وزارة الصحة	كلية الصحة العامة School of Public Health القدس- فلسطين	جامعة القدس

Deanship of Graduate Studies
Al-Quds University

Status of Supervision in Primary Health Care Sector at the Palestinian Ministry of Health- Gaza.

Maysoun Salem Suliman Turban

MPH Thesis

Jerusalem-Palestine

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Dedication

To my family: Parents, husband, daughter, brothers, sisters, and sisters in law, for their patient, endless support and encouragement.

Declaration

I certify that this thesis submitted for the degree of Master is the result of my own research, except where otherwise acknowledged, and that this thesis (or any part of the same) has been submitted for a higher degree to any other university or institution.

Signed_____

Maysoun Salem Suliman Turban

Date:

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Abstract

Supervision remains an important aspect for empowering, motivating and enhancing quality of work. The overall aim of this study was to assess the status of supervision at governmental primary health care and perception of both supervisors and supervisees toward the supervision. That's could help in improving the situation for the benefit of staff and organization.

A descriptive, analytic design with survey sample for supervisors and a systematic stratified random sample for supervisees were used and was conducted between the year 2006-2007. A two standard questionnaires were developed. The sample size for supervisors was 300 subject, with response rate 81.5%. The selected sample size for supervisees was 200 subject with response rate 86%.

The analysis of the quantitative extracted six domains that reflected MOH/PHC supervisors perceptions. These are managerial role, quality improvement, human resource management, supervisory approach, facility and environment management and communication and support. Four domains that reflect the supervisees perceptions, including management behavior, communication and support, fairness, and involvement. The study showed that the supervisors positively perceive the supervision at PHC by 72% and the supervisees by 66.9%, but their perceptions could be improved. The study clarified the general picture of PHC staff by demonstrating their personal, organizational and supervisory characteristics and provided some insights into the relationships between these variables. The identified factors for both supervisors and supervisees as well the organization and supervisory variable that have impact on staff perception needed to be taken by policy maker in order to improve their perception.

The supervisory variables that showed to have no effect needed to be evaluated in other study in order to detect there effect on work.

ملخص الدراسة

وضع الإشراف في الرعاية الصحية الأولية بوزارة الصحة

يعتبر الإشراف بكافة أنواعه أساسي في الرعاية الصحية الأولية، و ذلك لما له تأثير علي كفاءة العمل و العاملين بالمؤسسة، كما أن الإشراف لم يتم التطرق له في الرعاية الصحية من قبل الباحثين، لذلك تم اختيار هذا الموضوع. تهدف هذه الدراسة إلى فحص وضع الإشراف و المشرفين في الرعاية الأولية بوزارة الصحة، و معرفة وجهة نظر الموظفين تجاه هذا الإشراف، كما أنها ستضيف معرفة تأثير العوامل الديموغرافية و الإشرافية على المشرفين و العاملين في الرعاية الأولية. هذه الدراسة وصفية تحليلية، أخذت للمشرفين جميعهم، أما العاملين فقد تم اختيارهم بعينة عشوائية طبقية. و قد استهدفت جميع العاملين في الرعاية الأولية من مشرفين و العاملين. تم جمع البيانات من خلال استبان تحتوى على مجموعة من المعطيات الشخصية و الوظيفية التي تؤثر على وجهة نظر الموظفين و المشرفين، و إعطاء فرصة لهم لإبداء رأيهم في عملية الإشراف بالرعاية الأولية. و من الجدير بالذكر أنه تم توزيع 300 استبان على المشرفين بالرعاية و قد استجاب 244 مشرف، و كانت نسبة الاستجابة 81% . أما العاملين من جميع الفئات فقد تم توزيع 200 استبان و قد استجاب منهم 172 موظف، و كانت نسبة الاستجابة 85%. استخدم البرنامج الإحصائي " SPSS" و تم اختبار النتائج باستخدام اختبارات إحصائية مثل اختبار" T-test" و اختبار" ANOVA ". لقد استخدمت الباحثة ستة عوامل للمشرفين وأربعة عوامل للموظفين لمعرفة توجهاتهم للإشراف و قد سجلت الدراسة أن توجهات المشرفين تميل إلى تقبل أدوارهم الإشرافية بمقدار 72%، و أن توجه الموظفين ايجابيا بمقدار 66.6% و أوضحت الدراسة أن نسبة الراغبين في الاستمرار بالعمل من المشرفين 62.9% بينما نسبة الموظفين الذين يستمتعون في عملهم 78.9%.

خرجت هذه الدراسة بعدة مفاهيم و التي يتوجب على صناع القرار أخذها بالحسبان، منها ضرورة مشاركة الطاقم بالقرارات و وضع السياسات و القوانين الخاصة بالإشراف، من أجل جعلهم يتبنوها و يطبقونها في الرعاية الصحية الأولية.

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List of abbreviations

AM/S	Administrative Supervision
ANOVA	Analysis of Variance
CBD	Community Based Disability
CHW	Community Health Worker
CS	Clinical Supervision
DPHC	Department of Primary Health Care
GDP	Gross Domestic Product
IMCI	Integrated Management of Child Illness
IVF	Invetro Fertilization
MBI	Maslach Burnout Inventory Scale
MCH	Mother and Child Health
MOH	Ministry of Health
MSH	Management Science of Health Organization
NGOs	Non-Governmental Organizations
OH	Occupational Health
Ph.D	Philosophy of Doctorate
PHC	Primary Health Care
PLO	Palestinian Liberation Organization
PNA	Palestinian National Authority
PWE	Psychological Work Environment
SD	Standard Deviation
SPSS	Statistical Package for Social Sciences
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing
UNICEF	United Nation Children's Fund
UNRWA	United Nations Relief and Works Agency
USAID	United States Agency for International Development
WHO	World Health Organization

