supervision has contributed to the uptake of primary health care delivery in the Upper West Region.

4. To examine the challenges of facilitative supervision in the Upper West Region.

1.5 Significance of the Study

Findings of the study will be very helpful to all stakeholders (implementers of FS, staff of facilities and policy makers). First it will expose them to the various stages of participation and make information available to them on the stage that facilitative supervision is operating currently. This information will guide their decisions in steering the health system towards better outcomes. Secondly, it will lay bare to each

stakeholder, comprising the supervisors, supervisees and policy makers their respective interest. It will also help to expose knowledge and skills transmitted, through capacity building, at the various levels of health services provision. This will help all stakeholders appreciate the level of quality improvement that has been achieved in health services provision in the region.

1.6 Organisation of the study

The study is organised into five chapters. Chapter one is the introduction where the background of the study, the problem statement, research questions and objectives, scope and relevance of the study are considered. The second chapter has to do with the literature review. The literature is reviewed according to the research questions used in the study. Theories of facilitative supervision for the study is also looked at. Various books, journals, articles and the internet helped the researcher to extract information on the topic for this study. Chapter three is dedicated to research methodology. It outlines the research design, sample size and sampling techniques that were used in the study. It explains the sources of data, the data collection instruments that is employed in obtaining data for this study. It also describes the data analysis methods for the study. Chapter four has to do with the analysis and discussion of results. Chapter five is where the work is summarized, conclusions drawn and recommendations given for future policy implication.

CHAPTER TWO

REVIEW OF RELEVANT LITERATURE

2.1 Introduction

The previous chapter looked at the background and the problem statement where research objectives were mentioned. In this chapter, literature which consist of the writings of authors and experts on facilitative supervision in the health sector has been reviewed. To ensure the logical flow of the review, it has been structured according to the research questions and objectives which guide the study. This review takes the form of the search, assemblage, summary and critical analysis of these writings in order to establish gaps that exist in these works for them to serve as basis for this research. These gaps are in line with the research questions and objectives that guided the methodology and for that matter shaped the results and subsequently the findings, conclusions and recommendations of the study. The sources of these writings that form the basis for review in this chapter have been accessed from various books, book chapters, journal articles, periodicals and articles from internet blogs among a host of other sources; the researcher extracted information from these sources for review for the research. The chapter is phased into four main sections, commencing with the conceptual review, theoretical review, through to the review of empirical review that underpins the analysis.

2.2 Conceptual Review

The conceptual review focused on the various concepts used in this study, looking at how other authors, experts and researchers have defined them and how these terminologies have been conceptualized in this particular research.

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2.2.1 Facilitation

Facilitation has been defined differently by a number of authors**.** The word facilitate comes from the Latin word which means to 'make easy'. Facilitation is believed to be the art of focusing group energy on a specific goal.

Trevor Bentley defined facilitation as "the provision of opportunities, resources, encouragement and support for the group to succeed in achieving its objectives and to do this through enabling the group to take control and responsibility for the way they proceed" (Bentley, 1994)*.*

Again, Fennberg and Xin (2010) defined Facilitation as the art of leadership in group communication. Facilitation in both online and face to face settings aim to promote a congenial social atmosphere and a lively exchange of views. A facilitator is therefore one who fulfills this leadership role as espoused by Fennberg and Xin (2010). It is evident from the above definitions that facilitation has to do with leadership and how the roles of these leaders are executed or performed to achieve a certain objective or goal. For the purpose of this study, facilitation has been conceived of as a process of leadership which culminates in the creation of opportunities and provision of resources in supporting health services delivery staff and their functions in achieving set goals and objectives. To help in the creation of opportunities and provision of resources in order to achieve the set goals and objectives, the facilitator is at the heart of the whole process as an enabler and must necessarily possess such qualities as humility, excellent listening capabilities, empathy, patience, time consciousness, on-the-spot learning, coaching and must possess a wealth of knowledge on the subject matter in which the facilitation is being conducted.

2.2.2 Supervision

Supervision is a process of directing and supporting staff so that they may effectively perform their duties (Stinson, Logel, Zanna, Holmes, Cameron, Wood, & Spencer, 2008). The aspect of directing in this definition suggests that there is broadly the existence of a goal or purpose or narrowly objective or target toward which efforts are being directed to enable the staff achieve. Supervision may include periodic events, such as site visits or performance reviews; but it also refers to the ongoing relationship between a staff member referred to as supervisee and a supervisor (USAID, 2019). The on-going relationship is borne out of the feeling of empathy of the supervisor towards the supervisee in which case the supervisor tries to see issues or content of supervision through the lenses of the supervisee within the context in which the issues are emerging. This enables joint-problem solving between the supervisor and supervisee and help improve the quality of health care delivery, particularly at the peripheral areas of developing countries.

Again, supervision has been defined as a complex mix of skills that will help improve the quality of an organization (MSH, UNICEF 1998). Supervision is vital in every organization especially in the health sector. This is because once goals and objectives are formulated and duties are defined for health service delivery staff to perform for purposes of achieving these goals and objectives, there is a likelihood that both endogenous and exogenous factors will influence the staff to deviate from achievement of these goals and objectives. These factors are what constitute problems that bedevil the health services worker which calls for the joint problem-solving between the health services supervisor and supervisee (Bosch-Capblanch & Garner, 2008). To this end, an organization that does not have a supervisory component to ensure that the right

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things are done, in the face of tithing problems that may confront the health services workers, are bound to fail.

Bosch-Capblanch & Garner (2008: 371) summarized what goes into health services supervision as "frequent visits to the supervisees' place of work" to establish "the link between the central (district) tier of the health system and the peripheral rural health care delivery staff in the district" with the intent of improving "performance and helping motivate staff". It is said to involve "(a) problem solving; (b) reviewing records; (c) observation of clinical practice." Inherent in Bosch-Capblanch & Garner's definition is the assumption that health workers found in the peripheral areas of developing countries are often low skilled and with little experiences. They are also bedeviled with a myriad of environmental challenges that negatively influence performance of their tasks. Thus, the frequent visits of supervisors from the higher order health facilities to the work places of the supervisees, who are at lower order health facilities does not only help motivate staff at the lower level health facility to put up their best in achieving their targets but also help the supervisors have first-hand information on how the workers are meeting standards of clinical practice as well as practical challenges that health workers face, particularly those that bother on their skills levels.

2.2.3 Facilitative Supervision

Facilitative supervision (FS) also referred to as supportive supervision (SS) according to EngenderHealth (2001) is an approach to supervision which focuses attention on mentoring, joint-problem solving and two-way communication between the supervisors and those being supervised. The facilitative approach to supervision emphasizes the supervisor's role in leading a team of staff through a continuous process to better

understand and meet the needs of their health care clients. Facilitative supervisors at all levels do this by focusing on the needs of the staff they oversee, and consider staff to be their own customers or clients. They again, focus on the importance of improving processes and systems rather than focusing on individual mistakes (EngenderHealth, 2001). Here, the individual mistakes are seen as a part of constellation of problems that need to be solved rather than as the only challenge that bedevils the whole process. Facilitative (supportive) supervision is done in three forms. We have the individual facilitative supervision, integrated facilitative supervision for health care services and integrated supportive supervision of management systems (Ministry of Health Training Manual, 2018). The individual facilitative supervision is done to improve the individual technical and/or managerial performance and to strengthen linkages with other programmes. In this case, the individual's focus in the whole organization is deemed very vital since the character and function of the individuals come together to constitute the whole health delivery system. Given these systems of health services provision, the malfunction of any individual within the whole system will derail the whole system from achieving its purpose. The integrated facilitative supervision for health care services is done to improve teamwork and technical performance. In trying to integrate health care services, facilitative supervision focuses on strengthening the relationships and linkages between and among the various units or components within the whole system. Examples include linkages between the Out Patients Department (OPD) and the consulting unit; the consulting units and the laboratory services and consulting units and pharmacy/dispensary unit. One can also talk of the linkages between the consulting units and the operating theatre, the consulting units, the operating theatre and drug dispensary. In the case of integrated supportive supervision of management systems, the aim is focused on effective functioning of high-quality systems. The assumption is

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that proper health services institutional structures can be put in place, well-staffed with highly trained and skilled personnel with state-of-the-art equipment, but if no proper management structure staffed with managers with high competencies are in place in such a facility, it will be difficult for the facility to achieve its purpose.

2.2.4 Participatory Monitoring and Evaluation

Participatory Monitoring and Evaluation (PM&E) is a process of self-assessment, collective knowledge generation, and cooperative action in which stakeholders in a programme or intervention substantively and collaboratively identify the monitoring and evaluation issues, collect and analyze data, and take action as a result of what they learn through this process (Onyango, 2018). Participatory Monitoring and Evaluation help individuals and stakeholders to influence decision-making, work through different views, gain knowledge from initiative and collectively strategize in order to achieve desired results. According to the National Development Planning Commission [NDPC] (2013:35), PM&E is a process involving "primary stakeholders' active participation in tracking progress towards the achievement of self-selected or jointly agreed results to draw actionable conclusions". NDPC identifies two types of participation in this context viz. broad participation which involves the whole range of staff, beneficiaries and partners; and narrow participation which targets just one or two groups of partners. The PM&E process involves planning and design, gathering and analyzing data, identifying the evaluation findings, conclusions and recommendations, disseminating results and preparing an action plan to improve performance. Frequently used PM&E include Participatory Rapid/Rural Appraisal (PRA), Participatory Learning and Action (PLA), Self-esteem, Association, Resourcefulness, Action Planning and Responsibility (SARAR), Citizen Report Card (CRC) and Community Score Card (CSC) (see NDPC,

2013: 38-53 for more details on the tools and techniques for conducting PM&E). In applying these methods, local knowledge is emphasized to ensure successful community development planning, implementation, monitoring and evaluation. This way a congenial atmosphere is created to aid mutual learning, deepen public consultation and to provoke thinking and action (NDPC, 2013:35).

Some key characteristics of PM&E according to NDPC (2013:35) include:

- Team work;

- Interaction among team member, made up of evaluation facilitators and key stakeholders (e.g. community members) to generate the data and information;

- Team members examining their own experiences and learning from them;

- Organizing the data and information and feeding these findings back to those people who reported the information while allowing sufficient time for reactions;

- Determining the real meaning and validity of the information gathered; and

- Deciding with the people plans for future actions.

The participatory methods and tools outlined above can be used to generate a wide range of qualitative and quantitative data and information in such areas as baselines, gender equity, issues on relevance, effectiveness, efficiency impact and sustainability of an intervention. Other issues that the methods are used to assess include participation of poor women, vulnerable and excluded groups and management and power relations in the household, institutions and organizations.

2.2.5 Quality Health Care

According to Quality Digest, quality, like beauty, is in the eye of the beholder, and like truth, quality is in the mind of the believer (www.qualitydigest.com). In the words of Chambers Dictionary, quality is the "grade of goodness" or "excellence". To the Oxford English Dictionary (OED) quality involves "the degree of excellence of a thing". The above two dictionary definitions point to the fact that there can be good quality just as there can be poor quality. Again, it is clear that the concept of quality can lend itself to so many definitions depending on the context.

Quality in a health care setting is meeting the needs and expectations of clients (the customers of health care services) with a minimum of effort, rework and waste (Berwick, Godfrey and Roessner 1990). As can be seen, Berwick et al's. (1990) definition focus only on health services managers' and clients' concern without a focus on those of the staff and professional bodies. In the health care sector quality is defined depending upon which stakeholder's lens is being used. For patients and clients, quality means the extent to which needs and expectations are being met within the context of vulnerability and in some cases pain and agony. They also view quality in the context of value for money especially in a policy environment of cash-and-carry as well as the amount of time spent at the facility. To the health services delivery staff, quality is viewed in the context of the service delivery process, looking at its user-friendliness and ease of use. They will also focus on the facilities and equipment available in terms of user-friendliness, modernity and skills level to man the equipment. Staff concern for quality will also Centre on further training which can take the form of further studies or on-the-job training. In the framework of facilitative supervision, to the supervisor and health professional bodies, quality is on how professionals and practitioners meet

health services provision standards set by these bodies. Quality health care improvement on the other hand, consists of systematic and continuous actions that lead to measurable improvement in health care services and health status of targeted patient groups. The Institute of Medicine (IOM), which is a recognised leader and advisor on improving the Nation's health care, defines quality in health care as a direct correlation between the level of improved health services and the desired health outcomes of individuals and population (*http://www.iom.edu./About-IOM.aspx*, *accessed on 25th September 2019).* It should be pointed out that IOM's definition of quality health care improvement is limited only to the broad definition of demand and supply side of health services delivery. In the context of this study, quality health care improvement is viewed as an incremental exercise which involves governemnt as a supplier and health services providers as being at the demand side. Even within the shealth services providers, management of health facilities, to some extent can be seen as being at the supply side while health care providing staff can be seen as being at the demand side. Quality health care improvement can, therefore, be defined as the incremental improvement or betterment of health care services functions performed from the governmental level, through health care services management and staff levels, all considered as being of the supply side on the one hand to the health care services management, staff and clients levels, considered as of the demand side on the other hand.

2.2.6 Primary Health Care

Primary Health Care (PHC) is an essential health care made universally accessible to individuals and acceptable to them, through full participation and at a cost the community and country can afford. It is an approach to health beyond the traditional

health care system that focuses on health equity-producing social policy (WHO, 2019). Primary Health-Care (PHC) has basic essential elements and objectives that help to attain better health services (Mona, 2016).

Primary health care is a whole-of-society approach to health and well-being centered on the needs and preferences of individuals, families and communities. It addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental and social health and wellbeing (WHO, 2019).

2.2.7 Community-Based Health Planning and Services (CHPS)

Community-Based Health Planning and services is a national strategy to deliver essential community -based health services involving health planning and service delivery with the communities. The Community-Based Health Planning and Services (CHPS) Initiative (n.d.) refers to the CHPS as a model for community-based service delivery. Its primary focus is communities in deprived sub-districts and bringing health services close to these communities. The general principles include: a) Community participation, empowerment, ownership, gender considerations and volunteerism, b) Focus on community health needs to determine the package of CHPS services, c) Task shifting to achieve universal access, d) Communities as social and human capital for health system development and delivery, e) Health services delivered using systems approach and f) Community Health Officer (CHO) as a leader and community mobilizer. The CHPS strategy is a breakthrough in enhancing community involvement and ownership of primary health care interventions towards achieving Universal Health Coverage (Ghana Health Service, 2018).

The Community-Based Health Planning and Services (CHPS) Initiative (n.d.) documents that in 1998 two major events occurred in Ghana that serve as precursors to

the emergence of CHPS as a health service provision approach. The first had to do with dissemination of results from experiments launched earlier in Navrongo by the Navrongo Health Research Centre to all the 110 districts in the country. There was also information about how District Health Management Teams could establish these Community-based Health Centres (CHCs). The second issue emerged from Nkwanta in the then Volta but now Oti Region where it was proven based on an experimental trial that it was possible to replicate the community-based service with limited incremental funding from Ghana Health Service as it provided opportunity for reliance on community resources ranging from community labour to materials with local level leadership support for the process. These two events led to a general consensus that replication of the CHPS strategy on a large scale across the country was feasible. In 1999, a national health policy statement was issued leading to the launching of the CHPS initiative across the country based on the Nkwanta experience. The initiative was considered at the planning and implementation stages. By 2002, 95 out of the 110 districts in Ghana have launched the planning stage of the CHPS programme. Of these, 20 have launched nearly all elements of the CHPS approach in one or more service implementation areas; seven districts have completed the CHPS programme in one or more implementation zones.

According to the Community-Based Health Planning and Services (CHPS) Initiative (n.d.) the CHPS process goes through a number of steps. These include the District Health Management Team programme planning in the most remote and deprived communities of the district taking the initiative. This is followed by communities mapping, problems assessment, and community entry which involves dialogue between health care providers and community leaders. After clarification of leadership responsibilities, communities are then led to mobilise revenue and form teams of

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volunteers to construct village clinics known as "Community Health Compounds (CHC)." After the completion of the CHC, a Community Health Officers (CHOs), are posted to the facilities who are community-based front-line health workers. These nurses are charged with the following responsibilities:

- Visit to households;

- Organize community health services; and

- Conduct CHC clinics.

The CHOs receive midwifery training to enable them supervise births, perform the procedure for manual removal of placenta, oxytocin injection for labour management and emergency obstetric referral as well as family planning services; all provided at the door steps of their clients. One key feature of the CHPS strategy was the financial access it provided for its patrons, most of whom were poor community members who could defer payments for services until family members made arrangements to settle the bills. This was said to lay the foundation for the mutual health insurance schemes that has contributed greatly to the current health insurance scheme operational in Ghana.

2.3 Theoretical Underpinning of the Study

Facilitative supervision (FS) in public health services provision is a refined form of PM&E or review which involves self-introspection, reflexivity and mutual learning from both the mentor and mentee. The focus of this study, which is an assessment or evaluation of facilitative (supportive) supervision as an intervention, calls for two theories to constitute its guiding framework. The first theory is theory X and Y, propounded by McGregor (1960) while the second theory is the theory of change also put forward by the Aspen Institute Roundtable on Community Change (Weiss, 1995). The merger of these two theories is important in that while theory X and Y focuses on

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the inborn characteristics of the actors in the FS enterprise that will spur them onto participation, the theory of change is centered on why and how the FS itself works. Even though theory of change concerns itself with participation, its focus is more on how the actors will participate in the development of the theory rather than participation in the programme that is being assessed, in this context, health services provision, which constitutes the content of this study. In this case, while theory X and Y will add participation as part of the content to the FS programme, theory of change will answer the methodological question as to how and why the programme works or not (Rogers, 2014; Weiss, 1995).

Theory X and Y are two sides of the same theory propounded by McGregor (1960). The main proposition of theory X states that human beings by their nature detest work and that they engage in it as a matter of necessity. Proponents of theory X, therefore, advocate for supervision, monitoring and control, in addition to motivation of employees if they are to buy into and work towards the achievement of their organizational goals. It is important to note that these are the surest ways to initiate and sustain employees' participation in health services provision within the Wa Municipality and Wa West District. The flip side of theory X is theory Y. In contrast with theory X, theory Y espouses that employees, characteristically, love to work and that they have inner satisfaction in their career progression. The type of supervision advocated under Theory Y is that of a facilitator, a teacher and a mentor. McGregor and his exponents are of the view that all that supervisors require to do is to provide a congenial, pleasant, healthy and engaging working environment for employees, who are highly motivated from within to implement their activities for the delivery of their outputs in order to achieve health services provision goals and objectives. Since the employees already have the organization at heart, management needs to engage them

in the decision-making process, create a congenial environment for mutual understanding and learning; and this will aid them unleash their skills and responsibility for the success of the organization. These will lead, not only to growth and development of the organisation, but also capacity building and empowerment for both the health services supervior and supervisee.