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Definitions of terms

Supervision:	The way of ensuring competence, effectiveness and efficiency through observation, discussion, support and guidance.
Supervisor:	The person usually in the middle who is responsible for major task of organization and performs supervisory activities.
Internal supervisor:	Is the person who works inside the organization
External supervisor:	Is the person who was sorted out from the outside organizations
Supervisee	Practitioner in any clinical setting, health care support staff.
Perceptions:	A process by which individuals organize and interpret their sensory impressions in order to give meaning to their environment.
A practitioner:	Is anyone offering a professional service to a client, so the term refers equally to doctor, psychiatrist, psychotherapist, nurse, lawyer, teacher and so on.
Primary Health Care:	Primary care the principles of accessible, comprehensive, continuous, and coordinated personal care**.** Providing services to people based on preventive care such as immunization, antenatal care and so on.
Quality:	In health care, "quality" refers to the presence of certain services and to how they are provided to intended beneficiaries**.**
Management:	Getting things done through and with people within the available time and resources, by directing and motivating individuals.
Human Resource Management:	The planning of present and future human needs including recruitment, training, development, compensation and selection

of employees.

Communication: Is the process of exchanging information and understanding from one person to another.

Chapter 1: Introduction

1.1 Research Background

Supervision is a concept that has been prominent in human race for a long time and behind that good supervision produces positive out comes of organization (Consedine, 2004). One of the important feature to be considered in any organization for successes, is an effective supervision at all levels, supervision plays a vital role in maintaining the quality of performance of health providers and the services they deliver. Supportive feedback is also highly valued by health providers and helps to motivate them in their work (WHO, 2004).

Staff at every level, from service delivery to administration, needs supervision as it's methods work for a whole range of organizational levels and functions (MSH, 2006). In health organizations, the needs and demands for the highest quality management in all health care activities are growing to such degree, that survival has become an issue for some of today's healthcare organizations. As it is known, supervisory position within the administrative structure has been acknowledged as a difficult and demanding one (Haimann, 1991). The lines of supervision, like a chain of command, as one person is supervised by another with more responsibility, who is in turn supervised by someone else higher up in the organization, and so on (MSH, 2006). Fone (2006), sees supervision as two sided relationship between supervisors and supervisees, depend on the need of supervisees which seen as essential component of professional practice, and it is applicable to people at all levels of practice **(**Fone, 2006**)**.

Supervision is an important management tool which could be used to improve staff performance, and to monitor, to identify, and to address problems early. Supervision helps the organization to achieve its objectives and to improve the performance of the workers (MSH, 2006). Added to the benefit of supervision, effects on quality of care, reducing stress, increasing skills and job satisfaction (Bégat, Berggren, Ellefsen and Severinsson, 2003).

Increasing pressure on supervisees within the current climate in health care rinses the need for more accessible supportive mechanism which supervision may provide, as it encourages professional development and personal growth (Gordon, 2000).

The literature focuses on supervision shows a great needs for it while there is still certain lack of it's clarity (Lindgren, Burline, Holmlund and Athlin, 2005). Supervision is seen as complex concept for all health professionals (Kilminster and Jolly, 2000; Alun, 2006). Some literature shows very clearly that there are certain general principle that guide supervisors work regardless of the culture or country (Hyrkäs**,** 2006). Supervision plays an important role in postgraduate medical education (Kilminster and Jolly, 2000). As well it plays an important role in many disciplines. But there is insufficient knowledge of how it helps profession (Alun, 2006).

Palestinians are experiencing instable political status, as well there are many obstacles facing supervisors in Ministry of Health (MOH). So the researcher conclude that there is a huge need to effective supervision as it helps them to provide high quality work and saving their limited resources. There is an international direction towards developing a national supervisory systems, and guidelines in order to achieve the health for all and all for health policy. However, routine supervision is one of the weakest areas in many developing country settings. Lack of transportation means, energy, financial resources, as well as inadequate training in

supervisory skills, approach to supervision and supervisors' attitudes are some of constraints reported to supervision (WHO, 2004).

This analytical cross sectional study is intended to explore the status of supervision at Primary Health Care facilities (PHC), in the main health care provider, which is MOH, to reflect the perception of supervisors and supervisees towards supervision. The study used structured questionnaires to assess supervisors and supervisees perception. With the best of researcher knowledge this study is the first one considering supervision in PHC in Palestine, so it will be a basis for further researches regarding supervision.

1.2 Research Problem

In Palestine, a very little studies mentioned supervision, one of them is MARAM project survey of women and child health in the West Bank and Gaza Strip it considers that, Palestinian health facilities to develop and use functional management system needs to be supported in supervisory system and health facilities infrastructure needs management tool, as challenges that needs further examination. This study will focus on supervision weak and strong points in the PHC, area needs improvement, supervisory system and tools, as well recommendation for future improvement from supervisors point of views, supervisees and the researcher. Even it doesn't answer all the questions about supervision, it gives signals which help encourage positive practicing, and pointed the major obstacles the supervisors facing.

1.3 Justification of the Study

Supervision is an universal issue as the literature from various places all over the world points to it's importance in developed, developing and under developed countries. In Palestine, this

system has been adopted for improving human resources at the MOH and there is a supervisory position with different levels but it is undefined and needs more clarification.

At the PHC which is considered a major health care sector in the MOH, there is a considerable need for dealing with the instability of situation and scarcity of resource by good supervision. The effective supervision provides the organization with a good work situation, and productivity where we are in a enormous need specially in our instable situation which we live nowadays. There is a concentration on supervision and its effectiveness internationally as there are clear guidelines, well known directions, roles and regulations that's help the people in designing the way they deal with others. Many of these guidelines were missed or not improved in Palestinian context. There is a change in the Palestinian health system as effected by the political situation as well these included; changes in age structure of population and economical, informational development, these changes accompanied changes in the management system as well. Palestinian health care system and services provided faced a high pressure, and needs for development to face the new challenges in economy and technology in the world around us, these could be enhanced with good supervision.

PHC are wide range services characterized by relatively distance geographical areas with important and various services provided to all individuals based on accessible and affordable services, as well the centers are distributed faraway from their management center. That's points to the importance of both internal and external supervisors for each centers, to maintain the supervisees with continuous follow up in order to provide high quality and safe care. Therefore, this study is a unique trial in developing and understanding what factors affects supervisors and supervisees.

Studying supervision is very important in term of building and developing the Palestinian organization in the light of scarce resources and economical constrains. In addition, the

number of international studies relating to the impact of supervision is growing all the time. However, the supervision intervention itself has remained almost without attention, and studies of its content, process, working methods, theoretical basis and evaluation are still minimal (Hyrkäs**,** 2006). All the above mentioned data and other issues justify the needs to study supervision in Primary health care.

1.4 Objectives of Study

1.4.1 General Aim of the Study:

The aim of this study is to assess the supervision status at primary health care facilities at Ministry of Health-Gaza Strip, in order to better understand it's features and how it could enhance the staff and the supervisor relationships and quality of services.

1.4.2 Specific Objectives of the Study:

1.To assess supervision main features at governmental primary health care facilities.

2.To explore the staff perceptions towards supervision in governmental PHC facilities.

3.To analyze the relationships between, socio-demographic, organizational factors and staff perceptions towards supervision.

4.To explore the strong and weak points of supervision at primary health care.

5.To provide recommendations to the supervisors and managers in order to improve their supervision skills.

1.5 Research Questions

1. Are the supervision system is existing in primary health care sector?
2. What are the main domains of supervision from supervisors perception?
3. What are the main domains of supervision from supervisees perception?

4. Is there a positive and negative perception towards supervision at governmental organizations?
5. What is the relationships between socio-demographic characteristics and perceptions towards supervision?
6. What are the strong and weak points of supervision systems?
7. What is the supervisor activities performed at primary health care?
8. Does the supervisor pay adequate concern to support supervisees?
9. Is there difference in perceptions about supervision regarding to level of education, years of experience, and organizational and supervisory variable?
10. How organizational factors affect supervisees perception towards their supervisors?
11. What are the supervisory tools used in PHC?
12. What are the recommended strategies to development of supervision?

1.6 Feasibility and Cost

This study was conducted at primary health care centers in Gaza Strip in the five governorates as a requirement for the MPH at the School of Public Health, Al-Quds University. Discussion and exchange of ideas with responsible persons from the School of Public Health, PHC Director General and different specialties, made the implementation of this study more feasible. This study was self funded; the researcher was responsible for all the needed costs. It is supervised by the School of Public Health and PHC administration, they provided the researcher with the necessary research support such as access to study population, and ethical approval to conduct the study.

1.7 Context of the Study

The researcher provided some helpful background information about health care sectors in order to put in some perspective to the health care system. As primary health care can be influenced by many factors concerning the demographical, socio-economical and political circumstances. The current study conducted at the Gaza Strip in Palestine so some of the demographical, socio-economical and political factors were important to the study as it affects the primary health care facilities.

1.7.1 Demographic Context:

Palestine is a small country, the total surface area is approximately 27,000 Km^2, has it's importance as it's located in North East of Asia, it is bordered on the west by the Mediterranean, on the east by Syria, and Jordan, on the north by Lebanon and on the south by the Sinai and the Gulf of Aqaba (Annex 1) (MOH, 2006).

As it has a strategic location many foreign forces tried to occupy it over the centuries. However, after the II World War at 1917, the British mandate gifted it to the Jewish according to the Belfour Declaration, as a result, struggle started with the Jews since then. After the Arab-Israeli war in 1948, Palestine separated geographically into two area, the West Bank and Gaza Strip (MOH, 2006).

Gaza Strip is a narrow piece of land lying on the coast of Mediterranean Sea between Egypt and Israel, It is 45 kilometers long and 6-12 kilometers wide with an area of 362 square kilometers and an altitude of 0-40 meters above the Mediterranean Sea level. It was divided into five governorates after the peace accord which was signed between Palestinian Liberation Organization and Israel, which provided the Palestinian with the National Health Authority (NHA). These governorates are; North Governorate, Gaza Governorate, Mid-Zone Governorate, Khan-Younis Governorate, and Rafah Governorate (MOH, 2006). Gaza Strip is

very crowded place where the population is mainly concentrated in the five cities and small villages and eight refugee camps (MOH, 2006). Supervisors distributed over all these governorates according to it's clinics number.

After the Israeli unilateral disengagement in August 2005 from 22 settlement the borders between cities and villages were disappeared and the movement has become more easily internally, in fact, the Israeli unilateral disengagement has imposed huge prison for the Palestinian people (MOH, 2006).

The population number in Gaza was estimated by the year 2005 1,389,789 with population density of 3,808 inhabitants/Km^2 and 69% of them are refugees (MOH, 2006). This large number in the small surface area with this density creates a worried health, educational and economical problem and made a pressure on supervisors role. The worst is that 46.3% of the population in Palestine is under age 15 years and the percentage of Palestinian who are above 65 years is 2.8%. This made Palestinian a young population which made an economical burden on the NHA. The median age in Palestine is increased from 16.4 in 1997 to 16.7 years in 2004 (MOH, 2006). This youth population need future plan to improve PHC activities which made a burden over the supervisors.

The natural increase rate in Palestine is 3.3%, while the population natural increase rate estimated in Gaza as 3.1% (MOH, 2006). This could increase the load on the MOH workers as it is considered the major health care providers, led to increase the value of supervision. The researcher assumes that these demographical and political situations affect health care systems plans and management systems which badly impacts on supervisors urged them to increase their efforts to provide better health services.