Theory of change is also christened as the logic model or the programme theory (Rogers, 2014). Due to the fact that programmes are developed from varied fields and different organizational settings, theories of change present themselves in different forms. However, every theory of change concern itself with the causal logic of how and why programmes work, the workings of the programme in the form of rules, or design innovation and reaching its intended outcomes. According to Weiss (1995) cited in Archibald et al. (2016; 3) theory of change is "a theory of how and why an initiative works". It indicates the assumptions underlying the workings of the programme under assessment and defines the causal pathway(s) through which the programme proceeds to function as well as the various inputs, activities and intermediate outcomes that build on into the final outcome and subsequently impact of the intervention (Gertler *et a*l., 2016). In this study under FS in the health services provision in the Wa Municipality, human resources, means of transport, medical (both preventive and curative) equipment and other infrastructural facilities constitute inputs into the FS programme. Specific activities include routine health services provision and supervision sessions. The fundamental assumption in the study is that when supervisors engage their mentees in appropriately congenial working environments with appropriate motivational and sanction packages, health services employees will perform their daily roles and responsibilities for the achievement of improved health statuses of the populace, mutual

learning and empowerment of the supervisors and the supervisees. See the diagrammatic depiction in Figure 2.1.

Inputs	Activities	Outputs	Outcomes	Final Outcomes

All inputs Procured using financial Resources	Inputs converted into health services and FS Sessions	Supervision undertaken at the health facility	Improvements in the quality of Health Services Provision	Health statuses of the populace improved

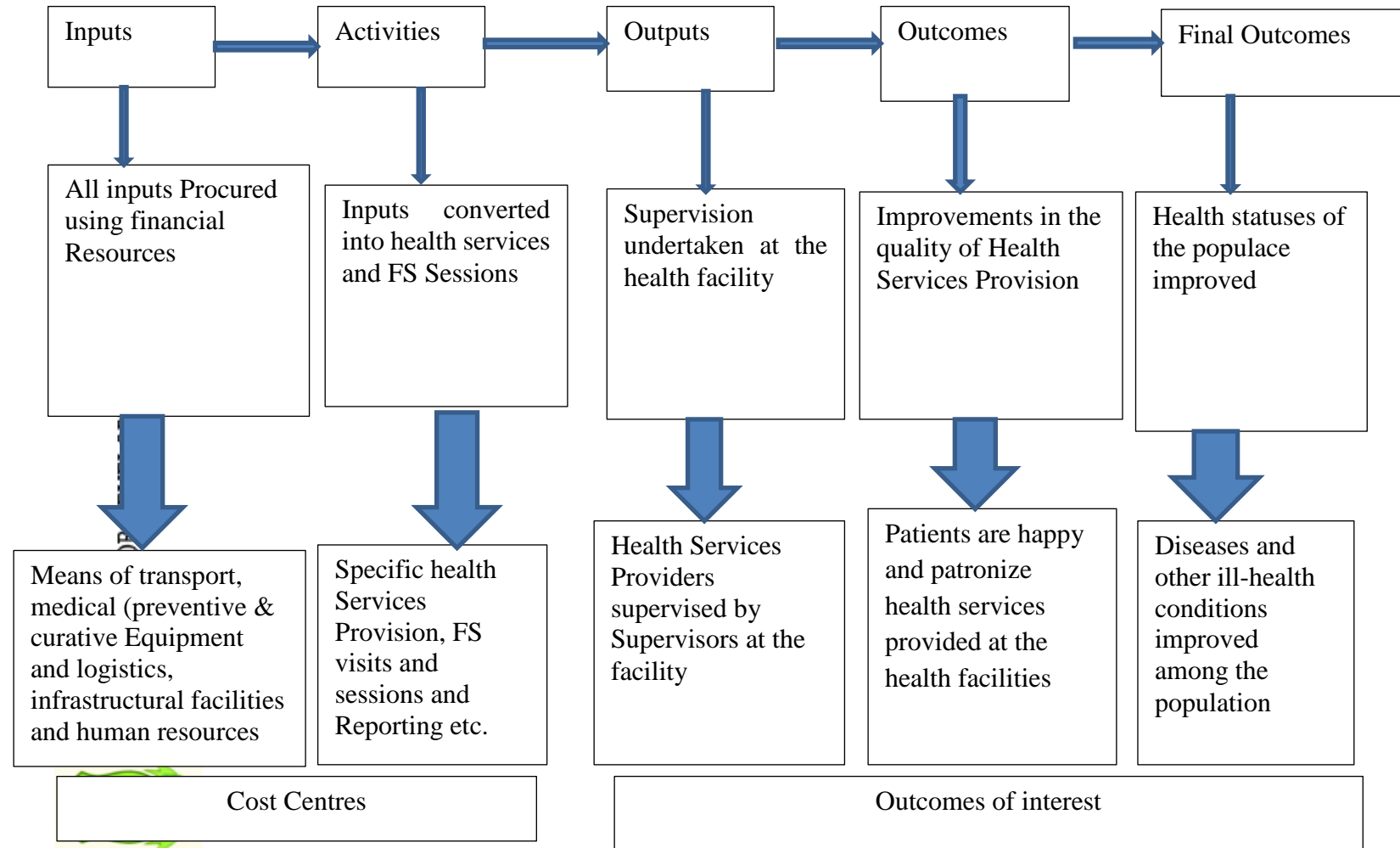| Means of transport, medical (preventive & curative Equipment and logistics, infrastructural facilities and human resources	Specific health Services Provision, FS visits and sessions and Reporting etc.	Health Services Providers supervised by Supervisors at the facility	Patients are happy and patronize health services provided at the health facilities	Diseases and other ill-health conditions improved among the population

Cost Centres	Outcomes of interest

Figure 2.1 A Logic Model of Change Processes, Activities and Milestones in FS Programme

Source: Adapted from Gertler et al. (2016: 35; 2011: 25 – 26); Rogers (2014)

2.4 Conceptual Framework for Facilitative Supervision of health services provision

The conceptual framework for this study hinges on concepts that have emerged from review of theory of supervision and theory of change as they apply in facilitative supervision of health services provision. In brief, it can be said that facilitative supervision embodies mentoring, joint problem-solving, two-way communication between supervisors and supervisees, capacity building and mutual empowerment (Aikins *et al*., 2013). Three main components can be discerned in the health service provision within the context of FS; viz. actors/players characteristics component, programme characteristics component and policy/regulatory/legal environment component, which interplay to produce the achievement of programme goals and objectives. It is argued in this study that within the framework of facilitative supervision of health services provision, there are two perspectives on employees when it comes to attitude towards work. In the first perspective, beneficiaries/clients or patients, health services providers as well as supervisors are averse to and abhor work and do not buy into organizational and programme goals and objectives while in the second perspective beneficiaries/clients or patients, health services providers as well as supervisors naturally like to work for purposes of achieving organizational or programme goals and objectives. The two perspectives on how the characteristics of players in the FS programme on health services provision have birthed two different but interdependent approaches to facilitative supervision. The first approach calls for the creation of congenial, pleasant, healthy and engaging working environment for players. However, because this group of actors naturally abhors working, the supervision package should include monitoring and control to ensure achievement of programme goal of improved health status of the populace. The second approach which targets

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players who are amenable to work only need the creation of congenial, pleasant, healthy and engaging working environment for the players to function to achieve programme goal of improved health status of the populace.

In addition to the characteristics of players, which constitute a critical input into the FS programme, the second component is the programme characteristics in the form of inputs, activities, processes and milestones also in the form of outputs and outcomes play very critical roles in the achievement of programme goals and objectives.

The third component of the conceptual framework is the policy/regulatory/legal environment in which the FS programme is being implemented. To begin with under this component, one can talk of policy areas such as a shift of sole attention on curative health services provision to inclusion and more emphasis on preventive health services provision, public health issues, maternal and child health care issues and taxes on health care services programme inputs (particularly the imported ones). Besides the policy considerations, health services regulatory environment is also very worthy of consideration. Here, the concentration is on health workers condition of service, performance standards to measure effectiveness, efficiency and relevance of health services workers and other standards within the health services sector (doctor-patient ratios, nurse-patience ratio, facility-bed ratios and the presence of certain facilities/equipment at various levels of health facilities). In addition to the above is the legal environment of health services provision. Under this, constitutional provisions and Acts of parliament become essential for the proper functioning of FS programme of health services provision.

Finally, it is being proposed in this conceptual framework that since health services provision takes on a systemic characteristic, the proper functioning of all the three

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components of FS (actors, programme characteristics and the policy or regulatory and legal environment) will lead to achievement of the goals and objectives of the FS programme while a dysfunction in one or more of these components will spell a failure of some kind in the programme. Figure 2.2 depicts the diagrammatic representation of the conceptual framework.

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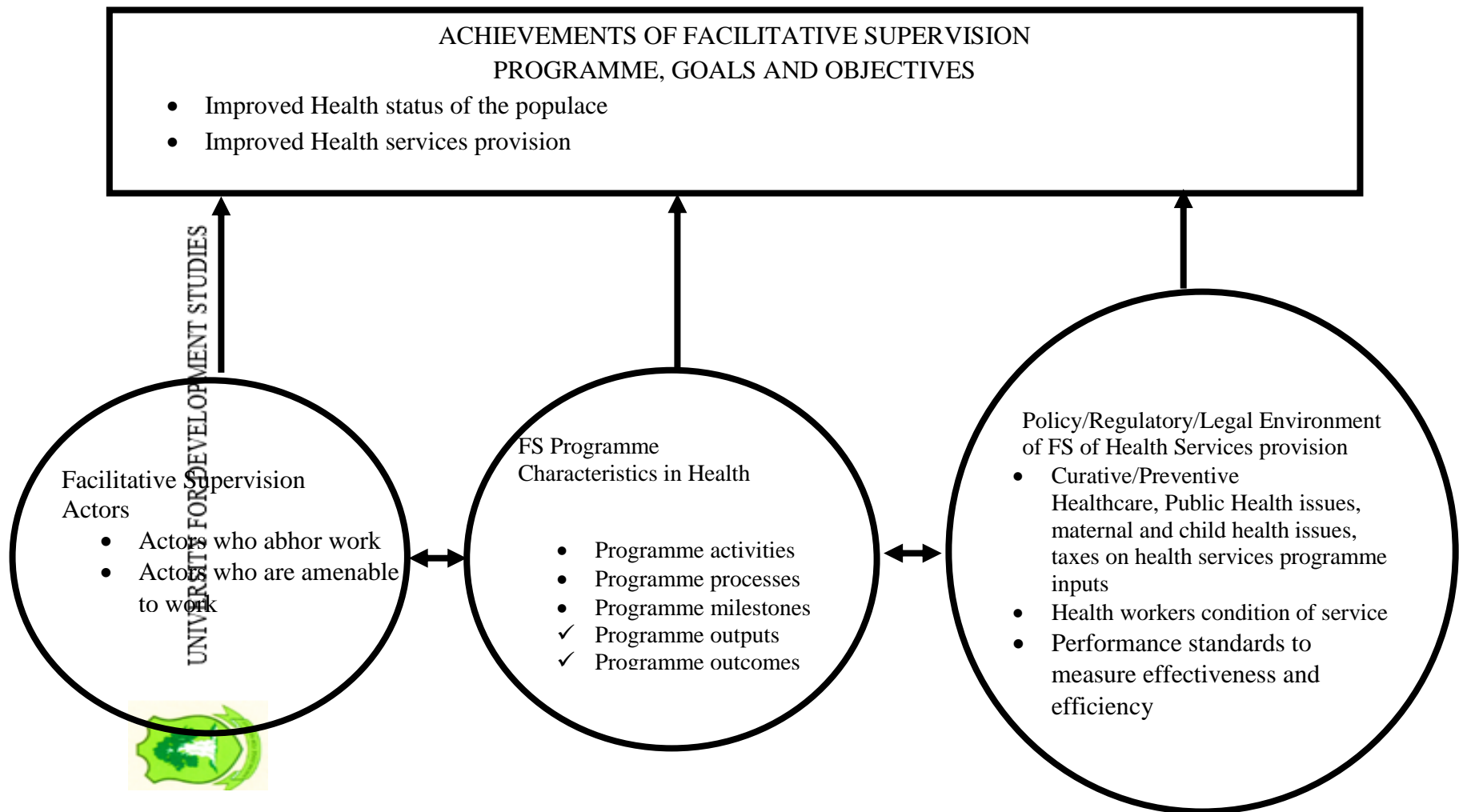
Figure 2.2: Conceptual Framework. Based on Mcgregor (1960) and Weiss (1995)

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2.5 Empirical review

2.5.1 Facilitative Supervision in Health Facilities

Facilitative Supervision also known as supportive supervision is an approach to supervision that ensures mentoring, joint problem solving, and two-way communication between the supervisor and those being supervised (Engenderhealth, 2001). To this end it must be noted that Facilitative supervision can strengthen public health programmes and public health outcomes due to the participatory nature of the supervision. In a health care system, facilitative supervision enables and empowers health care workers to effectively identify and solve problems, facilitate team work, provide leadership and monitoring and improve their own performance (NASTAD, 2016). Practically, facilitative supervision is not just ensuring that the work is being done but also helps in building capacity of the supervisees by setting standards, designing user-driven tools, directing and supporting skills and knowledge growth, and facilitating problem solving for quality and process improvement. This way, staff are retained and performance and the quality of the services delivered are improved (NASTAD, 2016). Unlike the traditional supervision which is generally directive and authoritative, facilitative supervision is designed to be more collaborative (Marquez and Kean 2002). In the health care setting, traditional supervision often involves facility or performance inspection rather than guidance for problem-solving to improve performance. The directive and authoritative nature of traditional supervision makes supervisees only comply with guidelines to satisfy requirement. This can have significant drawbacks, particularly in the health care setting where new skills and knowledge are expected to be continuously gained and applied. A supervisor serves as a teacher, a mentor, a leader, an observer, a listener, an excellent communicator, and

above all someone who desires to empower others and provides opportunities for growth (EngenderHealth, 2001). According to EngenderHealth (2001), supervisors who possess these characteristics are prepared to become successful facilitative supervisors. They stated again that facilitators with these characteristics are able to come out with what is or is not working, to aid identification of strategies for the improvement of ongoing processes.

Asante and Roberts (2011) noted that in facilitative supervision the supervisor works closely with people he or she supervises to establish goals, monitor progress and identify opportunities for improvement. Facilitative supervision is done in teams with supervisees identifying problems and coming out with solutions (EngenderHealth, 2001). They look at what is working for them and what is not. This makes it possible for them to device ways in addressing issues that may arise. Facilitative (supportive) Supervision in health service is done at various levels. In Tanzania, facilitative supervision is structured and functions at the national, regional, district and health care facility and community levels (National Aids Control Programme [NACP], 2010). However, in Ghana, facilitative (supportive) supervision is done at the regional, districts, sub-districts and community levels (Ministry of Health, 2015). Hill et al (2014) stated in their work that in adequate supportive supervision there must be regular visits to health facilities, and that both supervisors and supervisees must be aware of the timing of the visits. They again postulated that, the worth of the visits should also be certified by formulating facilitative (supportive) supervision policies and the continuous application of the standard tools developed for the exercise such as checklists. More so, it is proper that both supervisors and supervisees come together to develop action plans after each supervisory session, and followed up in the later

supervisory visits for purposes of continuity and implementation of recommendations made during the prior session.

Agoro, Osuga & Adogo (2015) in their research "Supportive Supervision for medicines management in government health facilities in Kiambu County, Kenya; a health workers' perspective" found that health workers in the counties still expected to be supervised by the National Health Management Team (NHMT), a team whose onus was not to conduct facilitative (supportive) supervision in health facilities delegated to the county governments. The study showed that majority of the health workers did not understand the difference in the obligations of the two ranks of government as far as the health sector was concerned. Again, it was deduced from their research that most respondents could not evidently agree on how often they expected a supervisory visit by the County Health Management Team (CHMT) and this was made worse by the irregular supervisory visits by the same team. They realized that the irregular supervisory visits were not only as a result of the absence of regular facilitative (supportive) supervision that the facilities received from the CHMT, but also the lack of information on the facilitative (supportive) supervision policy details among the health workers that should be supervised. A document by PATH (2003) showed that facilitative (supportive) supervision is done by staff from other facilities, colleagues from the same facility and community health committees unlike the traditional supervision where supervisors are designated by external management structure. The document further stated that, unlike the traditional supervision where little or no preparation is done, facilitative supervision ensures supervisors review previous supervisory reports and achievements, and further decides on what to focus on before the supervision visit. More so, during facilitative supervision observation of performance and comparison to standards are checked, there is immediate feedback

from supervisors, provision of technical updates, joint problem solving on possible solutions to performance problems as well as follow-up on previously identified problems. Numerous limitations to piloting consistent facilitative supervision in low- and middle-income countries have been identified by several studies. These challenges include restricted mobility of supervisors that constrains field supervision, lack of "supportive" skills due to lack of training, absence or lack of use of standard checklists during supervision, failure to develop and follow up on action plans, vertical programmes with vertical supervision lead to fragmentation, lack of clear guidelines for facilitative (supportive) supervision, and absence of a facilitative (supportive) supervision policy in health structures (Chankova, Muchiri & Kombe, 2009; Lynch & Happell, 2008; Manongi, Merchant & Bygbjerg, 2006; Otchere & Kayo, 2007).