1.7.2 Socio-Economic Context:

Gaza Strip was completely assumed authority after the Israeli disengagement in August 2005. However, the Israeli still has the upper hand over the borders which force more economical constrains on it. Palestinian economy has been steady decline due to strict closure and violence during the recent Intifada (MOH, Jan. 2005; World Bank[a], 2007). GDP levels have been maintained by government and private consumption funded by donor aid, while investment has fallen to low level. Employment, and particularly youth employment, must be the essence of any Palestinian economical strategy (World Bank[a], 2005). Despite, large flow of aid, unemployment and poverty have continued to raise (World Bank[a], 2007) that's made a burden on Ministry of Health managers and supervisors. The number of Palestinian workers in Israel decreased from 135,000 in 1999 to 36,000 in 2005. The workers in Palestine also decreased from 453,000 in 1999 to 135,000 in 2005 (MOH, 2006). The World Bank reported that the unemployment rose from 9.5% in 1999 to nearly 16% in 2006 however, it is higher in Gaza than the West Bank (World Bank[a], 2007). Increased scarcity of jobs has led to more part-time workers. Also the increasing level of unemployment increased burden on Palestinian Authority by overstaff in its supervisees (MOH, Jan. 2005; World Bank[a], 2007). This revealed sharply increasing the poverty rate in Palestine was 44% in 2005 (MOH, 2006). The poverty increases in 2006 at Gaza Strip to reach 51% (World Bank[a], 2007). This situation is a result of Israeli enforced restriction on Palestinian movement, military operations, land confiscation and leveling and the construction of barrier. In addition to other escalating activities imposed on Palestinian people (MOH, 2006). All the previous factors enforce the Palestinian managers to balance the work load with the employment levels.

In health, total expending is about 13% of GDP among the highest in the region. 53% to 45% of capital expenditure were spent by MOH (MOH, Jan. 2005). PA expenditure on health services has been driven by increasing public employment, with almost no funding for capital

expenditures and a diminishing share for operating costs (World Bank[b], 2007). As well Gross National Product (GNP) has been subjected to high fluctuations during the last five years (MOH, 2006). Added to socio-economical factors duo to political and economical instability the Palestinian shows the highest fertility rate in the region, the total fertility was calculated as 4.19 (MOH, 2005). They shows high interesting in education as there is 2,276 school in Palestine supervised by both Ministry of Education (MOE) and UNRWA. And only the illiterate mothers percent was .03% and fathers .01% which considered as low rate in relation to the world (MOH, 2006).

In fact, these factors are seen as not only affecting the life and experience of Palestinian, but also they affect and affected by the organization structure and management style, as they increase the burden over the manager and policy makers to improve and to satisfy the customers expectations. The supervisors play an important role as a link between managers and supervisees whom in contact with the people receiving care so it is worthy for the supervision to consider in the researches.

1.7.3 Health Care Context:

It is worthy to mention some information about health care system and health status of Palestinian, as other relevant contextual characteristics, which affect and affected by supervision. Since the Palestinian has taken their responsibilities of health at 1994, a great improvement and development in term of quantity and quality of health services including human resources development were taken place (MOH, Jan. 2005).

Palestine is a developing country, facing many obstacles and troubles vary between economical and political as well health related (MOH, Jan. 2005). The Palestinian health care system has been developing side by side with the development of Palestinian society over the

past years (MOH, Jan. 2005). However, it is extraordinary fragmented, Palestinian Ministry of Health is financed by a patchwork of patient payments, taxes, donor contributions and social insurance revenues. (MOH, Jan. 2005). Some indicators are interesting to mention in this study as indicator for the progress of health services in Gaza Strip. Infant Mortality Rate reported in Gaza Strip as 20.5 per 1000 at 2004, this reflects high mortality rate and the need to improve health care system but still acceptable in relation to other regions as 62 in Turkey, 41 in Egypt, 40 in Tunisia, 21 in Jordan and 7 in Israel (MOH, 2005). Crude Death Rate was reported in Gaza 3.1 per 1000, the most leading causes of death among adults are non communicable disease, which is similar to developed country causes including heart disease, cerebro vascular accident (MOH, 2006).

A lot of developments had occurred in the last few years, like increase number of hospitals, facilitate access to PHC, development of new department as well new specialties, and new diagnostic procedures, but still there is a need to develop other important services which is sophisticated (MOH, Jan. 2005), from our believe that low quality cost more, we are in a huge need to these services due to our political, economical instability and closure of borders. Assessment was performed by expert in Palestinian MOH on 2005 shows that the current provision of health services does not respond to the needs of the population and no systematic review of appropriateness of care is performed and the two main pillars of the system, namely the PHC network and hospitals seem to work separately. The analysis of the PHC assessments revealed the following core problems, weak gate keeping function by the PHC, shortage of Environment like drugs, limited supply of services as lack of laboratories, lack of confidence in PHC centers, shortage of human resources and inadequate distribution and time management and absence of community participation (MOH, Jan. 2005).

It could be urged that the Palestinians will be affected by such factors in managing their organizations. The researcher assumes that factors could be influenced by supervision, as MOH adopted strategy of providing training and developmental opportunities for human resource development among all health care system personnel, provider, and managerial/administrative staff (MOH, 1999).

The Palestinian health care system is a mixture of Governmental, Non Governmental Organization (NGOs), United Nations Relief and Works Agency (UNRWA), and private services delivery. MOH is responsible for a significant portion of both PHC and secondary care and some tertiary care (MOH, 2006). However, The MOH is the health authority responsible for supervision, regulation, licensure and control of the whole health services, the MOH purchases some of tertiary services from other health care providers both locally and abroad (MOH, Jan. 2005). A significant challenge for the MOH is to satisfy health need and to facilitate coordination among these service deliverers to ensure rational use of scarce Palestinian resources available for the health sector (MOH, 1999).

1.6.4 Primary Health Care Services (PHC):

Primary health care is the basic level of care provided equally to everyone by providing preventive, curative and rehabilitative services to maximize health and well being (MOH, 2005). PHC centers try to offer accessible and affordable health services for all Palestinians regardless the geographical locations (MOH, 2006). Palestinian PHC is a major component of health care system; this system has provided health care to all Palestinian people especially for children and other vulnerable groups (MOH, 2006).