2.5.2 The Facilitative Supervision Process

Facilitative supervision is a process that is implemented between the mentors and mentees. Just like any process related activity, facilitative supervision goes through various stages in order to achieve its purpose. Even though the available literature has presented a very limited information on the process itself, the information presented by National Alliance of State and Territorial AIDS Directors [NASTAD] (2016) is worth examining in this review. NASTAD's process of Facilitative Supervision includes the following:

- Define the Objectives
- Define the Supportive Supervision Plan
- Supervisor Preparation
- Supervisee Preparation
- Get out to the Field: Implement Supportive Supervision

- Give Constructive Feedback and Facilitate Skills Building

- Compile a Report Summarizing the Process

- Provide Follow-Up

- Ensure Transition and Integration

In the process of Facilitative Supervision, the first step to detail is formulation of objective for the exercise. In defining the objectives for supportive supervision in health service provision, NASTAD (2016) suggests that this should be done in collaboration with partner institutions and organization to ensure full understanding of the need for improvement in the service delivery through supportive supervision, obtain their buy-in, and jointly define standards and expectations. Questions relating to the need for planning to do supportive supervision, what the barriers are to meeting these needs and what the best ways are in addressing these needs based on what is already known to the team need to be answered. To answer these questions effectively require a number of steps. These include review of national standards and policies, meeting with policy and management decision-makers and donors or funders and field visits to engage in situational analysis.

The next step in the supportive supervision process is formulation of the Facilitative Supervision plan. After formulation of the objectives, these objectives need to be expanded into a fully-fledged plan. The plan will guide the supportive supervision process and help in measuring progress toward success of the plan. Content of the plan should have the following three main components: the right supervisors, the right tools and the right resources. By the right supervisors, we mean supervisors that have been train in Facilitative Supervision and are with the requisite knowledge and skills. The right tools are expected to expand the knowledge and skills base of the health worker-supervisees during the supervision visits and the right resources should be in the form

of required logistics in the right quantities to ensure productive supervisory visits. The plan, tools and performance expectations among others should be compiled into a package, supervision guide or standard procedure manual that can be relied upon during the whole process.

Specifics of the plan should center on the following areas:

- The various processes in place with partner institutions for ongoing planning, eventual transition, and autonomous sustainability of the new supportive supervision processes;

- What (program areas, systems), when, and who (staffing positions) are the focus of the supportive supervision;

- The way and manner in which the supportive supervision will be implemented. This should spell out who should do the implementation, where the implementation should take place and at what frequency

- Availability of trained supervisors. If they are not available, then there is the need to train fresh supervisors.

- Availability of supervision tools in the form of site visit checklists, templates, staff performance standards, standard operating procedures and/or materials in the form of training manuals and job aids among other;

- Details of the process and timeline for joint development of needed tools;

- Details of logistical arrangements that need to be accounted for in the form of staff scheduling, facility scheduling, transportation and accommodations among others;

- Monitoring system developed to put in place how success of the supportive supervision intervention will be measured; and

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- Put in place a system to foster interest and excitement among those to be supervised in the form of best ways of motivating the supervisees.

After the formulation of the supportive supervision plan, the next step to focus on is preparation of the staff that will implement the developed plan. These may be staff from the institution providing the supportive supervision, staff from the institution receiving the supportive supervision or partner institution(s). This should take the form of a dynamic, *hands-on* training which should last for at least a whole day. Trainees should be made to practice using all tools, adopting role-plays and "supportive supervision" (observation and feedback) with each other. In doing this, four key content areas need to be covered. These include: technical content, supervision strategies, expected Supportive Supervision Process and other logistical issues.

Having formulated the supportive supervision plan and trained the staff to be engaged in the Facilitative Supervision enterprise, the next item in the process is preparation of Supportive Supervisee. This involves a timey contact with facilities where the supervision is expected to take place. Contents to cover at this stage include introduction and explanation of the purpose and objectives of the exercise; discussion of the process, who will be involved touching on who will come and who they will expect to meet; and agree on the time that will be convenient for both prospective supervisors and supervisees.

Having prepared the supportive supervisors and supervisee we proceed with the supportive supervision by employing the designated tools and engaging the appropriate staff in the exercise. Supervisors can collect information using one or a combination of the following methods/tools: Listening to health workers and talking with beneficiaries,

reviewing the records, using a checklist, reviewing recommendations from past visits and conducting a rapid community survey.

The following should be taken into consideration as the team focuses on problem solving:

- With the supervisee, explore the impact (long-term and short-term) of the problem.
- Tackle one problem at a time.
- Be specific in explaining the problem. If possible, back it up with facts rather than judgment alone.
- Discuss the causes of the problem with health staff. This should not be an opportunity to blame others or blame the system. It may sometimes be necessary to seek causes in other sources (e.g. community members, data, etc.).
- Prioritize causes, emphasizing those that can be more easily addressed.

In developing solutions to identified problems supportive supervisors should focus attention on what needs to be done, how, when, where and by whom, all captured in the form of an implementation plan. Following this, solutions that can be implemented immediately should be implemented first. The Facilitative Supervisor should be engaged and motivated, listening attentively, observing critically and providing encouragement to sustain interests of the whole system.

The next step which is very crucial in the process of Facilitative Supervision after carrying with the Supportive Supervision itself is giving of constructive feedback and facilitating skills building. The feedback serves as inputs for improvement of the new processes that have been initiated in the health services delivery system and are useful

during the Supportive Supervision process itself and during follow-ups, coaching and mentoring sessions.

The provision of useful inputs for improvement is then followed by compilation of a report that summarizes the whole process as was implemented. This is to take place in the office environment with the report following a standardized reporting format. Included in the reports should be a comparison of performance during the Facilitative Supervision process to existing standards and an outline of an action plan that describes steps, indicators of progress, roles and responsibilities, and a timeline. The last stage in the reporting process should be dissemination of the report to the relevant people at the institution or facility.

Follow-ups on the action plan developed to ensure continuous engagement of the supportive supervision process is very vital in the whole exercise. This follow-up itself may have to be planned with due cognizance to acting on issues the supervisor agreed to work on (new guidelines, job aids, etc.), discussing equipment supply and delivery problems with higher levels and reviewing monthly reports and establishing regular communication with supervised staff to see if recommendations are being implemented. To achieve these outlined issues, follow-up should take a number of forms including personal follow-ups, over-the-phone follow-ups, through emails or memos and in partnership with other meetings.

The last but not least in the Supportive Supervision process is ensuring transition and integration for purposes of sustainability of the process. This can be achieved through empowerment of health services provider staff who are expected to own and internalize processes, skills and tools imparted to them during the Facilitative Supervision process.

NASTAD (2016) has outlined four steps that need to be followed in ensuring the integration and sustainability of Supportive Supervision. These include:

- Planning for integration and sustainability with the partner institution from the outset;

- Supporting the partner institution to modify/adapt and incorporate the supportive supervision package into existing human resource policies and procedures;

- Establishing supportive supervision expertise within the institution through training of trainers, and comprehensive training curricula; and

- Working with the partner institution to assess costs of supportive supervision and integrate into routine budgeting and resource generation.

2.5.3 Guidelines of Facilitative (Supportive) Supervision

Guidelines may relate to all events or activities carried out by health professionals. For instance, guidelines have been produced on screening, counselling, diagnosis, test requests, medical treatment, surgical interventions, follow-up, record keeping, communication, patient information, health promotion, machine calibration and maintenance and teamwork (Charny, 1999). Facilitative supervision guidelines are meant to aid supervisors and staff in understanding the intent of facilitative (supportive) supervision, and to provide direction on how to make supervision as effective as possible (PATH, 2003). The guidelines provide step-by-step information on how to prepare for, conduct, report on, and then follow up supervision. In other words, guidelines define how and when work should be done. An appropriate guideline should be made to tackle the problem in similar terms in which it is understood by those who will use it. In Ghana, the Ministry of Health (MOH) as a body have guidelines that

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shape its activities (MOH Report, 2018). However, health workers often receive little guidance or mentoring on how to improve their performance. Until the next supervisory visit, most heath workers are left undirected, with few or no milestones to help evaluate their performance (PATH, 2003). It therefore becomes difficult to get motivated in such an environment. Different organizations have developed a number of guidelines for facilitative (supportive) supervision as an intervention for health care delivery across the globe. Programme for Appropriate Technology in Health (PATH) and World Health Organization [WHO] (2003), for example in their guideline for facilitative supervision, outlined five major steps or guidelines to facilitative supervision as follows; 1) Understand the country context and mobilize appropriate national support; 2) Make supervisors part of the training process; 3) Work with supervisors to plan and conduct supportive supervision; 4) Stay motivated and 5) Build sustainability. However USAID (2008) suggested an eleven step for the implementation of Facilitative Supervision to include ''*step 1: Planning for Supervision, Step 2: Preparing for Supervision, Step 3: Conducting Supportive Supervision, Step 4: Starting the Supervision, Step 5: Follow-up of Issues from Previous Supervision, Step 6: Review of Progress in Plan Implementation, Step 7: Interviews and Record Reviews, Step 8: Observation of Service Delivery, Step 9: Problem-solving and Action Planning, Step 10: Recording and Reporting 11: Follow-up after Supportive Supervision*'' (USAID, 2008 : 20-26).

NASTAD Global (2016) on the other hand, suggested that for a facilitative Supervision to be successful, the following nine steps should be followed. These steps are a) define objectives, b) define facilitative supervision plan, c)supervisor preparation, d) supervisee preparation, e) Get out to the field; implement facilitative supervision, f) Give constructive feedback and facilitate skills building, g) compile a report, h) provide

follow-up and i) transition and integration. They believe that, for the goal of supportive supervision to be achieved, supervisors and supervisees must partner each other in a more collaborative manner to ensure proper planning and implementation of the intervention.

2.5.4 Contribution of Facilitative Supervision to Quality Health Care

The contribution of Facilitative Supervision has been empirically acknowledged. PATH, (2003) postulated that Facilitative (Supportive) supervision fosters a collaborative approach to strengthen health worker performance and immunization services and has been an effective tool for improving performance for many organizations.

The Global Alliance for Vaccines and Immunization (GAVI) partners have identified supportive supervision as a high priority and a critical gap in immunization training (PATH, 2003).

Aikin et al (2013) intimated that though some may believe that Facilitative Supervision may take too much time, resources, thoughts and attention than is possible and that the conventional approach of policing stood the test of time, contrary to this in the Upper West Region, management at the district and regional levels remained responsible for planning and implementing work, making available the needed resources and training need for the running and delivery of health care. It has been reported in Tanzania that since the facilitative (supportive) supervision system was implemented, health workers have noticed a significant improvement in supervision. Supervisory contact has become more frequent, problems have been resolved and on-the-job training has been conducted (Roberts, 2011). This made supervisory visits an opportunity for health workers to resolve problems and learn additional knowledge and skills. This has the

leverage of health workers no longer afraid to address challenges and able to work with the district team to resolve any issues. In addition, positive and supportive supervisory practices demonstrated by nursing leaders has been associated with increased patient satisfaction and decreases in adverse events and complications (Anderson, Issel, & McDaniel, 2003; Houser, 2003; Wong & Cummings, 2007).

Heidi W Reynolds, Cathy Toroitich-Ruto, Marlina Nasution, Aaron Beaston-Blaakman and Barbara Janowitz (2007), who conducted an evaluative study on the effectiveness of a training intervention for on-site, in-charge reproductive health supervisors in Kenya using an experimental design with pre- and post-test measures in 60 health facilities, concluded in their study that through Facilitative Supervision, health facility supervisors are in a position to increase motivation, manage resources, facilitate communication, increase accountability and conduct outreach. It was further concluded by the authors that in sum, the intervention resulted in significant improvements in quality of health care at the supervisor, provider and client–provider interaction levels. It was found in the evaluation that supervisors in the treatment group (training group) had significantly more knowledge in techniques than supervisors in the comparison group (control group) in assessing provider performance, motivation of staff, and communication of their expectations to staff. These techniques include the following: obtaining client feedback, obtaining client satisfaction data, seeking general impressions from staff, observing skills and relying on service statistics. In the area of staff motivation, techniques that were widely used included tea breaks or staff parties, time-off, financial benefits, and awards or certificates. For purpose of communication of expectations, supervisors used demonstration of their expectations, holding of group meetings, engaging in one-on-one conversations and allocation of duties or issuance of memos.

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Focusing on knowledge of job, Heidi et al. (2007) reported that supervisors in the treatment group (training groups) were significantly more familiar with crucial elements of team building, planning of meetings or conducting meetings. Elements of team building mentioned by participants included knowing the importance of limiting the size of the team, developing goals, providing feedback and developing an action plan. On the subject of planning of meeting, participating supervisors were able to mention elements including determining the need for the meeting, developing objectives, gathering information prior to the meeting and preparing an agenda. Elements of meeting made reference to included starting the meeting on time, welcoming attendees, facilitating discussion and summarizing the content of the meeting.

In their evaluation study, Heidi et al. (2007) also focused on improvements in facility functioning and health services provider working environment. In terms of facility functioning, the proportion of supervisors in both groups that report identifying performance problems increased over time (77% to 93% in the training group vs. 53% to 90% in the control group). These findings were confirmed by providers who reported that the identification of major facility performance problems had increased over time for both groups (40% to 54% in the training group vs. 41% to 51% in the control group). Because both groups improved by similar amounts over time, there were no statistically significant differences across all but one of the facility amenities and examination area indicators, while the control group facilities' auditory privacy, visual privacy, clean linen and cleanliness were observed to have decreased between pre- and post-test.

On service providers' work environment, on-site supervisors and colleague service providers were made to conduct more observations while the providers engage in interaction with their clients. The study concluded that providers in the group in which

supervisors were trained were significantly more likely to report being observed during interactions with their clients compared with providers in the control group. Again, service providers in the treatment group had a higher likelihood of generating feedback than their counterparts in the comparison group.

In the United Republic of Tanzania as reported by the Tanzanian Ministry of Health and Social Welfare (2010), although Supportive Supervision and Mentoring are conducted separately by different teams and at different times in the year, on the National AIDS Control Programme (NACP), national efforts are made to forge synergies between the two approaches. This is said to be made possible by meetings held between the teams conducting the Supportive Supervision and the Mentoring. At the national, regional, district and facility levels synergy meetings, issues for discussion are similar and include the under listed:

- Key findings during supportive supervision and mentoring;
- Lessons learned and best practices in supportive supervision and mentoring;
- Challenges identified during supportive supervision and mentoring and action taken;
- Further action recommended to improve service delivery/patient care;
- Action plan; and
- Monitoring and evaluation plans

In addition to the above, at the meeting monitoring and evaluation frameworks are drawn for the two approaches with reports from the two approaches kept in the National AIDS Control Programme library and shared in folders on computers of all stakeholders for easy access and dissemination. The cost of supportive supervision is said to be enormous. NASTAD (2016); Openshaw (2012), Rudd (n.d.) and Crigler (2013) have

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all alluded to the fact that supportive supervision requires lots of resource outlays to see it fulfil its purpose in health services delivery. Despite its challenge of huge resource requirement, NASTAD (2016: 8) has been quick in outlining the following as positive results which supportive supervision help in achieving in health services delivery:

- Helps leaders to define and implement standards

- Is a key approach for service providers and supervisors to identify problems and solve them in a timely manner in order to improve the quality of health care and the performance of health care providers

- Promotes better job satisfaction and improves the retention and performance of health workers

- Helps programs and staff to grow over time, building on their own past achievements

- Helps to reinforce communication between supervisors and supervisees, and health workers

- Helps to build sustainable programs through skill and knowledge transfer, and user-generated continuous quality improvement

- Helps to identify innovative strategies and best practices to be documented and disseminated.

2.5.5 Monitoring and Evaluation of Supportive Supervision and Mentoring Systems within the Health Care Provision

As presented by the Tanzanian Ministry of Health and Social Welfare (2010), Supportive Supervision, mentoring and Quality Improvement are different approaches; however, they are closely interrelated and perform complementary functions towards expanding and improving clinical services specially within the Primary Health Care

System at the health facility levels. To this end, it has been advocated that Supportive Supervision, Mentoring and Quality Improvement approaches are monitored and evaluated to ensure they are meeting their set targets and achieving their goals and objectives effectively, efficiently and with the relevance they require. The M&E systems advocated here are meant to share knowledge and aid in coordinating activities across the three approaches. The Tanzanian Ministry of Health and Social Welfare (2010: 39) has outlined the various Monitory and Evaluation activities to be undertaken within the framework of Facilitative (supportive) Supervision, Mentoring and Quality Improvement as:

- Baseline information collection;

- Review of written reports from supervisors/mentors – whom, where, on what, when, Supportive Supervision or mentoring, (check against the plan);

- Feedback from supervisees and mentees on supervisors and mentors' performance;

- Reports of meetings between supervisors and mentors;

- Use of comprehensive Supportive Supervision/Mentoring manual by supervisors and mentors;

- Periodical assessment of supervisors and mentors; and

- Simple evaluation to investigate: change in Health Care Workers (HCW) performance, utilization of services, client exit interview, observation of clinical practice, stocks of drugs and supplies, timely and accurate reporting and data utilization.

2.5.6 Challenges of Facilitative Supervision

A study conducted by Agoro et al. (2014) on Supportive Supervision for medicines management in government health facilities in Kiambu County, Kenya: a health workers' perspective concluded that Supportive Supervision by the health managers was not regularly conducted and most health workers did not know how often to expect supervisory visits from the different levels of management. The study added that the quality of the visits was also low since standard checklists were not always used despite their availability and also there was lack of continuity in the supervisions since action plans were rarely followed up in the subsequent visits by the supervisory teams. Health workers managing medicines in the county were not satisfied with the level of supervision that they received from the different levels of health management in the county (Agoro, 2014). However, JICA's application of Facilitative Supervision (FS) to review the conventional monitoring 'apparatus' within Ghana's health care delivery system, reveals that the approach as a supervisory system of practice, improved the administration of healthcare in the Upper West Region (Aikins et al. 2013). Whiles JICA concentrated at the very last level of Facilitative Supervision which is at the facility and community levels, Agoro concentrated on the administrative level of supervision. Supervision outcomes varies at different levels.

Crigler Lauren, Jessica Gergen, and Henry Perry (2013) discussed six different challenges that bedevil the Facilitative Supervision enterprise in health care provision. These include Travel expense and logistics, Supervisors are really not "supervisors", Supervisors do not have appropriate tools and support to conduct supervision, Supervision is not a priority, Supervisors don't understand the Community Health Workers' role or the context in which they operate, Gender issues complicate the

supervisory process because often supervisors are men and Community Health Workers are women. These challenges are briefly dilated on in the current section. Facilitative Supervision is often conducted by staff of higher-level ranks who are usually domicile in more urbanized areas on staff of relatively lower-level ranks and who usually reside in remote, usually difficult to access villages. The periodic visits to these remote locations require the use of motorized means of transport in the form of motor cycles or vehicles. According to Crigler et al. (2013), at least one of the following four conditions are likely to play out at a particular point in time: (a) there is no vehicle or motorbike assigned to the facility, (b) the source of transport is not in working order, (c) there is no money to buy fuel and (d) the vehicle is being used for some other purpose. This condition alone suffices to derail the scheduled visits to the supervisory sites to lend the needed support to the staff at the level. The truncation of the scheduled visits in itself come with lots of repercussions. Among them are loss of track of what was concentrated on during the previous visit and break in the familiarity established between the supervisor and supervisee. The second challenge christened supervisors are not really "supervisors" stems from the fact that often in the health service system Facilitative Supervision is not seen as a full-time job but as a part of other jobs given to staff working at the district or regional levels of the health sector. In some cases, one can find a nurse or midwife at the lower level of the health system performing this function. They really do not constitute part of the job description of the staff which regularity can be determined and followed. The consequence of this is intermittent supervisory visits. The results are the same as lack of regular transport which produce the same effect.

It is established that often, supervisors are not equipped with the necessary supervisory knowledge and skills, especially when they happen to be district health officers or

Dewane (2007) cited in Openshaw (2012: 10) has also outlined some challenges that often ensues between supervisors and supervisee. These challenges include:

- The supervisor using the supervisee as a confidante

- The supervisor degrading the supervisee with personal comments

- The internal supervisor could have the supervisee carry a great deal of the supervisor's work load

- The supervisee reporting personal problems to the supervisor and the supervisor helping therapeutically with the problems

- The inability to maintain a collegial relationship once the supervisory relationship starts

According to Dewane (2007) cited in Openshaw (2012), problems emerge between the supervisor and supervisee due to abuses that exist in the supervisory relationships, other challenges are birthed that jeopardize the supervisory process. Outlined below are some of the ethical challenges that emerge between the supervisor and supervisee once the supervisory relationship has been abused (Openshaw, 2012:11):

- Documentation is a major issue for external supervisors because they do not have access to the documents. Supervisors and supervisees should both keep their own records regarding the supervisory sessions, content, and length of time.

- Dual relationships (a relationship that is no longer just professional develops: gift giving, talking to each other away from supervision, over-protecting.

- Dilemmas must be recognized by the supervisee and brought to the supervisor for discussion and resolutions. Failure to recognize ethical problems, as well as conflicting advice from internal and external supervisors is an ethical problem.

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- Discretion is vital from both the supervisee and supervisor to recognize potential problems and proactively deal with them in advance when possible, and if not, then to find valid options for resolution.

Duty to warn is difficult to address in supervision, but is particularly difficult in states that do not have it as mandatory such as Texas. The supervisor must help the supervisee recognize the four elements that should be explored: the existence of professional relationship, identifiable threat, identification of a specific victim, and professional assessment of the seriousness of the risk. The next chapter looks at the methodology where sampling strategy and instruments for data collection is discussed.

CHAPTER THREE

RESEARCH CONTEXT AND METHODOLOGY

3.1 Introduction

Relevant literature which consists of the writings of authors and experts on facilitative supervision in the health sector has been reviewed in the preceding chapter. This chapter however, focuses on the research context and methodology. Specifically, the chapter presents the study area and discusses the philosophical orientation of the study, rationale for adopting a qualitative approach (borne out of the constructivist world view), the sampling strategy and the methods and instruments used for the data collection. The chapter also discusses the anticipated challenges of collecting and analyzing the data, as well as presentation of results. Some of the ethical issues that came into play during the fieldwork are also described in the concluding part of the chapter.

3.2 Study municipality and district

The study was conducted in two districts (Wa Municipality and Wa-West district) in the Upper West Region. These districts were selected on purpose of Wa being an urban district (Municipality) and Wa West a rural district. These selections are to aid in determining whether facilitative supervision takes on the same way empirically in both rural and urban health facilities. Wa is both the capital of the Upper West Region and Wa Municipality. The Upper West Region can be found between Latitude 9^0 32'N and 11^0 30'N and Longitude $1^0$30'W and 2^0 45'W and has a size of 18,476km^2. This constitutes about 12.7 per cent of the total land area of Ghana. The region is bounded to the east by Upper East Region, to the west and north by Burkina Faso and to the south by Northern Region.

3.2.1 Location
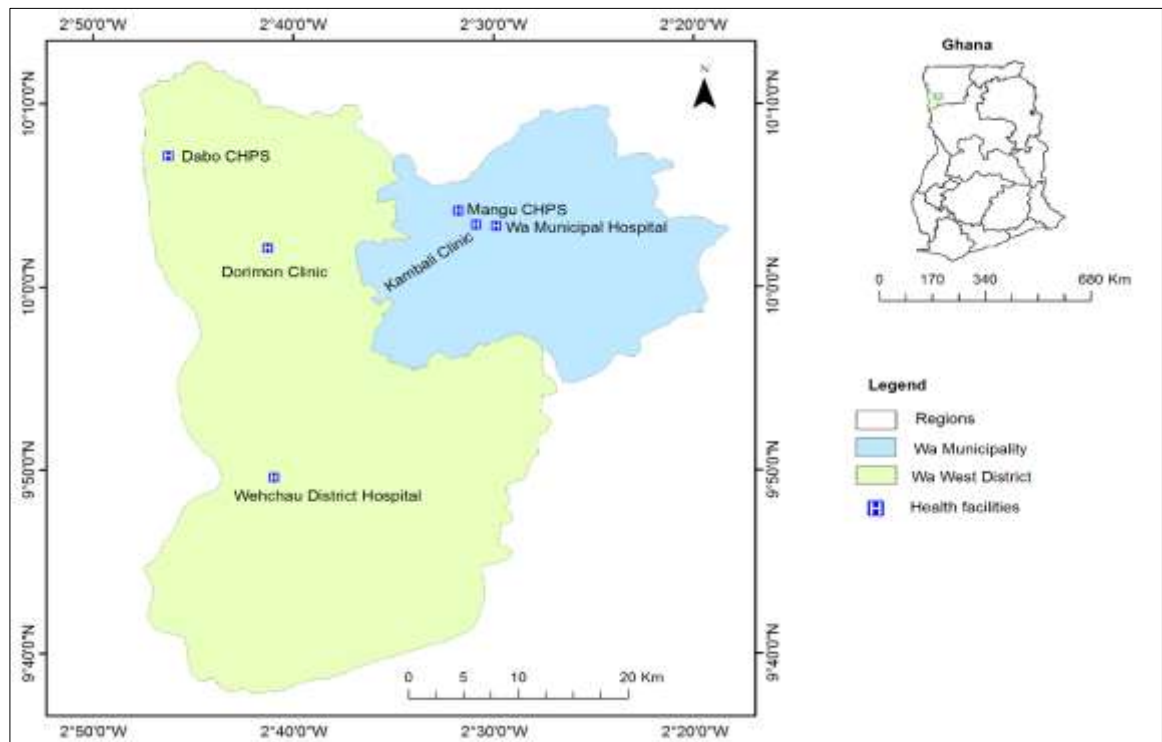
Figure 3.1: A context map of Wa municipality and Wa-West district showing study facilities.

Source: Author's construct, 2020

Wa Municipality is located between Latitudes 1^0 40' W and 2^0 45' W, and Longitudes 9^0 32' N and 10^0 20' N and has a size of 5,899.30km^2, constituting about 32% of the land mass of Upper West Region. It shares boarders with Wa West District to the west, Wa East District to the east, Nadowli-Kaleo District to the north and Northern Region to the south (Dickson & Benneh, 1990 and Republic of Ghana, 2005)

Wa West District on the other hand, is one of the eleven (11) districts in the Upper West Region of northern Ghana, and is located to the north-western part of the Region. It is located between longitudes 40°N to245°N and latitudes 9"W to32°W and covers a land mass of about 5,899.3 Square Kilometers. The capital is Wechiau. The Wa West

district was curved out of the Wa Municipality and made an autonomous district by L.I 1746. The District Shares Boundaries with Sawla-Tuna-Karlba District to the South, Wa Municipality to the East, Nadowli-Kaleo District to the North and to the West with Ivory Coast (Wa West District Medium Term Development Plan, 2019; Businessghana, n.d.)

The implications for the location of the two districts are that Wa Municipality, by virtue of the fact that it is a regional capital as well, it is also located at the most nodal point with respect to road network within the Region. This often results in the disgorgement of both people and goods and services into the township. This, coupled with the various administration functions located in it due to its dual roles as a regional and municipal capital, Wa Municipality has grown to become, not a town with key urban features but also as a primate city within the Region. Wa West District, thanks to its location within the Guinea Savannah zone, with its paucity of rainfall, excessive sunshine and high temperatures with its characteristic sparse vegetation, together with its remoteness from the arterial road network of the Region, has not developed beyond a status of a rural district and also the poorest district, not only within the Upper West Region, but Ghana as a whole.

3.2.2 Population of Wa Municipality and Wa-West District

The total population of Wa Municipality according to the 2010 Population and Housing Census (PHC) is 107,214 and forms 15.3 percent of the entire population of the Region (Ghana Statistical Service, 2013). A total of 52,996 of the population representing 49.74% are males whiles 54,218 representing 50.6% are females (Ghana Statistical Service, 2013). The sex ratio for all ages is 97.7 percent with the highest sex ratio (110.0) being age 20-24 years and that of the lowest (62.3) being age 80-84 years in the

Municipality (Ghana Statistical Service, 2013). It is important to note that Wa Municipality has a youthful population structure with a broad base which consists of a large number of the population that belong to ages 0-24 years however persons in the age group 20-24 years form the largest population (Ghana Statistical Service, 2013).

The population of Wa-West according to the 2010 Population and Housing Census (PHC) stood at 81,348 denoting 11.6 percent of the Regional population (Ghana Statistical Service, 2013). The total population of males is 40,227 (49.5%) and female is 41,121 representing 50.5% (Ghana Statistical Service, 2013). Wa-West is basically a rural district with all its population living in rural localities. Just like Wa Municipality, the District also has a youthful population with the 0-14 age groups having a high proportion of 45.5 percent and the adult population 15-65 constituting 48.7 percent of the entire population in the Municipality (Ghana Statistical Service, 2013).

3.2.3 Health Profile of Wa Municipality and Wa West District

The content of this thesis is facilitative supervision of health services provision in the Wa Municipality and Wa West District of the Upper West Region. Thus, it is expedient that in establishing the setting of the study, issues concerning the health of the two districts are well dilated upon.

Wa Municipality, due to its status as the Regional and Municipal capital within the Region, has most of the resourced health facilities within the Region. It houses a regional hospital, a municipal hospital and sub-municipal health facilities. In all, the Municipality has 45 health facilities as at 2017. These are made up of one regional hospital, one municipal hospital, 6 health centers, 4 clinics, 27 CHPS compounds, 1 adolescent health centre and 5 private health facilities that have not been classified.

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In terms of staff of the health sector, the Municipal Health Administration has a total of 402 as at 2017. The composition of these staff members are one Medical Director of Health Services, 6 Nursing Officers, one Optician, 79 Midwives, 2 Physician Assistants, 93 Community Health Nurses, 118 Enrolled Nurses, 12 Technical Officers, 9 Field Technicians, 7 Mental Health Nurses, 22 Staff Nurses, one Laboratory Assistant, one Administrative Manager, 2 Accountants, one Supply Officer, 2 Executive Officers, 20 Health Aids (Orderlies), 1 Stenographer, 1 Security Person and 2 Drivers (WMDMTDP, 2019). To augment the regular staff of the health sector within the Municipality, it also has 264 Community-based Agents distributed across the Municipality as follows: 36 agents in Bamahu, 28 in Busa, 26 in Charia, 30 in Charingu, 40 in Kambali with 104 in Wa Central. On the CHPS Programme, as at 2017, there were 44 demarcated zones, 27 of which were functioning and 25 were with compounds.

Some challenges confront the health sector in the Wa Municipality. Of the CHPS that are functional ten were without water, six without electricity, and three without compounds. In addition to the above challenges, the programme is saddled with inadequate logistics, inadequate Community health Officers (CHOs) and non-functioning community health committees. Challenges facing the general health care services delivery in the Municipality include inadequate critical health staff (these include medical assistants, pharmacists, laboratory Assistants), inadequate official residential accommodation, inadequate medicines and records management and delayed reimbursement for NHIS clients. Others include staff indiscipline, weak continuum of care, high communicable disease burden of malaria, tuberculosis and HIV/AIDS, high infant, maternal and neonatal mortality and lack of collaboration with private health care providers within the Municipality.

As compared to the Wa Municipality which has 45 health facilities, Wa-West District has 40 health facilities. The spread of these facilities within the District are as follows: one district hospital located in Wechiau, the district capital, 6 health centres two each in Dorimon and Vieri and one each in Ga and Gurungu. There is only one maternity home in the district located in Ga. The district has only one community health agent located in Vieri. There are 30 CHPS compounds spread across the District (5 in Wechiau community, 10 in Dorimon community, 7 in Vieri community, 9 in Ga community and 5 in Gurungu community).

The top ten causes of OPD attendance in the District are malaria, upper respiratory tract infections, diarrhoea diseases, Rheumatism and other joint pains, acute urinary tract infection, skin diseases, anaemia, intestinal worms, pneumonia and acute eye infection. In all, malaria brought 19,184 patients for treatment at the various facilities. Out of this total and as in previous years, children under five were the hardest hit by this morbidity accounting for 47.3% of all the malaria cases in the District while pregnant women's share of the malaria case in the District stood at 318 (1.7%).

The year 2014 recorded 5 maternal deaths, 2015 recorded 4, 2016 recorded 3 and 2017 recorded 3 within the District. As at the close of 2016, the District recorded 6 HIV positive cases for a total of 675 mothers tested for HIV out of the 715 pregnant women registered for ante-natal care (ANC). This figure oscillated from 8 positive cases in 2014 through 4 cases in 2015. Again in 2016 a total of 2077 clients were screened for HIV with 21 turning out to be positive. The HIV prevalence rate is stable within the District at 0.01 percent since 2014 (2612 tested in 2014 with 12 testing positive, 2864 tested in 2015 with 8 testing positive and in 2016, 2941 were tested and 21 were positive). Challenges confronting the District are poor physical accessibility to health services notwithstanding the increased outreach stations and static health facilities in

the district, inadequate equipment for health facilities, patient and staff accommodation is inadequate to meet current demands and communication between communities and health delivery outlets remains a huge challenge. The remaining were low skilled delivery, inadequate midwives in the District, maternal and infant death are on the increase and there is no residential accommodation for District Director and other critical staff within the District.

3.3 Philosophical Foundation of the Study

Research philosophies are very important in every study. It has been argued that their importance stems from the fact that in every research, the researcher either intentionally or otherwise is influenced by or makes use of one research philosophical world view or the other, which ends up shaping its content, style and approach (Creswell, 2009; Slife & Williams, 1995). It is therefore important that in research of this kind, the researcher unambiguously states the philosophy that guides her study. The philosophical underpinning of the study is social construction. Even though there are quite a number of research philosophical world views, for purposes of this study, I have organised the section around the ontological assumptions, of facilitative supervision under social constructionism (Saunders et al., 2019; Babbie and Mouton, 2004).

Ontologically, the origination of social construction is an attempt to come to terms with the nature of reality or veracity. Constructivists view knowledge as created by the interactions of individuals within society which is central to constructionism (Andrew, 2012). In a constructivist perspective, a social fact is always given as a product of interpretation. Members of a society are not in any direct sense governed by 'external' or 'real' social structures. Whether an external reality is supported or not, it is not reality as such that informs social action but action from members and with regard to

information, knowledge, insight, and belief from interpretation of information they establish conditions for meaningful social participation. Social structures as 'causes' of behavior are reflexively generated (Mehan & Wood 1975). Concepts are believed to be mostly constructed rather than discovered, however they correspond to something real in the world. This supports the thought of Berger and Luckmann (1991) that reality is socially defined and this reality refers to the subjective experience of everyday life, how the world is understood rather than to the objective reality of the natural world. The subjectivists hold that the knowledge or reality that a researcher seeks to study comes in the form of concepts and labels which human beings have evolved to enable them understand these realities. Labels such as attitudes, perceptions, beliefs, values and norms are mere human creations, which happen in specific contexts, to enable them make meaning of the knowledge or reality so created (Burrel & Morgan, 1979). For example, the level of satisfaction by health services employees of their working conditions or by clients of health services they receive in the form of treatment or preventive services cannot be objectivated but are just perceptions of employees and patients. Social constructionism has been criticized for having limited focus on society and culture as a pivotal factor in human behavior, excluding the influence of innate biological tendencies (Pinker, 2016). Despite this criticism, they are appropriate for studying context-specific, unique, or idiosyncratic events or processes. Furthermore, given the relative novelty of facilitative supervision and the fact that not much has been done on it, particularly in Ghana, it is important that any study into such an area adopts a philosophy that can help in theory building to serve as a basis for other researchers, who will follow up, to engage in empirical studies. Even though studies have been conducted on facilitative supervision elsewhere in the world, the context in Ghana especially the Upper West Region, which has been adjudged as the poorest region in

Ghana, presents a unique case that begs for the application of constructivists approach to unearth such uniqueness. More so, constructive research can help uncover interesting and relevant research questions and issues for follow-up research, which can then adopt other research paradigms. The constructivist paradigm underlies this study because the goal of the study is to evaluate providers (supervisors) and client's (supervisees) perceptions on facilitative supervision and make meanings based on their construction. This way, meanings are developed through interacting with others rather than separately within each individual.

3.4 Research Design

A research design is a plan that guides the research process towards achieving its objectives. The research design specifies the type of research approach used to gather information for the study (Marczyk & DeMatteo, 2005). The design for this study is a qualitative bi-case studies design. Qualitative research is a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem. The process of research involves emerging questions and procedures, data typically collected in the participant's setting, data analysis inductively building from particulars to general themes, and the researcher making interpretations of the meaning of the data. The final written report has a flexible structure. Those who engage in this form of inquiry support a way of looking at research that honours an inductive style, a focus on individual meaning, and the importance of rendering the complexity of a situation (Creswell & Poth, 2016). An advantage of a qualitative research is that, it offers a different approach; thus, it can adapt to the quality of information that is being gathered. If the available data does not provide the required results, the researcher can quickly shift gears and seek to gather data from a different source or in a new direction.