PHC centers in Palestine provide primary and secondary health care services as well as tertiary services. In the Last five years and after the uprising of second Intifada, PHC centers in

Palestine have been developed in a dynamic way (MOH, 2006), but the management system still not developed. As a result of the needs assessment carried out by the MOH- Department of Planning, both at the district and national level, it was determined that the Palestinian society looks for more PHC interventions at the community level with greater emphasis on health promotion, education and prevention (MOH, 1999). Therefore, the national strategy adopted objectives for health tackles specifically the utilization of the full potential of PHC services while improving secondary and tertiary care. The two focus of concern for the MOH with respect to public health as a whole and PHC in particular, have been health promotion and education and environmental health, food safety, water quality and vector control (MOH, 1999). According to MOH policy, PHC centers classified into 4 levels (Annex, 6), offering different health services according to clinic level, these services include maternal and child health, care of chronic diseases, daily care, family planning, dental, mental services and other services. The MOH is working with other health sectors in providing the primary health services, as MOH is considered the main provider with 63.6% from the total PHC centers, followed by the NGOs with 28.3%, then the UNRWA with 8.1% (MOH, 2006).

At the end of 2005, there are 654 PHC centers in Palestine, the total number of PHC was increased compared with 595 in the year 2000, these centers are cared for about 3.7 million people, 129 of these centers are in Gaza Strip, 56 of them were managed by MOH (MOH, 2005; MOH, 2006). Despite increasing the number of PHC centers since the establishment of the PNA, Palestinian health services have been developed much closer to a hospital-based model, with a concentration on a few key public hospitals (MOH, January 2005).

The average ratio of persons per center was 10,774 in Gaza Strip, this ratio is high reflecting the high density in Gaza Strip. PHC system in Gaza Strip is well established and functioning

despite the high population density and the over crowded of population, but these changes doesn't accompanied by progress in the supervision systems (MOH, 2006).

The number of staff at primary health care in Gaza were 2117 according to PHC directorate at Rimal clinic and MOH (2006), about 300 of them are supervisors divided on different specialties and different levels. About 1700 were subordinate and distributed in various disciplines, these numbers were changeable frequently according to clinics needs and due to instability of PHC/MOH situation. However, efficiency and effectiveness of the health care system will only be obtained if a strong move towards decentralization and strengthening of PHC network is pursued (MOH, Jan. 2005).

In summary, this chapter include the general explanation of the study which aimed to explore the status of supervision at PHC in Palestinian MOH and to assess some strong and week points of supervisors. Justifications of doing this study were mentioned above. Brief discussion about context of the study including demographical, socio-economic and health care context all were mentioned.

1.8 Definitions:

Supervision:

It is the way of ensuring competence, effectiveness and efficiency through observation, discussion, support and guidance (Jaralla and Khoja, 1998).

Supervisor:

The person usually in the middle position between higher managers and supervisees, who is responsible for the organizations task and perform supervisory functions (Tavrow, Young-Mikim and Malianga, 2002).

Internal and external supervisor:

Internal supervisor is the person who works inside the organization while the external supervisor that who was sorted out from the outside organizations (Todd and O'Connor, 2005).

Supervisees

Practitioner in any clinical setting, health care support staff will had supervisor (Telfored ,Wrekin and Shtopshire, 2005).

A practitioner:

Is anyone offering a professional service, the term refers equally to doctor, psychiatrist, psychotherapist, nurse, lawyer and teacher (Sloan and Watson, 2002).

Primary Health Care:

Is a vital means through which not only many preventive, diagnostic, treatment, rehabilitative and support services are provided for individuals, but importantly the means through which many public health services and interventions are provided for local communities (WHO, 2005).

Perceptions:

A process by which individuals organize and interpret their sensory impressions in order to give meaning to their environment (Robbins, 1998).

Quality:

In health care, “quality” refers to the presence of certain services and to how they are provided to intended beneficiaries (Haimann, 19991). WHO defining quality: "Proper performance of interventions, that are Known to be safe, that are affordable to the society in question and that have the ability to produce an impact on mortality, morbidity, disability, and malnutrition" (WHO[b], 2007).

Management:

Getting things done through and with people within available time and resources, by directing and motivating individuals (Haimann, 19991).

Human Resource:

The planning of present and future needs of the department including recruitment, training, development, compensation and selection supervisees (Haimann, 19991).

Communication:

Is the process of transmitting information and understanding it from one person to another (Haimann, 19991).

The next chapter discuses the literature review about what was written on supervision and the studies conducted from different places and authors. The researcher tried to cover the major factors that affect on supervision, which may help the policy makers and supervisors to recognize the most important aspect of supervision. Hopefully to cover most important points.

Chapter 2: Literature Review

This chapter reviews the literature about supervision types, and the different issues that affect on supervisors perception to their role. As well it's important to focus light on supervisees perception. It starts with historical review, definitions, focus on different types of supervision. It explores the different responsibilities and models of supervision. Followed by explanation of different variables like supervisory activity and other variables which are illustrated in the literature and could be present in PHC centers. Furthermore, it reviews the related supervision studies at primary health care setting. A conceptual framework was illustrated by the researcher and demonstrated in the next chapter.

2.1 Historical Review

The word supervisors and supervision had different meanings from place to another, as well it changes from past to nowadays. Supervisor has its roots in Latin; it means "look over" (O'Donoghue, 2003). The supervisor is the person assigning cases, organizing work and taking decisions related to the organization, he/she was basically an 'overseer' according to Smith (2005), as well he clarifies the word as in Latin they call it super vidêre, super means 'over', and, vidêre means 'to watch, or see' (Smith, 2005). In Germany supervision is called a Vorabeiter which means fore worker, while in England the word "charge hand" is used, he returned the use of supervisors for 100 years ago, as it was used for a group of artisans (O'Donoghue, 2003). August (2006), mention that practicing effective therapeutic supervision since 100 years ago (August, 2006).

The historical inception of clinical supervision (CS) which is one type of supervision, takes place at the United States of America in the year 1920/1930s, and in the United Kingdom, in Scandinavian countries like Finland, the history of supervision is more current as trace back to the 1960s (Yegdish, 1999; Cutcliffe and Hyrkäs, 2006; Hyrkäs, 2006).

In profession, supervision in the past was started as multidisciplinary with social work from the late 19 the century (O'Donoghue, 2003 and Smith, 2005). Turning into psychiatry and psychology supervision in the early 20 the century, and to the nursing emerging in the early 1990s (O'Donoghue, 2003). Hyrkäs (2006), as well mention that clinical supervision was introduced to nursing more than two decades ago.

The 1902 midwifes Act in UK were appointed to supervise the practice of midwives and ensure that the midwives obeyed their role, the supervisor was named "inspector" and the name changed in 1936 to "supervisor" of midwife, and in 1977 the regulations specified that midwives supervisor should practice midwifery (Bentnett and Brown, 1996). The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), set out it's initial supervisory position in 1995 (Edwared, et al, 2005). The concept meaning changed over the years as traditionally supervision has been seen as educational and monitoring, today supervision is seen as staff support (Williamson and Dodds, 1999). As mentioned above we conclude that supervision is newly emerged to discipline and needs to more research and clarification.

2.2 Definitions and concepts of Supervision

Supervision is a complex activity, occurring in a variety of settings, has various definitions, functions and modes of delivery. It is an interpersonal exchange (Kilminster and Jolly, 2000). Clinical supervision, is another type of supervision which has many definitions and models but

it is undefined (Gordon, 2000). This complexity and variety of the supervision concept guide the researcher to explore all definitions and types of supervision in order to provide the reader/s with more clarifications. These definitions reflect the perception of the person who defines it as well according to the program and reasons for supervision. Each supervisory relationship will vary according to the needs and experience of the supervisees and the style of the supervisor (Todd and O'Connor, 2005).

In supervision there is attempt to change supervisees way of working, who goes to affects on patient, who turned to effect on large number of people in their life (August, 2006). The supervision is a necessity in today's health care environment, it is important in professional development as driven by the need of supervisees (Fone, 2006). In Arab health care organizations, it is viewed as a way of ensuring competence, effectiveness and efficiency, through observation, discussion, support and guidance (Jarallah and Khoja, 1998). Supervision is seen as activity carried out to oversee the work of others, productivity and progress of supervisees (MSH, 2006; MacNamara, 2006). Stock-Ward (2003), supported them by mentioning that supervision is an over seeing to the supervisees work, or inspecting their performance in order to ensure that quality services are being provided, and added that supervision can also be a powerful means of fostering personal growth and professional development in staff members (Stock-Ward and Javorek, 2003). On the other hand, the Kenya In-service Reproductive Health Training Curriculum defines supervision as "all the activities that ensure that personnel perform their duties effectively" (MOH/ Kenya, 1995).

Clinical supervision, is a common concept in many practitioners literature like nurses, educationalist, psychotherapist, occupational health, physiotherapist, medicine and others. It is seen to be broad and included in the literature more in health organization than other types of supervision. This supported by Alun (1998), mentions that clinical supervision nevertheless, is

not new, as it is related to many of the human services such as social work, occupational therapy, psychotherapy and its derivatives. It is also an aspect of professional practice (Alun, 1998).

In medicine the following definition of supervision is provided: "the provision of monitoring, guidance and feedback for personal and professional development in the context of the doctor's care of patients" (Kilminster and Jolly, 2000). CS is considered a vital support system for effective, highly qualified health services (Tavrow, Young-Mikim and Malianga, 2002). Many agreement that CS is professional relationships as, it is a support mechanism for practicing professionals within which they can share clinical, organizational, developmental and emotional experiences with another professional in a secure, confidential environment in order to enhance knowledge and skills (Gordon, 2000). It is a designated reflective exchange between two or more professionals in a safe and supportive environment which critically analyses practice through normative, formative and restorative means to promote and enhance the quality of patient care (Howatson, 2003**)**. Farrington (1995), supported that CS is a professional relationship between a supervisor and supervisees that is stuck in the idea of joint responsibility and ownership, each partner plays equal role in terms of commitment and open, honest discussion. The UKCC defines Clinical Supervision as "a term used to describe a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence" (Foster, 1997).

Clinical supervision, supports a less experienced supervisees, and guided more by the experienced supervisor in clinical setting. The CS relationship is characterized by regular, systematic and detailed exploration of a supervisees work with clients or patients (Todd and O'Connor, 2005). With management policy, it is seen as decentralized process as CS was predicated as being a democratic process concerned with professional growth, and occurred in

a good atmosphere of partnership, open-mindedness and support, had no authoritarian suggestions and was in no way to be wrapped (Cutcliffe and Hyrkas, 2006).

The other types of supervision was mentioned by a few group of authors, it was not broad but it is worthy to be mentioned in this review of definitions. They include, Facilitative supervision, is another type which seen as an approach to supervision that emphasizes mentoring, joint problem solving, and two-ways communication between the supervisor and supervisees (Ben-Salem and Beattie, 1996). By district supervisors in Zimbabwe facilitative supervision mentioned as ensuring provider in peripheral primary health care facilities to follow guideline, overcome barriers, improve performance and motivation (Tavrow, Young-Mikim, Malianga, 2002). As supervision is considered an impact on learning and professional development (Lindgren, Bruline, Holmlund and Athlin, 2005). Some use the term educational supervision, which refers to the facilitation of learning within an academic setting the focus is on guidance with regard to specified educational aims and objectives. Often this takes the form of individual or group tutorials sessions (Alun, 1998). Another relatively similar definition for educational supervision, is a method of supervision within a framework of education were the professionally educated supervisors are responsible for a small group (Severinsson and Borgenhammar, 1997).