However, the quality of data gathered in qualitative research is highly subjective. In facilitative (supportive) supervision, individual experiential and context-specific situations which can only be unearthed using a qualitative research design such as a case study. According to Bryman (2008: 52) a case study design "entails detailed and intensive analysis of a single case". In the view of Stake (1995) cited in Bryman (2008:52) a case study research dons the characteristic of "complexity and particular nature of the case in question". The purpose of employing a bi-case study, what Bryman (2008:58) refers to as a "comparative design of two case" is to allow for comparing the two contrasting cases of Wa Municipality the most urbanized and only one of the three municipalities in the whole of Upper West Region and the Wa West District, one of the eight rural districts and the poorest in the Region.

3.5 Study Population and Sampling

3.5.1 Target Population

Supervisors from the regional, districts, sub-districts and supervisees (staff of facilities) formed the target population for this study. These individuals have experienced facilitative (supportive) supervision and so provided significant or appropriate information that helped addressed the research questions and objectives.

3.5.2. Sample Size Determination

Due to the number of factors that can influence the determination of sample size in qualitative study, a number of researchers do not want to come out with what constitute sufficiency in sample size. Some researchers, however, find this situation very disturbing. Guest, Bunce and Johnson (2006: 59) recommend that, "although the idea of saturation is helpful at the conceptual level, it provides little practical guidance for

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estimating sample sizes for robust research prior to data collection". Some authors have offered some numbers as guidance for sample sizes in qualitative study even though they have not explored in detail why these numbers and not others. For example, Morse (1994) states that for ethnography and ethnoscience research, a sample size of 30-50 interviews for both studies are accepted. Creswell (1998) states that most studies are grounded on samples between 5-25 for phenomenology and 20-30 for grounded theory methodology. Regarding the topic 'Facilitative Supervision of Health Services Provision', the researcher engaged supervisors and supervisees who have experienced Facilitative Supervision by examining their experiences and views on the issue under study. In all, 46 respondents were selected for the study using saturation. Urquhart (2012:194) defines saturation as: 'the point in coding when you find that no new codes occur in the data and there are mounting instances of the same codes, but no new ones.' In the case of this study and for sampling participants for data collection purposes, it is when the researcher reached a point where no new information is obtained from further engaging new participants in the data collection process. It determined the sample size in qualitative research as it indicated that adequate data had been collected for a detailed analysis. Some authors have raised concerns on the (non) emergence of new codes or themes. For example, Birks and Mills 2015; Olshansky 2015 stated that these definitions indicate a change of emphasis, and suggest a second model of saturation. They are of the view that, whilst the focus remains at the level of analysis, the decision to be made appears to relate to the emergence of new codes or themes, rather than the degree of development of those already identified. Saunders et al (2017), stated in their write-up that decisions about when further data collection is unnecessary are commonly based on the researcher's sense of what they are hearing within interviews, and this decision can therefore be made prior to coding and category development. An

advantage of saturation is that, it has a positive impact on the validity on one's study results (Kerr et al., 2010; Roe & Just, 2009). However, the use of a personal lens primarily because novice researchers such as students assume that they have no bias in their data collection will make them unable to recognize when the data is actually saturated (Fusch & Ness, 2015).

3.5.3 Multi-stage and purposive sampling

The purposive and snowball sampling methods were used to select individual research participants for the primary data collection. However, before reaching these individuals, the multi-stage sampling method was adopted in selecting the health facilities (Kumar, 2011; Bryman, 2012). Even though in the research methods literature, multi-stage sampling is often associated with quantitative research approach, it was found useful for this study because health facilities and for that matter their services provisions are found at various levels within any spatial unit such as a country, region, district and sub-districts.

In this study, the first stage has to do with the regional level where the municipality and the district were selected. Here the most urbanised (Wa Municipality) and the most rural (poorest district, not only within the region but the country as a whole) (Wa West District) were selected for the study. Even though Upper West Region can be described as a near homogenous cultural setting, rurality and urbanism of the two cases selected at this stage served as providing different contexts that can form the basis for comparison. The second level has to do with the municipal and district level health facilities (the Municipal Hospital located in the Wa Municipality and Wechiau District Hospital also located in Wa-West District) that were selected purposively. Supervisors

and supervisees were identified and selected for data collection at this stage. Four (4) supervisors were selected for both the municipal and district hospitals with seven (7) and five (5) supervisees selected at the municipal and district level facilities respectively for interviewing. The supervisors were from the regional level while the supervisees were from the district level facilities. Now to the third level of the sampling process. The third level involves the sub-district level health facilities (health centres) in both the Municipality and District. In all, nineteen (19) health centres were identified within the Wa Municipality and six (6) centres were identified at the Wa-West District levels. Out of these totals, one (1) was selected at the Municipal level and one (1) at the District level. They include the health centre in Kambali a community in the Wa Municipality and that in the Dorimon community in the Wa-West District with eight (8) facilitators or supervisors and ten (10) mentees selected for interviewing. Here, the facilitators or supervisors were from the municipal and district level while the mentees were from the facilities selected. The fourth and last stage in this process has to do with the CHPS compounds, which are the lowest level of formal health services provision in the study area. In all, twenty-six (26) CHPS compounds were identified in the Wa Municipality while Wa West-District has thirty-five (35) CHPS compounds. Of these totals, a facility was selected from both Wa municipal and Wa-West district. These facilities (CHPS compounds) are located in Mangu community in the Wa Municipality and Dabo community in the Wa-West District. At this level, two (2) supervisors each from the sub-district levels as well as three (3) supervisees each from the facilities were selected for interviewing.

Purposive sampling, also known as judgemental, selective or subjective sampling on the other hand is a form of non-probability sampling in which researchers rely on their own judgment when choosing members from the population to participate in their

study. This sampling method requires the researcher to have prior knowledge about the purpose of their study so that the researcher can properly choose and approach eligible participants (Foley, 2018). Purposive sampling was employed to select supervisors and supervisees at the district's health, sub-district health and CHPS compound levels for interviewing. The selection of the supervisees and supervisors is based on expert sampling which is a type of purposive sampling. The researcher purposively engaged four (4) supervisors from the Regional Health Management Team (RHMT) whose mandate is to supervised the municipal and district levels health facilities. Four (4) each from the Municipal and District Health Management Team (MDHMT) whose duty is to supervised facilities at the sub-district levels and two (2) each from the Sub-District Health Management Team (SDHMT) who are assigned to supervised the CHPS zones for the study. However, thirty-two (32) supervisees were selected from the districts, sub-districts and CHPS health facilities. In all 46 respondents were selected for the study using saturation.

3.6 Source of Data

Primary and secondary data were collected for the study. A primary data is the one which is collected for the first time by the researcher. Primary data is factual and original and has surveys, questionnaire, observations, personal interviews etc. as sources of data (Ajayi, 2017). The researcher gathered primary data directly from interviewees who are the supervisors and supervisees from the various levels of health services provision institutions and constitute one critical source of data for the study. Data from primary sources are more reliable since they come from the original sources and are collected specifically for the purpose of the study (Axinn & Pearce, 2006).

Secondary data on the other hand is a data that have already been collected for some other purpose, processed and subsequently stored (Saunders, Lewis & Thornhill, 2019). The secondary data was collected from quarterly and annual supervision reports, training manuals and user guides with data extraction sheets prepared to aid the process of gathering the data. Secondary data provides comparative and contextual data. It can result in unforeseen discoveries. The disadvantage however is that, the secondary data may not be current as compared to any data collected by the researcher (Saunders, Lewis &Thornhill, 2019). In some case, the data may not be in the form that the researcher may require, thus, making utility of the data very limited.

3.7 Data collection methods and instruments

To gather data for the inquiry, requires qualitative data collection methods and tools that can elicit the needed data for achievement of objectives of the study. Three methods and tools were employed for this purpose. While interview as a method was implemented using interview guide as a data collection tool, observation method was accompanied with observation guide and document review method was also implemented using data extraction sheet as the data collection tool. These have been discussed into more details in the sub-sections that follow.

3.7.1. Interviews

Interviews can be defined as a qualitative research technique which involves "conducting intensive individual interviews with a small number of respondents to explore their perspective of a particular idea, program or situation" (Dudovskiy, 2018). In this study face-to-face semi-structured interviews were conducted with interviewees. The interviews took place at the various health facilities and lasted for about forty-five to sixty minutes. Relevant questions were posed to the interviewees

and where necessary follow up questions were asked for in-depth information and clarification of important emerging issues. Semi-structured interview guide was used and all of the interviews were digitally recorded.

3.7.2 Observation

Observation "is one of the oldest and most fundamental research methods approaches. This approach involves collecting data using one's senses, especially looking and listening in a systematic and meaningful way" (McKechnie, 2008, p. 573). In other words, it is a way of collecting data by observing. During observation, respondents can know they are being observed and vice versa. Some advantages of observation data collection method include its direct access to research issues, high levels of flexibility in terms of application and generating a permanent record of phenomena to be referred to later (Liu & Maitlies, 2010). It however, has a disadvantaged of a high level of observer bias as well as the observer influencing the behavior of participants (Liu & Maitlies, 2010). There are several types of observation, however, for the purposes of this study, non-participant observation was used. Non participant observation involves observing participants without keenly participating. It is used to understand an event by entering the community or social system involved, while staying out of the activities being observed (Liu & Maitlies, 2010). With this, the researcher informed the research participants about the objective of performing the observation. With information to participants, the researcher observed how facilitative supervision is conducted in the facility using observation checklist. The researcher asked questions where necessary. This helped the researcher to closely observe how facilitative supervision is carried out in the facility.

3.7.3 Document Review

Document review is a process of collecting independently verifiable data and information from variety of existing sources (data files, reports, documents and other written artifacts). The document review process affords the researcher an orderly way for identifying, analyzing and deriving useful information from these existing documents (Witkin & Altschuld, 1995). Document review is less expensive than the researcher collecting the data on first hand. The document review process can be done independently without needing to solicit extensive input from other sources. However, the researcher is not able to control data collected and must rely on the information provided in the document to assess quality and usability of the source. This was done by first of all developing a list of attributes or characteristic that the researcher is looking for in an existing record. By doing this, the researcher was able to identify available resources. Again, the researcher developed a document review checklist form to ensure that valuable information is identified, coded analyzed, and documented.

3.8 Data Analysis and Presentation

Data was analysed in a thematic manner. This was done by first transcribing the audio recordings into texts and merging them with the manually recorded interviews. Codes were identified which were later grouped into sub-themes and eventually themes (Braun & Clarke, 2006). The findings of the study were discussed under the themes generated during the analysis stage of the investigation. The themes are as follows: a) Facilitative Supervision in Health facilities b) Adherence of Facilitative Supervision Guidelines c) Contribution of Facilitative Supervision to Quality health care and d) Challenges associated with Facilitative Supervision. The discussions include a blend of both narratives and quotes from the transcribed data and information.

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3.9 Ethical Considerations

Letters were served to the Regional Health Directorate, Municipal Health Directorate and the Wa- West District Health Directorate to seek for permission to conduct the research at the various facilities chosen for the study. In order to ensure trust and confidentiality, participants were duly informed as to why the research is conducted. This made respondents to understand the purpose of the study and why their participation is relevant to the achievement of objectives of the study. Participants were given the chance to willingly participate or opt-out of the research. They were assured of confidentiality of any personal information that they may willingly or involuntarily give out. At the facility levels, Interview Guide was designed with a cover letter explaining the aims and objectives of the study to respondents. This was done to ensure anonymity and confidentiality of respondents. Participants were informed and their permission sought before their voices were recorded during interviews. This gave participants the confidence to give information without fear. Furthermore, anonymity of respondents was considered by omitting names of respondents and their exact locations from verbatim quotations in the results. Lastly, all information taken from other sources within- text and out- text references were acknowledged by the researcher. This was done to avoid plagiarism of any sought.

3.10 Challenges and Limitation of the Study

The research was not without challenges. Study participants were a lot of the times difficult to find to respond to interviews due to the nature of their job. This delayed the completion of the research process. That notwithstanding, the global crisis which is the covid-19 had a toll on the research by dawdling data collection. Additionally, the findings of the study are limited in statistical generalization due to the use of case study

research design, purposive and snowball sampling. There was a risk of selection bias of health facilities within the two-districts due to the sampling method used. However, the high response rate among interviewees minimized this risk. Furthermore, the use of bi-case studies made it possible for a comparison of results from different cases in order to reach conclusions. Despite these limitations, the study adds to the body of knowledge exploring Facilitative Supervision in Health facilities, adherence of Facilitative Supervision, contribution of Facilitative Supervision to health care delivery and challenges associated with Facilitative Supervision.

The next chapter focuses on the results of the information collected from the field.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introduction

This chapter presents the results of the data gathered from the field. Key issues emerging from the results are then discussed. The results and discussions are presented in sub sections based on the objectives of the study. These sections include: a brief profile of respondents; facilitative supervision in health facilities, adherence to facilitative supervision guidelines by facility staff, contribution of facilitative supervision to health care delivery, challenges associated with facilitative supervision and finally a discussion of the results.

4.2 Profile of Respondents

All respondents from both Wa-West district and Wa Municipal have formal education and have so much experience in Facilitative Supervision and experienced in the health care systems. This made it possible for the researcher to explore their views on the issue under study. The average age of respondents in Mangu CHPS is the lowest with 30 years and the highest being municipal hospital with 47 years.

Table 4.1 Profile of Respondents

Location	Name of facility	Average age of respondents	Educational status of respondent	Number of years worked	Job positions of respondents
Wa Municipality	**Kambali clinic**	32	Degree in Nursing Diploma in Nursing Certificate in Nursing	Five Six Nine Seven Ten	In- charge (supervisor) Nurse
Wa Municipality	**Mangu CHPS**	30	Diploma in Nursing Certificate in Nursing	Six Seven Nine Ten Eight	In-charge Community health officer
Wa Municipality	**Municipal Hospital**	47	Degree in Nursing Diploma in Nursing	Seven Six Five Ten Eight Thirteen	Administrator (supervisor) Head of female ward Head of OPD Head of Laboratory Head of Dental unit Head of antenatal Unit
Wa west district	**Wechiau district hospital**	42	Degree in nursing Diploma in nursing Certificate in nursing	Ten Seven Five Twelve Six	Administrator Head of male ward Head of OPD Head of Dental unit

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					Head of pediatric unit Head of antenatal unit Head of Laboratory
Wa-West district	**Dorimon clinic**	38	Degree Diploma Certificate	Seven Six Eight Five	In-charge Nurse
Wa-West district	**Dabo CHPS**	33	Diploma Certificate	Five Six Four	In-charge Nurse

Source: Field Survey, 2020.

4.3 Forms of facilitative (supportive) supervision

Both supervisors and supervisees were asked the forms of facilitative supervision (FS) they have and practiced in the various health facilities. Respondents reported three forms of facilitative (supportive) supervision within the health care system. They are individual supportive supervision, integrated supportive supervision for healthcare services and integrated supportive supervision of management systems. The study discovered that not all the forms of facilitative supervision are practiced at the various facilities. This was attributed to the fact that the integrated supportive supervision for health care systems touches on the other two types and also the lack of resources makes it impossible to undertake all the other forms of FS. Respondents from both urban (Wa Municipality) and rural (Wa -West district) health facilities mentioned that among the three forms, the most practiced is the integrated facilitative (supportive) supervision for health care services. As illustrated by the following expressions by supervisees from health facilities in both the Wa Municipality and Wa-West district, the most practiced

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is the integrated supportive supervision for healthcare services. A supervisee had this to say when asked about the type of supervision practiced at the facility: "We practice integrated supportive supervision for healthcare services because it cuts across the other two types. That is aspect of the other two types are imbedded in it. More so, the checklist which is also the FS guidelines touches on all the other two types. Apart from that, it ensures that all issues concerning health care service delivery is looked at and addressed properly (A supervisee, Kambali clinic, Wa municipality, 4/3/2020).

In the same way, a respondent from Wa-West district explained: "Integrated facilitative supervision for healthcare services is practiced here because it allows staff of facility to come together to help identify problems as well as coming out with solution together" (A supervisee, Dorimon health center, Wa-West district, 10/4/2020).

Supervisors from the regional, district and sub-district health management team gave a confirmation to what the supervisees mentioned and added that, the guidelines they use for facilitative supervision covers the other two forms of FS. Also, they stated that, the integrated facilitative supervision for health care systems when done well improves staff performance and build their capacity as well.

A supervisor from the Regional Health Management Team (RHMT) opined that:

"We do the integrated facilitative supervision for healthcare systems in almost all the facilities we visit because it allows supervisees or staff from the various health departments to come together and discuss their needs and also devise solutions to problems identified. Even though the most practiced is the integrated FS for health care systems, our checklist is designed in a way that captures the other two forms. In fact, we would have love to do all the forms of supervision mentioned but due to lack of

resources, the integrated facilitative supervision is practiced for now" (A supervisor, RHMT, Wa, 12/4/2020).

Similarly, in Wa-West district, a supervisor from the District Health Management Team (DHMT) disclosed:

"For all the facilities we visit, we do what we call the integrated supportive supervision for health care systems. This type of supervision encourages teamwork and allows individual staff to freely express themselves without any fear. With this type of supervision, staff are able to continuously improve on their work and build their capacity as well" (A supervisor, DHMT, Wa-West district, 20/4/2020).

4.4 Qualities of a Supervisor/Facilitator

The study explored qualities that supervisors or facilitators must possess to ensure effective implementation of Facilitative Supervision. The results are summarized in table 4.1. The study showed that, for one to be a facilitator or a supervisor, he/she must first of all be a health worker who is familiar with the health care systems. It was established that those who do the facilitative supervision are all health workers who have been in the service for long and have undergone some level of training in facilitative supervision. Respondents disclosed that facilitators/supervisors should have the ability to listen, probe and help supervisees identify problems and propose solutions as well. It was further revealed that for one to be a supervisor or facilitator, the fellow should be able to lead, motivate, train and give support to those he/she supervises.

Table 4.2 Summary of Qualities of a Facilitator / Supervisor.