Research supervision, refers to the systematic supervision of a researcher, which may or may not contribute towards a qualification. Which is similar to Consultative supervision, an arrangement whereby a supervisor can seek help and advice on case work (Alun, 1998). Organizational supervision, simply allows for the focus on issues emerging organizationally, and network supervision, is concerned with the whole network of workers cross organizationally concerned with a particular clients. Common to each type of supervision are

functions of facilitation, education and protection; for the client or patient and the organization (Johen, 1999).

Managerial supervision which has many doubts on it's relationships with clinical supervision. However, some authors support that managerial and clinical supervision are similar, and others were not supportive to this approach. A review of the literature shows that there is a confusion around amalgamating clinical supervision and managerial supervision (Edwared, et al, 2005). A study in Australia found that the nurses in hospital based staff mistrust clinical supervision process, as they may be still confused with managerial supervision (White and Winstanley, 2006). Many support supervision as a management activity and supervisors have a management role in the organization as (MacNamera, 2006). Tanzania MOH defines supervision as "a management function planned and carried out in order to guide, support and assist staff in carrying out their assigned tasks". It involves on job transfer of knowledge and skills between the supervisor and supervisees through opening of administrative and technical communication channel (Tanzania/MOH, 2006). Scandinavian countries stated clearly that having line managers also Similarly, in Finland, having managers, first-line managers or Head Nurses acting as clinical supervisors with their subordinates (Cutcliffe and Hyrkas, 2006).

Others don't support supervision as a management activity or role, and see that there is a distinct difference between clinical supervision and administrative or managerial supervision, and it is important to avoid overlap between clinical and administrative supervisory roles (Todd and O'Connor, 2005). There is an agreement that supervision is not seen as managerial tool in UK in nursing field (Gordan, 2000). Regarding UKCC the clinical supervision Should not be the work out of managerial responsibility, a system of formal individual performance, and should not be as well hierarchical in nature (Farrington, 1995). There is a link between CS and administrative supervision as development and establishment of clinical supervision

should, therefore, involve managers and practitioners with the emphasis on a light touch management influence (Cutcliffe and Hyrkas, 2006).

Administrative or managerial supervision is directed to help the worker to meet organizational requirements. Specifically, administrative supervision addresses supervisees performance in regard to organizational goals, expectations and standards. Administrative supervision is typically provided by a worker's manager or supervisor (Todd and O'Connor, 2005). Managerial supervision, is also concerned with accountability and monitoring of work which has been commissioned by an organization (Alun, 1998).

Administrative clinical supervision is a another unique form of CS in the Finnish CS culture (Sirola-Karvinen and Hyrkas, 2006). Administrative clinical supervision is organized, in health care organizations. The goal of administrative clinical supervision emphasizes quality management based on the organization's mission and vision statements in addition to the supervisee's learning in order to support career development. Administrative clinical supervision is defined as CS targeted at managers, administrators and leaders (Sirola-Karvinen and Hyrkas, 2006).

Teasdale, (2001) described a mixed methods study which attempted to evaluate the effects of CS within a region of the United Kingdom. The authors claim they accessed a sample of 211 Registered Nurse participants, who completed two instruments/ questionnaires and 146 completed critical incident forms, which appear to have served as the qualitative data and indicate the sample size. It is interesting to note that where the respondents could choose their own supervisor, they in majority (78%) elected not to have a line manager acts as a supervisor; whereas where the supervisees were afforded no choice, then 63% of line managers predominated also as supervisors. However, the authors report some quantitative data that suggested supervisees reported more positive factor scores when their supervisor was also

their manager (Teasdale, Brocklehurst and Thom, 2001). A study for a multidiscipline team using a rank order for 17 statements on supervision, the participant asked to rank the statements according to the characteristics of group supervision they wish to engage as 1 for the most important and 2 for the second and so on. Almost all respondent 90% was ranked "Supervisors should be a manager" as the least important one for clinical supervision. The issue of managers also acting as supervisors and the resultant conflicts and confusion that this can create, will be neither new nor surprising. This confusion is well documented in the literature (Cutcliffe and Hyrkas , 2006).

Regardless of the different types of supervision, and the roles of supervisors there is agreement that it is a relationship between two parities supervisors and supervisees. This relationship might be formal or informal, within the organization and this relationships aiming to achieve organizational goals in order to achieve and maintain high quality, efficient and effective services.

2.3 Roles and Responsibilities of Supervision

At primary health care the supervision is comprehensive because of the wide range activities performed and the variety of services provided (Jarallah and Khoja, 1998). Supervision is an activity which performed by supervisors. Supervisors are essential to achieve an organization's mission (Ben-Salem and Beattie, 1996**)**. There is an agreement that the job of supervisors is both difficult and responsible, the tasks and responsibilities are multifaceted and require a variety of skills. Clouder, (2004) argued that supervision is both necessary and beneficial for the organization (Clouder and Sellars, 2004). The Management science of health organization classifies supervision functions to three primary functions: technical assistance, monitoring and evaluation, motivation and support of workers (MSH, 2006). The different researchers

mention different dimensions for supervision responsibilities. These dimensions were arranged according to the researcher conceptual framework as follow:

2.3.1 Managerial Roles:

As the role of supervisors has changed. In the past, the supervisor has directed and controlled what and how work was performed. Today's supervisor need to do more than these roles and to meet the organizational goals he/she fulfills a number of important roles one of these is organizer (Braddock, et al, 1996). According to position: many use the term supervisor, to designate the managerial position that is responsible for a major function in the organization (Mac Namara, 2006). He/she is the person in the middle, since he/she serves as the principal link between higher administration and the supervisees. In developing countries, supervisors are viewed as the main link between health facilities and management (Tavrow, Young-Mikim and Malianga, 2002). One of the four responsibilities mentioned by Hiamann (1991), is that supervisors must be a good boss, a good manager, and leader of the supervisees, and must have the technical, professional, clinical competence, and must be a competent subordinate to the next higher manager (Haimann, 1991).