District	Qualities
Supervisees (Wa-West district)	• Health worker • Ability to listen, probe and propose solutions to problems • Knowledgeable • Good communication skills
Supervisees (Wa-municipality)	• Health professional • Ability to train and motivate • Excellent communication skills • Ability to listen • Knowledgeable

Source: Field Survey, 2020.

More so, having good communication skills as well as being knowledgeable were mentioned by supervisees as some of the qualities a facilitator must possessed. Supervisees narrated that the level of care and respect supervisors who visit the facilities demonstrate, motivates them to do more. A respondent recounted that supervisors help them solve problems they encounter within the facility. Additionally, they provide them updates on current guidelines and other information such as vaccination campaigns. Respondents stressed that supervisors who come to their facilities possess a number of the attributes mentioned.

A supervisee explained that:

"Every supervisor must have certain qualities. However, the person must first of all be a health worker who understands how the health system operate. For example, you cannot go for a cleaner to be a supervisor or facilitator. Again, a supervisor must have

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good communication skills. This is because if you do not have good communication skills, you would realize that when you get to a facility and there are problems or things to fix, you would end up fighting with the people instead of helping address the problem. A supervisor should be able to guide and lead. You must be on point; you just cannot afford to mislead your supervisees. I must say that supervisors who come to this facility have demonstrated these qualities I have mentioned" (An in-charge, municipal hospital, Wa Municipality, 4/3/2020).

A supervisee from the Dorimon clinic in the Wa-West district remarked:

"It is important for supervisors to hold well-defined qualities to enable them perform their task well. As a supervisor, you should have distinct qualities like, ability to speak well and listen to your customers or clients. A supervisor should also be accessible such that even if they leave the facility and you have some questions or doubt about something you can still reach out to them. Supervisors who come to this facility allow us to freely express ourselves, they listen to everything we have to say without any interruptions, in fact they have time for us. After listening to us, they help us to find solutions to problems identified together. These are some of the qualities I think supervisors should possess and I can confidently say that supervisors who come here have these qualities and many more" (A nurse from the Dorimon clinic, Wa-West district, 14/4/2020).

4.5 Structure of facilitative supervision

Supervisors from both Wa-West district and Wa Municipality mentioned that supervision is done in teams and lay emphasis on why it was vital to carry out facilitative supervision in teams of supervisors. They opined that the team is made up of 2-4 health professionals who have undergone comprehensive training in facilitative

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supervision. They highlighted that the team conducts the facilitative supervision at the district levels, sub-district levels and at the community levels. At the district level, a team of four (4) members from the regional level, thus, the Regional Health Management Team (RHMT) does the supervision. The team targets the hospitals and health centers within the region. The team does the supervision quarterly (in every year) and spends a day and half day at the hospitals and health centers respectively. Supervisors from the district level made up of the District Health Management Team (DHMT) supervises the sub-district level with a team of four (4) members and the clinics being their target. The supervision is done quarterly with the team spending half a day or more at the facilities. The last level which is the community level have two (2) team members from the sub-district consisting of the Sub-District Health Management Team (SDHMT) doing the supervision.

A summary of the structure of Facilitative Supervision is depicted in Figure 4.1
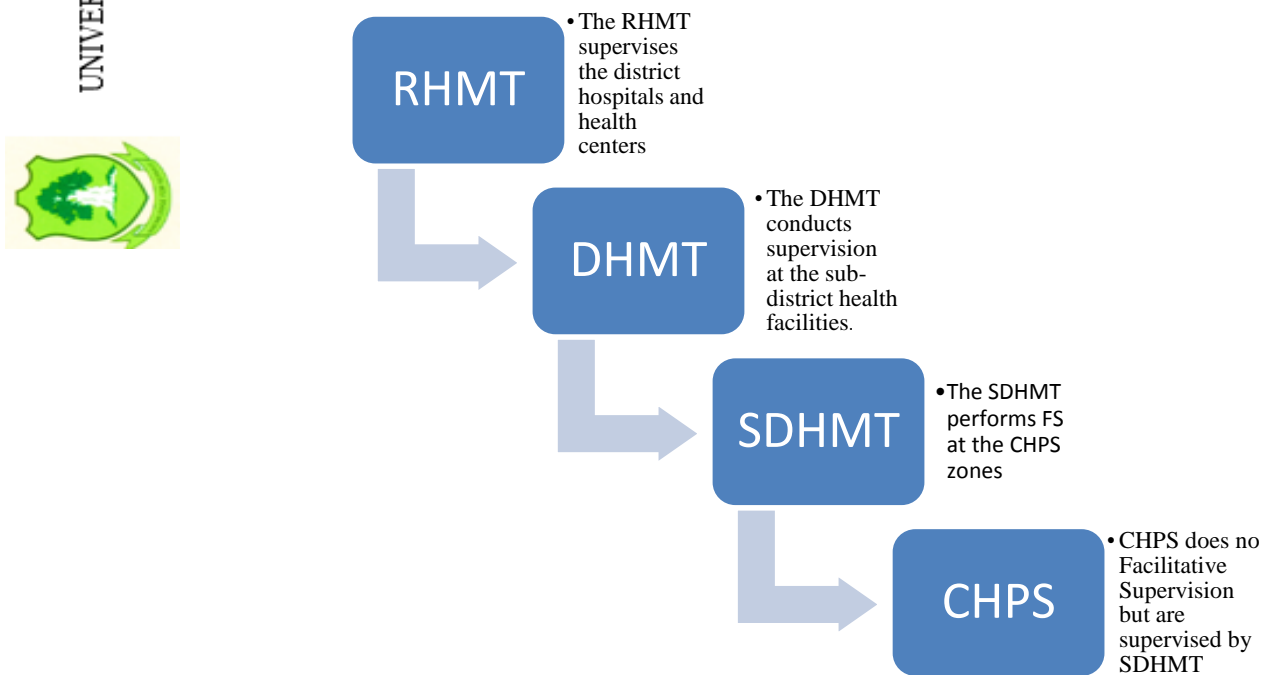
Figure 4.1 Structure of Facilitative Supervision

Source: Field Survey, 2020.

4.6 Facilitative Supervision Process

The process of implementing facilitative supervision is summarized in table 4.3 followed with explanation.

Table 4.3 Processes of Facilitative Supervision

Health Management Team	Processes of Facilitative Supervision
Wa Municipality	1. Planning and preparation, 2. Conducting the facilitative supervision 3. Offering guidance, identifying priority, challenges and developing action plans 4. Documenting and reporting 5. Providing follow-up and on-going support 6. Review of reports
Wa-West district	1. Planning and preparation **2.** Conducting the facilitative supervision 3. Offering guidance, identifying priority, challenges and developing action plans 4. Documenting and reporting 5. Providing follow-up and on-going support **6.** Review of reports

Source: Field survey, 2020.

4.6.1 Planning and preparation stage

The study discovered that before supervisors move out to do FS, they meet as a team and plan. During the planning and preparatory stage, route maps are drawn and decisions on which facilities to visit are reached. Again, they take into consideration the availability of human resources, logistics checklist etc. with information given to

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supervisees on the date and time the visit will take place. Supervisors stressed that the planning and preparation is done to ensure that the right things are done and also to build the capacities of those they supervise.

4.6.2 Conducting Facilitative Supervision

The study identified that from the planning and preparatory stage, the team then move to the health facilities to perform the FS. At the facilities, the team introduce themselves to the staff /supervisees and communicate to them why they have come. The supervisees also introduce themselves to the team. This they mentioned helps to create some kind of relationship between the team and the supervisees. They explained that their interest at this point is to ensure that supervisees actively involve themselves in all activities as a supervisor from the RHMT stated:

"We try as much as possible to ensure supervisees are actively involved in all activities" (A supervisor, RHMT, 18/3/2020).

Furthermore, there is a revision of previous supervision to ensure mistakes that were identified at the previous supervision have being corrected. The study revealed that supervisors at this stage used the checklist/guidelines to gather information and observe activities at the facilities. Also, the team checked registers and reports on services rendered to clients who visit the facilities. This they expressed enables the team and the supervisees to identify problems and challenges facing the facility. The problems and challenges are then addressed.

4.6.3 Guidance, Identifying Priority, Challenges and Developing Action Plans Stage

The research discovered that, the team at this stage do not concentrate on individual staff but concentrates on the processes and the activities at the facilities. The team explained that, during observation of activities at the facilities, if it is observed that a procedure is performed wrongly, they provide corrective measures by demonstrating the correct procedure and ask supervisees to replicate to make sure they have understood the procedure. They however stated that, they do not provide on- the job training for staff all the time but do so only when it is needed. Supervisors recounted that, staff are commended on areas they have done so well and also pinpoint areas that need upgrading and reach an agreement on the action plan using a joint problem-solving approach. They highlighted that supervisees are given adequate time to ask questions and, in the process, individuals are identified to solve some of the problems discovered. A supervisor from the SDHMT in Wa-West district remarked that:

" if a facility for example does not have a register, we identify one person from amongst the supervisees and direct the fellow where he/she can get the register for the facility" (A supervisor, SDHMT, 20/3/2020).

The team also tries to find out from supervisees if everything went well hence questions like: how did the exercise go? Are there things you think need to be improved with regards to this supervision? Did you need something which the team did not address today? Findings are then shared with supervisees. This is to help staff understand what they are doing well and what they need to improve upon.

4.6.4 Documentation and Reporting Stage

The study showed that all the findings, activities as well as plans taken during the Facilitative Supervision Visit (FSV) are put in to writing and documented. Copies of the report are given to in-charges of facilities.

4.6.5 Providing Follow-up and On-going Support Stage

Respondents stated that, M&E officers make a follow-up to check progress of work and to make certain that staff of facilities are in reality adhering to standards and guidelines of the health care system. This they said put staff in-check and ensures continue support for facility staff as well.

4.6.6 Review of Report

Supervisors explained that monthly reports are revised and there is continuous communication with supervisors and supervised staff to determine if recommendations are being implemented.

4.7 Personnel Who Conducts Facilitative Supervision

In all the facilities (both Wa Municipality and Wa-West district) visited, integrated facilitative supervision for health care systems was mentioned as the most practiced form of facilitative supervision. The study revealed that persons who conduct facilitative supervision are health professionals who are members of either the RHMT, MHMT, DHMT or SDHMT and know much about the health care systems and have undergone extensive training in facilitative supervision. It was also disclosed that the supervision is done in teams as established in section 4.5. However, respondents

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stressed that supervisors are often times less than the actual number expected to do the supervision. A supervisee reported that,

"At this facility, a team of four member supervisors are expected to conduct the supervision but only two visit the facility" (A supervisee, Dorimon clinic, 23/4/2020).

It was also found that a few of the supervisors who supervise at the community levels are actually not supervisors but are colleague health workers who have been taken through the processes of FS by the supervisors who are members of the SDHMT to conduct the supervision on their behalf.

4.8 Frequency of supervision

This sub-section describes the frequency at which facilitative supervision is performed. The study established that supervisors from both Wa-West district and Wa-municipality used guidelines/ checklist as a tool in conducting facilitative supervision. Also, facilitative supervision is supposed to be conducted quarterly in both districts as stated in section 4.5. However, it was discovered that they were unable to meet the quarterly supervision as planned. A supervisor from the RHMT disclosed that:

"FS has not been consistent like before. We hardly conduct all FS planned in a year. Occasionally, we carry out one or two instead of three supervisions in a year" (A supervisor, RHMT, 26/3/2020).

This irregularity was attributed to inadequate logistics, human resource, travel expenses and poor road network in some communities. For example, a supervisor bemoans that whenever she is occupy with work at the facility and it's time for supervision, she is forced to send some staff from the facility to conduct the exercise on her behalf. She expressed that, even though she takes them through the process and point out things to

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look out for in conducting the FS, she feels it's not the best and attributed this to inadequate human resource. Supervisees affirmed statements by supervisors and testified that some facilities received more supervision while others received less. The study showed that, supervisees at the Wa Municipality (urban) received relatively constant supervision whilst those within the Wa-West district (rural) did not. Comparatively, the municipal hospital within the Wa -municipality in terms of frequency of supervision, had a reasonable number of supervision than Wechiau district hospital in the Wa-West district (rural). In Wa Municipality, a supervisee recounted:

"Supervision has been very consistent in this facility. Supervisors visit this facility once in every three months within a year. And so, in a year we have like three facilitative supervisions. We are however, yet to be supervised this year. I know for sure before the end of March, supervisors will be here to do the supervision" (An in-charge, municipal hospital, Wa Municipality, 10/3/2020).

Contrary in Wa-West, a supervisee revealed:

"In 2018, we were fortunate to have had two out of the normal three supervisions. In 2019 however, we had one out of the three facilitative supervision. Supervision here has not been regular at all" (An in-charge, Wechiau-district hospital, Wa-West district, 15/4/2020).

4.9 Understanding how Facilitative Supervision is Carried Out

The study revealed that facilitative supervision involves so much activities which includes a team of supervisors visiting health facilities and undertaking activities such as observing departments, following up on gaps identified in the previous supervision, checking of reports and registers of services rendered to clients of facilities using the

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checklist/guidelines as a tool. The study discovered that at the sub-district and CHPS levels, most of the activities involves checking of registers and reports whereas activities such as observation of departments/units, checking of reports and registers were reported at the district levels. Supervisees explained that when the team arrive, they allow them to complete any sessions ongoing before the start of the exercise. They further detailed that, the team tries to enquire if the gaps and problems identified during the previous supervision has been resolved. A supervisee disclosed that, for example, if in the last supervision the team detected that certain procedures were not handled well, they verify if indeed amendments have been effected. Respondents however, did not mention what supervisors would do if the issues from the previous visit had not been fixed or resolved. The team further move to observe the various units in the facility and check registers as well. Respondents mentioned that, during observation, if the team notices any mistakes, they correct them. A supervisee expressed that:

"Supervisors listen to their problems and address them appropriately after which they ask questions. Finally, supervisors disclose updates on training opportunities and guidelines if any. The team then serve copies of the reports to heads of facility, thank us and leave for another facility" (A supervisee, Dabo CHPS, 22/4/2020).

It was however discovered that, FS at the district levels is targeted at the heads of units or departments who are also the in-charges at these facilities. Even though the FS is targeted at the heads of units at the district levels, the study uncovered that after each FS, the heads communicate the findings to the staff and ensure they benefit from whatever they have benefited during the FS sessions. The study further found that there

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were no differences in terms of how facilitative supervision is performed at health facilities in the two districts (Wa Municipality and Wa-West district).

A respondent recounted that:

 "Supervisors first of all ensure we finish attending to clients before they kick start the process. They enquire whether corrections made from the previous supervision have been implemented. The team then ask for our registers and reports. Supervisors use the standard checklist also known as the guidelines to assess our performance. Supervisors share with us their findings and commend us on areas we are doing well. More so, they stress on areas that needs improvement and help us to device solutions to address these challenges. The team gives us time to ask questions. Reports are handed over to us. After which they leave for another facility" (A nurse, Kambali, Wa Municipality, 29/3/2020).

Similarly, in Wechiau district hospital, an in -charge remarked:

"Supervisors who visit this facility are very welcoming. First of all, when they arrive at the facility, they call on all of us (in-charges of facility). In a situation where any of us is attending to clients, a colleague is either assigned to clients or the team waits until clients are attended to before supervision starts. Reports and registers are asked for by the team members. The team make enquiries of previous challenges to ascertain whether they have been resolved. Team members go around to make observations of the various units. If in the course of the observation they discovered, a thing or two are done wrongly, they alert us and quickly show us the correct way to go. The observations and checking of the reports and registers are done using the checklist or guidelines. After all these are done, the team share with us the outcome of the supervision and what

can be done. They give us copies of the report, thank us and leave" (An in-charge, Wechiau district hospital, Wa-West, 29/4/2020).

4.10 Monitoring and Evaluation (M&E) of Facilitative Supervision

The research established that, between two to four weeks after a team of supervisors visit the various health facilities to conduct FS, there is a follow-up to do Monitoring and Evaluation (M&E) by M&E health officers at these same facilities to ensure that staff of facilities are not deviating from doing what is right. Again, it was revealed that, ones in every year, some members from the national level visit these facilities to also make sure reports and figures they received from these health centers are accurate. A supervisor from the RHMT expressed:

"Some health professionals after our supervision exercise, visit these facilities to ensure staff are indeed doing the right thing. This way, we are able to monitor progress of work and also ensure effective functioning of the health care systems. Within a year, we have at least an officer from the national level who visit these same facilities to authenticate data that has been sent to the national level. All these exercises are done to ensure all of us are doing the right thing" (A supervisor, RHMT, Wa Municipality, 14/4/2020).

"It is normal to say that after our visit, some supervisees may not comply with standards and so colleagues move to these facilities to put them on track. They make sure supervisees are not repeating mistakes that have been corrected by supervisors and are adhering to the guidelines of the healthcare systems. Officers from the national level equally visit our facility to authenticate reports and figures we send to them" (A supervisor, SDHMT, Wa Municipality, 16/4/2020).

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In Wa-West district, a supervisor detailed that:

"Sometimes, after providing everything that these staff need, you will still have some who would not do the right thing. Since we deal with human life, we must ensure the appropriate things are always done. Hence, to put staff of facilities on track, we have monitors coming from both the regional and district levels to conduct monitoring and evaluation exercise after supervisors have come to facilities and left. Sometimes, my colleagues and I join in the M&E exercise too. Apart from this, we have some officers from the national level who come to cross-check if information served them are as they seemed" (A supervisor, DHMT, Wa-West district, 21/4/2020).

On the other hand, it was found that, while supervisees from the Wa Municipality attested to the fact that M&E officers visit facilities two to four weeks after supervision have taken place with at least an officer coming from the national level yearly to verify data they received, supervisees in Wa-West district did not. It was revealed that, M&E was mostly done via phone calls in Wa-West district. Again, it was disclosed that, personnel from the national level have not being frequent with their visit to facilities in the Wa-West district compare to facilities in Wa-municipality. This therefore contradict expressions by supervisors from the Wa-West district that, M&E officers visit facilities.

In Wa Municipality, a supervisee clarified:

"After the FS, some M&E officers come around to monitor what we do. They do this to make sure we comply with the guidelines of the health service provision and also to ensure that mistakes that were corrected by supervisors are not repeated. More so, someone from the national level visit this facility ones every year to confirm information we give to the national" (A supervisee, Municipal hospital, Wa Municipality, 16/3/2020).

In Mangu CHPS, a staff stressed:

"I feel sometimes these monitors come here to check on us so we don't do anything outside of the norm. I think it helps because it really puts us on our toes and we strive to give out our best no matter what" (A supervisee, Mangu CHPS, Wa-Municipality, 27/3/2020).

On the Contrary in Wa-West district, a supervisee expressed:

"Apart from the normal FS, we receive calls from some officers enquiring about how things are going in the facility. We equally used to have some personnel coming from the top (national level) to request for data that has been given to the RHMT. However, for the past two to three years, we have not had anyone like that" (A supervisee, Wechiau district hospital, Wa-West district, 28/4/2020).

4.11 Adherence of Facilitative Supervision Guidelines

The study revealed that, the facilitative supervision guideline also referred to as the standard checklist, is used as a tool in performing the FS. More so, it was disclosed that the guidelines are developed to shape and direct activities of both supervisors and staff of facilities. The research uncovered that, the guidelines are designed and documented by the Ghana Health Service (GHS) and the Ministry of Health (MOH). The implementation of these guidelines however, is done through health personnel from the regional, district and sub-district health management team within the Region. Also, M&E officers from the regional, district and sub-district levels ensure that these guidelines are adhered to. Supervisors stated that, in-charges of facilities are given copies of guidelines to ensure its compliance without staff being forced or pressured.

 A supervisor from the municipal hospital recounted:

"We have guidelines that we use for supervision which are designed and documented by the Ministry of Health and the Ghana Health Service. Although the guidelines are designed by MOH and GHS, we do the implementation. We make sure staff of facilities follow these guides and where they are falling- short we assist them. It will interest you to note that, even after our visit to these facilities, we still have personnel who make follow-ups to ensure the guides are adhered to and at the facility level, we have in-charges who ensure its adherence as well"(A supervisor, RHMT, Wa Municipality, 14/4/2020).

 Similarly, in Wa-West, a supervisor stressed:

"We have standard checklist and they are same as the guidelines we use for FS. These are developed by the MOH and GHS. Even though we do not force staff of facilities to stick to guidelines, we make sure they do not do anything outside the guide. We have officers who follow-up after our visit to make sure staff adhere to guidelines. Guidelines are given to in-charges to again ensure facility staffs follow them" (A supervisor, DHMT, Wa-West district, 21/4/2020).

4.12 Extent of Adherence of Facilitative Supervision Guidelines

This section explains the guidelines used in conducting facilitative supervision and its adherence in the health facilities. The study found that, adherence at the Wa Municipal health facilities is very high compared to health facilities in the Wa-West district. Supervisors stated that, facility staffs are not pressured or forced to follow guidelines. They expressed that staff of facilities adhere to guidelines to a large/ great extent. However, they were quick to mention that, the only time staff do not adhere to these guidelines is when things (referral forms, standardized notebook) they need to work with are not readily available and they have to improvise. In the same way, supervisees

from Wa Municipality confirmed that not until there is none availability of logistics like a standardized attendance book they need to work with, they always go by the guidelines. A supervisee expounded:

"We do follow the guidelines to a greater extent without being pressured or forced. However, in a situation where we need to improvise, then one can say we have not adhered to the guidelines but of course it is not our making. For example, we have a standardized notebook that we use for recording attendance of clients, however, whenever we are short of the notebook, we buy our own book, rule the lines and use for same purpose" (A respondent, Mangu CHPS, Wa-municipality, 11/3/2020).

Even though supervisors disclosed that facility staffs adhere to guidelines to a greater extent, supervisees in the Wa-West district mentioned that adherence to guidelines is limited. They reported that, the number of times they had to improvise to enable them perform their duties is enormous and this according to them makes it impossible for them to follow the guide as it should. An in-charge explained that there have been several instances where they carried patients on motorbikes to be transported to other facilities for treatment as a result of none availability of an ambulance. She added that although this is not the best, it saves life.

A supervisee bemoaned:

" Many at times we do not adhere to these guidelines not because we don't want to but because the things, we need to ensure these guides are followed are not there" (An in-charge, Wechiau-district hospital, 23/4/2020).

4.13 Observation of Facilitative Supervision in Health Facilities

The researcher carried out three direct observations at one sub-district and two at the community levels (CHPS) all in the Wa Municipality. This was due to the fact that, in Wa-West district, supervision hadn't begun as at the time the research was conducted and since the study was time bound, the researcher observed facilities where supervision was ongoing. All through the direct observation, the researcher discovered that, most of the Facilitative Supervision Visit (FSV) involved checking of reports and registers. Supervisors revisited issues from previous visit. However, there was no talks on what supervisors would do if the issues from the previous visit had not been fixed or solved. Again, it was observed that supervisors used FS checklists/ guidelines during the supervision sessions. More so, it was witnessed that FS was done to build the capacity of staff and not to find fault with staff. However, supervisors did not address motivation of staff but concentrated on improving performance. In one of the CHPS facility, supervisors used the opportunity to educate staff on the importance of keeping good and detailed reports. Supervisors mentioned that keeping accurate reports informs decision making and helps in resource mobilizations and allocation. Both supervisors and supervisees discussed problems and challenges identified in the course of the supervision and actions were taken to address them. For example, in one of the facilities, it was found that they did not have a register and so both supervisors and supervisees agreed to use a note book as a temporary measure while supervisors follow-up to get the register from the appropriate office for the facility. More so, excellent relationship was seen between supervisors and supervisees. Supervisors after each visit, gave copies of guidelines and reports to in-charges of the facilities. In all the facilities, supervision lasted for about forty-five minutes to an hour. After each supervision, supervisors thanked staff and leave for the next facility.

4.14 Contribution of Facilitative Supervision to Quality Health Care

This section describes how the implementation of facilitative supervision has contributed to the health care delivery systems within the study communities. There were no variations as to how FS has contributed to quality health care delivery in the two districts. Both supervisors and supervisees from the Wa Municipality and Wa-West district explained how the operation of facilitative supervision has impacted on their profession, implementation of health care policies and health care delivery as a whole. As a profession, the study revealed both supervisors and supervisees have become more discipline as they expressed that the intervention helps them perform their roles and responsibilities with so much discipline, even when it appears challenging. Again, they expressed such discipline allows them stick to standards and guidelines of the health care system even as MOH and GHS seek to improve these guidelines. More so, it was discovered that FS has helped both supervisors and supervisees to become confident than before as they equipped themselves with latest and updated knowledge in their area of work. This they emphasized made them attend to clients without fear of committing errors or mistakes. Again, it was learned that, supervisors and supervisees communication skills and human relations have improved as a result of the implementation of the FS. Supervisees reported that the excellent relationship they have with their supervisors make it possible for them to learn as a supervisee from the sub-district health facility explained:

"communication is key in every field especially for those of us in the health sector, hence good interpersonal relationship and your ability to communicate well to clients who visit your facility is a must and the application of FS has helped in that direction.

Also, the good relationship that exist between supervisors and staff of this facility makes us learn" (A supervisee, Kambali clinic, Wa-municipality, 20/3/2020).

In terms of the implementation of health care policies, it was found that feedback from supervisors after supervision actually informs the GHS and MOH as to how policies and guidelines should be designed and documented.

A supervisor from DHMT in Wa-West emphasized:

"whenever health officials from the GHS and the MOH decides to develop new guidelines or policies for the health service, they do so by consulting us. Even though findings of the supervision exercise are submitted to them in the form of reports, they most of the times contact us via phone calls to be certain of issues before the design and documentation of these policies and guidelines take place. It is therefore prudent to say results or findings of the implementation of FS shape policies and guidelines of the health care systems" (A supervisor, RHMT, Wa-Municipality, 16/3/2020).

As regards how FS has contributed to the health care delivery, supervisors reported that because of FS, supervisees now have a better understanding of why data are collected and how to use data to take action. This they mentioned, have improved their performance at work as well as helping in resource allocation to better health care delivery in their respective working communities. Secondly, as a result of FS, child health care and maternal health have improved. Both supervisors and supervisees narrated that before the implementation of FS, attendance of maternal and child health care was not encouraging, however, since the inception of FS, facilities have recorded high attendance. This was attributed to the excellent communication skills demonstrated by staff of facilities. A supervisee from the sub-district level stated:

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"Before the start of FS, we used to have very few pregnant women visiting this facility, very few nursing mothers bringing their babies for Routine Immunization (RI) and a few people coming for family planning. It became a worrying situation for us and so during one of the FS sessions, staff decided to put the issue before our supervisors as one of the problems of the facility. It was then that our supervisors took us through how to communicate and relate well with clients. After that session we started implementing what we were taught and it worked perfectly well. We began recording increases in attendance of clients" (A supervisee, Kambali clinic, Wa Municipality, 20/3/2020)

This quote represents views of most supervisees.

Additionally, supervisors and supervisees attributed to improved patient satisfaction and a reduction in complications to facilitative supervision. Overall, supervisees stated that the intervention really motivates them to perform well which reflects in the quality of care clients receive from these facilities.

4.15 Challenges of Facilitative Supervision

The result of the challenges of Facilitative Supervision has been summarized in table 4.4 followed with explanation.

Table 4.4 Challenges of Facilitative Supervision

District		Challenges
Wa Municipality	Supervisors	• Travel expenses • Inadequate logistics • Inadequate human resource
	Supervisees	• Time given prior to FS inadequate • Supervisors are not 'supervisors' • Irregular FS
Wa-West	Supervisors	• Poor road network • Inadequate logistics • Travel expenses • Inadequate human resource
	Supervisees	• Time spent for FS inadequate • Time given prior to FS inadequate • Irregular FS

Source: Field Survey, 2020.

The study identified that the implementation of the facilitative supervision is not without challenges. The study showed that facilitative supervision just like any other intervention come with its own challenges. Both supervisors and supervises within Wa-West district and Wa Municipality mentioned a number of challenges that bedevils facilitative supervision. Inadequate logistics, travel expenses and inadequate human

resources and irregular facilitative supervision were the most challenges mentioned by supervisors. Supervisors reported that, it is costly to do facilitative supervision and stated that until there is proper planning and budgeting for logistics, transportation expenses and human resource, there is high probability of the intervention failing. Supervisors disclosed that most of the FS they do requires they travel to communities where these facilities are located and requires the use of either motorbike or vehicle. However, often times there are no vehicles or motorbikes and even if there is, it is being used for other assignments. This they said slows supervision. Poor road networks to some health facilities in the rural district was also revealed as a challenge of FS. A supervisor from the DHMT in Wa-West district bemoaned:

"Most of the health facilities in this district have very bad roads. As a result, it becomes difficult whenever we have to go to these facilities for supervision especially during raining season" (A supervisor, DHMT, Wa-West district).

Again, supervisors expressed that, inadequate human resource made it impossible for them to have the accurate number of supervisors assign to a facility. For example, a supervisor explained that at the district level, there are supposed to be a four-member team of supervisors but due to their numbers, only two-member team normally conduct the supervision. Similarly, another supervisor reported that some of the supervisors are actually not "supervisors". She stressed that there were times when she had to go for supervision but sent staffs who she trained to go because she had so much to do at the facility where she works. She emphasized that these staffs have not gone through FS training entirely and hence might not provide the support supervisees might need. This she stated is a major concern which needs to be addressed. On the other hand, supervisees revealed that supervision was not regularly done and emphasized that one of the objectives of FS is to build capacity of staff and so if supervisory visit is not

consistent, that objective would not be realized. Again, they remarked that the time supervisors inform them and the time they come for the supervision is too short. This they mentioned does not give them adequate time to prepare for the supervision exercise. Additionally, they testified that some supervisors are actually not 'supervisors' but are colleagues who have been trained by some of these supervisors to undertake the FS.

4.16 Discussions

This section brings to bear the findings or results of the study. Facilitative Supervision is conducted at the health facilities by a team of health personnel who have undergone extensive training in FS. The study showed disparity in the adherence of FS guidelines in the two study locations. The variation in adherence of FS guidelines however was attributed to inadequate resources at the health facilities. Although there are challenges in the implementation of FS, the intervention has positively influenced the quality of health care delivery in the Region. The results are discussed in line with the study objectives.

4.16.1 Facilitative Supervision in health facilities

The study revealed that facilitative supervision is conducted in teams by health workers who have been given extensive training in facilitative supervision and are members of either the RHMT, DHMT or SDHMT. This is in line with Engenderhealth, (2001) contention that, FS when done in teams makes it possible for supervisors to device ways in addressing issues that may arise.

The study showed that, supervisors who perform FS have qualities such as ability to listen, probe and propose solutions to problems. They are also knowledgeable, have good communication skills and they have the ability to train, motivate and empower supervised staff. These findings support Engenderhealth, (2001) assertion that, supervisors who possess these characteristics/qualities are prepared to become successful facilitative supervisors. They stated that facilitators with these characteristics are able to come out with what is or is not working, to aid in the identification of strategies for the improvement of ongoing processes.

The study further revealed six processes that supervisors go through to ensure effective implementation of the intervention. The first process is the planning and preparatory stage where route maps are drawn and decisions on which facilities to visit are reached. At this stage, supervisors take into consideration the availability of human resources, logistics, checklist and transportation expenses with information given to supervisees on the date and time the visit will take place. This corroborates NASTAD, (2016) assertion that planning and preparatory stage of FS implementation should center on the availability of trained supervisors, availability of supervision tools such as checklist, staff performance standards, details of logistical arrangements that need to be accounted for in the form of facility scheduling, transportation and accommodation. This finding again is in line with the theory of change (Weiss, 1995) which states that, for an intervention to work, organizations or institutions must make certain commitments in the form of inputs (resources) to ensure a successful implementation of such an intervention.

The next process is conducting facilitative supervision. This is where a team of supervisors move to health facilities to do the FS. Supervisors at this stage ensure that, supervised staff are actively involved in all FS activities. More so, they revise previous

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supervision to make sure that problems identified have been rectify. The team further observe activities at departments/units, check reports and registers using standard checklist/guidelines as a tool for FS. This affirms NASTAD, (2016) argument that, having prepared the supportive supervisors and supervisee we proceed with the supportive supervision by employing the designated tools and engaging the appropriate staff in the exercise. Supervisors can collect information using one or a combination of the following methods/tools: Listening to health workers and talking with beneficiaries, reviewing the records, using a checklist, reviewing recommendations from past visits and conducting a rapid community survey.

Furthermore, the guidance, identifying priority, challenges and developing action plans stage focuses on the processes and the activities at the facilities and not the individual. Here, supervised staff are corrected if during observation the team found that a procedure is performed wrongly. The team commend staff on areas they have done well and identify areas that need improvement and reach an agreement on the action plan using a joint problem-solving approach NASTAD, (2016). The fourth stage is the documentation and reporting stage. This is where all the findings, activities as well as action plans taken during the Facilitative Supervision Visit (FSV) are put in to writing and documented. Copies of the report are then given to in-charges of facilities. The next stage is providing follow-up and on-going support where M&E officers make a follow-up to check progress of work and to make sure that staff of facilities are in reality adhering to standards and guidelines of the health care system. This is done to put staff in-check and ensures continue support for facility staff as well. This supports NASTAD (2016) statement that, follow-ups on the action plan developed to ensure continuous engagement of the supportive supervision process is very vital in the whole exercise. The final stage is review of report where monthly reports are revised and there is

continuous communication with supervisors and supervised staff to determine if recommendations are being implemented (NASTAD, 2016).

The study established that supervisors used guidelines/ checklist as a tool in conducting facilitative supervision. This finding agrees with Hill et al (2014) that the worth of FSV should be certified through the development of facilitative (supportive) supervision policies and the consistent use of the standard tools developed for the exercise such as checklists.

Moreover, the study discovered that both supervisors and supervisees knew when FS is supposed to be conducted though facilitative supervision visits were not regular. This however is in contrast with a study conducted by Agoro, Osuga and Adogo (2015) on "Supportive Supervision for medicines management in government health facilities in Kiambu County, Kenya; a health workers' perspective" which states that most respondents could not evidently agree on how often they expected a supervisory visit by the County Health Management Team (CHMT).

More so, it was unearthed that, Facilitative Supervision Visit (FSV) in the health facilities of both Wa Municipality and Wa-West district mostly involved checking of reports and registers. Also, supervisors revisited issues from previous visit even though there were no talks on what supervisors would do if the issues from the previous visit had not been fixed or resolved. Also, supervisors shared findings of the supervision with supervised staff. This supports Programme for Appropriate Technology in Health (PATH, 2013) assertion that facilitative supervision ensures supervisors review previous supervisory reports and achievements as well as observing performance and checking of standards. They argued that there should be immediate feedback from

supervisors, provision of technical updates, joint problem solving on possible solutions to performance.

The study disclosed that, action plans are drawn after each supervision and there is a follow-up to ensure the right things are done and also to ensure continue support for staff of health facilities as demonstrated by Hill et al, (2014).

In summing up, the study revealed that FS is done in teams of health personnel with so much knowledge and experience in the health care systems. The interpersonal relationship between supervised staff and supervisors motivates staff to learn. However, facilitative supervision visit did not address staff motivation but concentrated on areas of improvement. One key thing to note here is that supervision is not done to find fault with staff but to build their capacities in other to perform well at what they do.

4.16.2 Adherence to Facilitative Supervision Guideline

The study revealed that guidelines for the FS is designed by GHS and MOH to direct the activities of both supervisors and staff of health facilities and also ensure that the right things are done at the right time. This supports PATH, (2003) assertion that facilitative supervision guidelines are meant to aid supervisors and staff in understanding the intent of facilitative (supportive) supervision, and to provide direction on how to make supervision as effective as possible. Thus, guidelines define how and when work should be done. However, the implementation of these guidelines is done by health personnel from the regional, district and sub-district health management team who have undergone extensive training in FS within the Region.

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The empirical case studies on adherence of FS guidelines in the two districts showed that, supervisors used FS guideline also referred to as standard checklist as a tool in performing FS. This corroborates with Hill et al (2014) view that, the worth of FSV should be certified through the development of facilitative (supportive) supervision policies and the consistent use of the standard tools developed for the exercise such as checklists.

The study uncovered that apart from the various health management team who ensure compliance of FS guidelines, M&E officers also from the regional, district and sub-district levels ensure that these guidelines are adhered to. Again, in-charges of facilities are equally given copies of guidelines to ensure its compliance. These findings are in support of theory X and Y by McGregor (1960). The main proposition of theory X states that human beings by their nature detest work and that they engage in it as a matter of necessity. Proponents of theory X, therefore, advocate for supervision, monitoring and control, in addition to motivation of employees if they are to buy into and work towards the achievement of their organizational goals. It is natural for some individuals not to work even when all they need to work with are made available to them. For this reason, there must be continue monitoring and checks on such individuals to ensure they comply with standards to ensure the goal of the intervention is realized.

Furthermore, the study brought to light that some facility staff in Wa Municipality adhered to guidelines to a large extent whiles those in Wa-West district adhered to a small extent. It was revealed however that, the only time staff did not adhere to these guidelines was when things they needed to work with were not readily available and they have to improvise. There has not been any study to review this finding hence a contribution to knowledge.

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In concluding this section, the study disclosed that supervisors used facilitative supervision guideline also known as the checklist as a tool in conducting FS. These guidelines are designed and documented by the GHS and the MOH to help direct activities of both supervisors and supervised staff. The study showed that the guidelines were adhered to a large extent by staff in the Wa municipality compared to those in Wa-West district. The non-adherence was attributed to the lack of resources in the health facilities.

4.16.3 Contribution of Facilitative Supervision to Quality Health Care

The study showed that professionally, both supervisors and supervisees have become more disciplined and this was attributed to the application of FS. The study revealed that, the intervention helps staff to perform their roles and responsibilities with so much discipline, even when it appears challenging. Such discipline also allows them stick to standards and guidelines of the health care system even as MOH and GHS seek to improve these guidelines. No study has been conducted to review this finding hence a contribution to knowledge.

More so, it was discovered that, FS has helped both supervisors and supervisees become confident than before as they equipped themselves with latest and updated knowledge in their area of work. This they emphasized made them attend to clients without fear of committing errors or mistakes. These findings affirm Roberts, (2011) assertion that supervisory visits are opportunity for health workers to resolve problems and learn additional knowledge and skills. This he argues give health workers the power such that, they are no longer afraid to address challenges and are able to work with the district team to resolve any issues.

The study further unearthed that supervisors and supervisees communication skills and human relations have improved as a result of the implementation of the FS. The excellent relationship supervised staff have with their supervisors make it possible for them to learn. This is in line with Heidi et al. (2007) pronouncement that through Facilitative Supervision, health facility supervisors are in a position to increase motivation, facilitate communication and help supervised staff to manage resources effectively.

In terms of the implementation of health care policies, it was found that feedback from supervisors after supervision actually informs the GHS and MOH as to how policies and guidelines should be designed and documented. There is no literature to review this finding thus a contribution to knowledge.

The study showed that supervisees now have a better understanding of why data are collected and how to use data to take action. This has improved staff performance and the quality of services clients received from the facilities (Heidi et al, 2007).

The study brought to light that the implementation of FS, has led to improvement in maternal health and child health care as facilities recorded high attendance for antenatal and child immunization cases. This attest to PATH (2003) assertion that, Facilitative (Supportive) supervision when implemented well, fosters a collaborative approach to strengthen health worker performance and immunization services and has been an effective tool for improving performance for many organizations.

More so, the study unearthed improved patient satisfaction and a reduction in complications since the inception of facilitative supervision as demonstrated by other studies (Anderson, Issel, & McDaniel, 2003; Houser, 2003; Wong & Cummings, 2007).

Consequently, through FS, staff are motivated and are able to perform well which reflects in the quality of care clients receive from facilities they serve (Heidi et al, 2007).

In a nut shell, the excellent interpersonal relationship between supervisors and supervisees motivates staff to learn, consequently both supervisors and supervisees have become disciplined and confident with improvement in their communication skills leading to an improved performance at work.

4.16.4 Challenges of Facilitative Supervision

The study revealed that supervisors did not have adequate logistics to aid in the supervision. Furthermore, the study showed that most of the FS requires supervisors travel to communities where these facilities are located and requires the use of either motorbike or vehicle. However, often times there are no vehicles or motorbikes and even if there is, fueling them is always a challenge. Also, some communities especially those in the Wa-West district have very poor road networks which made supervision strenuous. This agrees with Crigler, Gergen, and Perry (2013) augment that facilitative supervision is often conducted by staff of higher-level ranks who are usually domicile in more urbanized areas on staff of relatively lower-level ranks and who usually reside in remote, usually difficult to access villages. They added that the periodic visits to these remote locations require the use of motorized means of transport in the form of motor cycles or vehicles. According to Crigler et al. (2013), at least one of the following four conditions are likely to play out at a particular point in time: (a) there is no vehicle or motorbike assigned to the facility, (b) the source of transport is not in working order, (c) there is no money to buy fuel and (d) the vehicle is being used for some other purpose.

More so, inadequate human resource was found as a challenge most supervisors faced in performing facilitative supervision. This made it impossible for the health management team to have the accurate number of supervisors assigned to conduct FS at the various health facilities. As a result, some staff from the sub-district level who have not received the requisite training in FS were made to perform supervision even though they were not supervisors. The study discovered that because these staffs have not gone through FS training entirely, they might not provide the support supervisees might need. These findings are in contrast with NASTAD (2016) contention that FS should have a plan that will guide the supervision process and help in measuring progress towards the success of the plan. The content of the plan they stated should have the following three main components: the right supervisors, the right tools and the right resources. By the right supervisors, they meant that supervisors have been trained in facilitative supervision and are with the requisite knowledge and skills. On the other hand, the findings support Crigler et al. (2013) assertion that when supervisors are not equipped with the necessary supervisory knowledge and skills, especially when they happen to be district health officers or primary health care nurses, they are not able to provide the kind of support that the community health worker needs.

The study unearthed that supervision was not regularly done and also the time supervisors inform supervised staff and the time they come for the supervision is too short. Hill et al. (2014) stated in their work that adequate supportive supervision requires that health facilities are regularly visited, and that both teams are aware of the scheduling of the visits. Some authors have also identified irregular supervision as a challenge health care system in Africa face (Manongi, Merchant &Bygbjerg, 2006).

This section concludes that, the irregular FSV was attributed to inadequate logistics, inadequate human resource and travel expenses for the implementation of Facilitative

Supervision. Inability to prepare adequately for supervision on the part of supervised staff was also attributed to limited time given prior to FS by supervisors.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Summary of Key Findings

5.1.1 Facilitative Supervision in Health Facilities

- Facilitative Supervision is conducted by health workers who understand the health care systems and have undergone extensive training in FS and are members of either the RHMT, DHMT or SDHMT.

- Six processes are involved in conducting FS: 1) Planning and preparation, 2) Conducting the facilitative supervision, 3) Offering guidance, identifying priority, challenges and developing action plans, 4) Documenting and reporting Providing, 5) Follow-up and on-going support and 6) Review of reports.

- FS is supposed to be conducted on a quarterly basis although it was not consistent in most of the facilities.

- The study revealed that FSV at the facility levels mostly involved checking of reports and registers. Also, supervisors revisited issues from previous visit. However, there was no talks on what supervisors would do if the issues from the previous visit had not been fixed or solved.

- Supervisors used FS checklists/ guidelines as a tool in performing FS.

- FS was done to build the capacity of staff and not to find fault with staff. Supervisors did not address motivation of staff but concentrated on improving performance.

- Both supervisors and supervisees discussed problems and challenges identified in the course of the supervision and actions were taken to address them.

- Supervisors after each visit, gave copies of guidelines and reports to in-charges of the facilities.

- There is a follow-up after FSV by M&E officers to ensure continue support to staff of facilities.

5.1.2 Adherence of Facilitative Supervision Guideline

- The study revealed that facilitative supervision guideline also known as the standard checklist is used as a tool in performing the FS.

- More so, it was disclosed that the guidelines are developed to shape and direct activities of both supervisors and staff of facilities.

- The research uncovered that, the guideline is designed and documented by the Ghana Health Service (GHS) and the Ministry of Health (MOH) and implemented by health personnel from the regional, district and sub-district health management team within the Region.

- Also, M&E officers from the regional, district and sub-district levels ensure that these guidelines are adhered to.

- Staff of facilities in Wa municipality adhered to guidelines to a large/ great extent whiles those in Wa-West adhered to guidelines to a small extent.

5.1.3 Contribution of Facilitative Supervision to Quality Healthcare

- The study revealed that both supervisors and supervisees have become more disciplined and confident as a result of the implementation of FS.

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- Again, supervisors and supervisees communication skills and human relations have improved.

- Feedback from supervisors after supervision actually informs the GHS and MOH as to how policies and guidelines should be designed and documented.

- Supervisees performance at work have improved with maternal and child health care also improving.

- Improved patient satisfaction and a reduction in complications were attributed to the implementation of facilitative supervision.

- The study found that, the intervention motivates staff to perform well which reflect in the quality of care clients receive from the facilities.

5.1.4 Challenges of Facilitative Supervision

The study unearthed that inadequate logistics, travel expenses, inadequate human resource, inadequate time prior to FS and irregularity of FSV were the challenges that bedevil the implementation of FS.

5.2 Conclusion

The study investigated how Facilitative Supervision is conducted in health facilities in the UWR, adherence to facilitative supervision guidelines, contribution of FS to quality healthcare and finally the challenges associated with Facilitative Supervision. The study concludes that, FS is very important in the provision of primary health care. It has helped to build the capacities of staff of facilities by making them discipline, confident as well as improve their communication skills. More so, improvement in maternal and child health care in all the facilities studied is partly attributed to the implementation of facilitative supervision. Despite these positive contributions, the

implementation process is faced with challenges such as inadequate logistics, travel expenses, inadequate human resources, and poor road networks. These challenges were pronounced in the Wa West district than in Wa municipality.

5.3 Recommendations

- Organization of resources for planning and conducing Facilitative Supervision: It is very costly to do facilitative supervision and until there is proper planning and budgeting for logistics, transportation expenses and human resource, there is high probability of the intervention failing. Implementers and policy makers (MOH/GHS) of the intervention (Facilitative Supervision) should properly plan by taken into consideration all the resources needed to ensure effective application of Facilitative Supervision.

- Frequency of Facilitative Supervision: The study showed that FSV was not regularly conducted hence it is important that future FS dwells on performing adequate FSV by ensuring that health facilities are regularly visited. This will strengthen staff and also help them make every effort in ensuring that the right things are always done.

- Information to staff prior to FSV: A finding of the study revealed that notification to supervised staff prior to FSV is very short. It is therefore relevant for supervisors to consider giving supervised staff amble time to prepare for FS. This will allow staff who would be off duty to equally prepare and participate in the exercise.

- Addressing staff motivation: The study demonstrated that FS did not address staff motivation but concentrated on areas of improvement. Future FS should address staff motivation in the form of rewards to staff who perform well. This

will boost their confidence and motivation as well as encouraging staff to do more.

- Future research should look at expanding the scope of the study context to aid generalization of findings.

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APPENDICES

Appendix A: INTERVIEW GUIDE FOR SUPERVISEES

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FACULTY OF PLANNING AND LAND MANAGEMENT

DEPARTMENT OF GOVERNANCE AND DEVELOPMENT

District: …………… Facility Name: ………………. Type: 01 [Urban]; 02 [Rural]

Pre-interview Guide

1.   Introduction.

I am Faustina an Mphil Student from the University for Development Studies, Wa Campus, and Studying Development Management. Please can you introduce yourself?

2.   Proceed to some version of the following script:

I am glad you have offered time to be interviewed. Let me explain how this will work. I will spend close to 45-minutes in this interview that will be tape recorded, transcribed, and then edited into something we call a "profile" that will include only your words, with my questions edited out.

In this interview, I would like to focus on facilitative supervision within the health services sector, how staff of facilities adhere to guidelines of facilitative supervision

and how facilitative supervision has contributed to health care delivery in the Upper West Region.

I would be pleased you focus on the health services, how you and members of this facility understand and implement Facilitative Supervision. You have the option of whether or not to be identified or remain anonymous in the final profile. I will send you a permission form where you can indicate the level of confidentiality you want to sustain. I will not use your profile in any way that you do not personally approve."

Interview Questions

Part One: How facilitative supervision is carried out in health services management in the Upper West Region.

1. What is your understanding of facilitative (supportive) supervision? Is facilitative supervision practiced in your facility? If it's not practiced in your facility why?

2. What form of Facilitative supervision do you practice in your facility and why?

3. Who does the facilitation?

4. Do you think a facilitator should possess certain qualities? What are these qualities?

5. Can you say facilitators who come to this facility possessed any of the qualities you mentioned above?

6. How is the form of facilitative supervision mentioned carried out in your facility?

7. How often is it done in your facility?

Part two: How Staff of Facilities Adhere to Guidelines of Facilitative (supportive) Supervision

1. Do you have guidelines for facilitative (supportive) supervision?

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2. Are the guidelines documented? Are they accessible to staff of facility? Who ensures that these guidelines are adhered to?

3. Do staff adhere to facilitative supervision guidelines at will or with some amount of enforcement measures?

4. Do you agree that FS guidelines have been adhered to?

5. In what ways do you think adherence to FS guidelines have been achieved?

6. Please indicate your agreement to the level at which FS guidelines have been adhered to.

7. At what point do you think there are no adherences to FS guidelines?

8. What in your opinion is responsible for the non-adherence to FS guidelines at health services facilities?

9. To what extend do you think adherence to FS guideline can be improved?

Part three: How facilitative supervision has contributed to health care delivery in the Upper West Region.

1. To what extent do you agree that facilitative supervision has contributed to health care delivery?

2. What is the reason(s)?

3. Please explain in the following areas, how FS has contributed to health care delivery?

   a) Staff performance

   b) Implementation of health care policies

    c) Quality of health care

    d) Improvement in professional service delivery

4. Please indicate your level of satisfaction on FS as an alternative to other forms of supervision?

Thank you for spending time with me in this interview. I'm most grateful

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Appendix B: INTERVIEW GUIDE FOR SUPERVISORS

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UNIVERSITY FOR DEVELOPMENT STUDIES

FACULTY OF PLANNING AND LAND MANAGEMENT

DEPARTMENT OF GOVERNANCE AND DEVELOPMENT

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District: ……………… Facility Name: ………………. Type: 01 [Urban]; 02 [Rural]

Pre-interview

3. Introduction.

I am Faustina an Mphil Student from the University for Development Studies, Wa Campus, and Studying Development Management. Please can you introduce yourself?

4. Proceed to some version of the following script:

I am glad you have offered time to be interviewed. Let me explain how this will work. I will spend close to 45-minutes in this interview that will be tape recorded, transcribed, and then edited into something we call a "profile" that will include only your words, with my questions edited out.

In this interview, I would like to focus on facilitative supervision within the health services sector, how staff of facilities adhere to guidelines of facilitative supervision, how facilitative supervision has contributed to health care delivery in the Upper West

Region and ascertain how adherence to FS guidelines differ in rural and urban health facilities.

You have the option of whether or not you want to be identified or remain anonymous in the final profile. I will send you a permission form where you can indicate the level of confidentiality you want to sustain. I will not use your profile in any way that you do not personally approve."

Interview Questions

Part One: How facilitative supervision is carried out in health services management in the Upper West Region.

1. What is your understanding of facilitative (supportive) supervision? What are the types of facilitative supervision?

2. Who does the facilitative supervision? What qualities do these facilitators need to possess? Would you say you possess such qualities?

3. Which of the types mentioned do you do most and why?

4. How is the type(s) mentioned above carried out?

5. How frequent is the supervision done and why?

Part two: How Staff of Facilities Adhere to Guidelines of Facilitative Supervision

10. Do you have guidelines for facilitative (supportive) supervision? How were these guidelines established or developed?

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11. Who were involved in the establishment of these guidelines?

12. At what level did staff of health facilities get involve in the development of the guidelines?

13. Are the guidelines documented? Are they accessible to staff of facilities?

14. Who ensures that these guidelines are adhered to and why?

15. Do staff adhere to facilitative supervision guidelines at will or with some amount of enforcement measures?

16. In what ways do you think adherence to FS guidelines have been achieved?

17. Please indicate your agreement to the level at which FS guidelines have been adhered to.

18. At what point do you think there are no adherences to FS guidelines?

19. What in your opinion is responsible for the non-adherence to FS guidelines at health facilities?

12. Please indicate your level of satisfaction on FS as an alternative to other forms of supervision?

Part three: How facilitative supervision has contributed to health care delivery in the Upper West Region.

5. To what extent do you agree that facilitative supervision has contributed to health care delivery?

6. What is the reason(s)?

7. Please explain in the following areas, how FS has contributed to health care delivery?

    e) Staff performance

    f) Implementation of health care policies

g) Quality of health care

h) Improvement in professional service delivery

Thank you for spending time with me in this interview. I'm most grateful

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Appendix C: OBSERVATION CHECKLIST

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District: ……………… Facility Name: ………………. Type: 01 [Urban]; 02 [Rural]

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5. *Introduction.*

I am Faustina an Mphil Student from the University for Development Studies, Wa Campus, and Studying Development Management. I'm here to observe how facilitative supervision is carried out in your facility to enable me write my thesis as part of the requirement for the award of my certificate. As part of my observation, I may ask questions where necessary. Your time and support will be of immense help for the success of my study.

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ITEM	YES	NO	COMMENTS
FACILITATIVE SUPERVISION IN HEALTH FACILITIES			
Facilitative (supportive) supervision is done in group/team			

Facilitative (supportive) supervision is done by a health personnel			
Supervisors used standard checklists			
The objective of supervisors is to improve quality and not to collect data			
Supervisors practice active listening and other communication skills when doing supervision			
Supervisors take enough time to understand facility problems			
Staff of facility are helped by supervisors to identify and solve their problems			
Supervisors provide training that facility staff need to provide high quality service			
Supervisors provide staff of facility with information they need to discharge their duties well			
Supervisors observed the day-to-day activities of the facility			

GUIDELINES OF FS			
Are there guidelines for supervision?			
Supervisors used guidelines			
Guidelines are documented			
Supervisors ensure guidelines are adhered to			
Staff of facility adhered to FS guidelines at will			
CONTRIBUTION OF FS TO QUALITY HEALTH CARE			
Supervisees are appreciative to FS			
Has FS helped in the output of staff			
Do Supervisors attribute good performance by staff to FS initiatives			
Are there specific instances staff indicate as a result of FS certain			

services were delivered according to planned work			
Do both Supervisor and staff discuss successes of work as a result of FS			