In relation with the tasks the supervisor is that member of the administration who must make sure that the work gets done (Haimann, 1991). The supervisor helps the supervisees to meet organizational standards (Todd et al, 2005). Supervisors typically have strong working knowledge of the activities in their group (Mac Namara, 2006). His/her responsibility is to see that staff carryout the plans and policies set by executives and middle managers **(**O'Donoghue, 2003). Responsible supervisors are consistent in their actions and in administering policies, are dependable and flexible (Braddock, et al, 1996)**.** That means, he/she is seen as typically responsible for their direct reports' progress and productivity in the organization. Supervision

often includes conducting basic management skills like, decision making, problem solving, planning, delegation and meeting management, and organizing teams, noticing the need for and designing new job roles in the group, hiring and training new employees (Mac Namara, 2006). In relation with the classification supervisors are classified as internal supervisor is the person who works inside the organization while the external supervisor that who was sorted out from the outside organizations (Todd and O'Connor, 2005). A significant proportion of the nursing research on clinical supervision highlights the use of group supervision with an external supervisor (Sloan and White, 2000).

2.3.2 Quality Improvement Roles:

Goal to achieve, productivity to increase, and to reach high quality care is one of the important responsibilities of supervision achieved by supervisors. The style for improving quality in healthcare has changed rapidly over the past decade, as a result of many factors including, increasing number of experience and specialties in healthcare, as well complexity of healthcare delivery and advanced knowledge (Massoud, et al, 2001). As Todd (2005), mentioned the clinical supervision has a range of benefits for both clinicians and the organization, these benefits are, maintain quality and standard performance (Todd and O'Connor, 2005). These benefits also improving the quality of patient care (Farrington, 1995). Supervisors play an essential role as intermediaries who can facilitate the implementation of institutional goals and who can facilitate problem solving and quality improvement (Ben-Salem and Beattie, 1996).

Effective supervisor focuses on training opportunities in order to provide high quality (MSH, and USAID, 2006). As supervisors need to coach and a collaborative team player who works with individuals, to ensure productivity and high quality customer service (Braddock, et al,

1996). Supervision helps to motivate personnel to do a good job; ensure that there is a good quality of care; train personnel to improve their capacity to perform their work activities (MSH and UNICEF, 1998**)**, and training to know the job duties, rules and documents effectively (Zawadsky, 2004).

Providing high-quality services means meeting the needs of clients with a minimum effort, waste, and rework as poor quality results not only in time wasted to redo work, but eventually in the loss of important customers (Ben-Salem and Beattie, 1996). Also, the highest quality in healthcare delivery is needed and demanded to the survival of the healthcare delivery (Haimann, 1997). Today, it is required that administrators and managers be qualified professionals in a health care organization (Sirola-Karvinen and Hyrkas, 2006). Through their technical and administrative roles the clinical supervisors can affected the quality of care at clinic level to service providers in guiding the provider-client interaction (MSH and USAID, 2006). However, supervision is a complex combine of skills that will help to improve the quality of organization. Supervision allows provider to observe activities, detect problems, and solve problems or prevent future problems through supervisors (MSH and UNICEF, 1998), also, to determine staff performance in relation to quality and standard in implementing planned activities (Tanzania/MOH, 1999), and to ensure the quality of program and clinic operations (MSH**,** 2006). Supervision is considered as modern way of improving working relationships among professional groups in order to deliver high quality and effective clinical services (Thomas, 1995). As it is considered one of the vital support systems for effective, high-quality health services (Tavrow, Young-Mikim and Malianga, 2002). With regular and facilitative supervision, it is expected that health care providers will have the guidance, encouragement, and resources they need to perform well Tools to measure directly the quality of district level supervision are needed as the first step in improving supervisory performance

(Tavrow, Young-Mikim and Malianga, 2002). However, there is still very little evidence yet in terms of the effect of CS on the quality of care or on patient outcomes (White and Winstanley, 2006).

The effect of supervision on quality in various disciplines was discussed by many researchers as found at medical profession, ethical accountability range from operating the principle of no harm through to maximizing the quality of care offered to patients. However, supervision provides a practical and economical means of building on experience to ensure quality and optimal standards of care (Clouder and Sellars, 2004).

Clinical supervision, is widely accepted as an essential prerequisite for high quality nursing care perceived quality of supervision was also higher for those nurses who had chosen their supervisors (Edwared, et al, 2005). As the goal of supervision in nursing is to ensure and improve the quality of care (Johansson**,** et al, 2006).

A group interview for multi professional team in study done in Finland exploring the effect of supervision on quality health care proved the importance of knowledge in providing care in quality management as knowledge concept differs in providing health care which depends on practical experience. The findings of this study showed team supervision effect the quality of care more positive (Hyrkäs and Paunonen-Ilmonen, 2001).

A little was written about supervision and it's cost. Masoud (2001), mention that the emerge of new needs for efficient and cost-effective care that increase the customer expectancy is considered the cause of increasing complexity in healthcare delivery (Masoud, et al, 2001). The supervision helps to reduce professional and administration costs (Todd and O'Connor, 2005). As budgetary constraints, and geographic constraints, can result in missed opportunities for quality improvement (Ben-Salem and Beattie, 1996).

The Australian author White (2006), in his study about cost effect of supervision, suggested that, the cost of giving peer group one-to-one supervision to a nurses represented a cost of about 1% of the nurse's annual salary. Indeed, the percentage unit cost remained fairly constant as grade increased. Such level of investment for CS which had a demonstrable effect on staff burnout and wellbeing was not excessive and, therefore, did not imply cost should be an impediment to establishing and running CS programs in any organization. He added that the interpretation of this financial modeling would not represent 1% increasing cost, but it's necessary to look for the benefit of supervision (White and Winstanley, 2006).

2.3.3 Human Resource Management Roles:

Effective supervisor focuses on internal and external environment. The internal part includes operations monitoring, and progress toward objectives, as well as on the external environment, includes policy and guideline changes (MSH, 2006). The supervisors also work as team builder (Braddock, et al, 1996).

Supervision includes supervisees performance management like, setting goals, observing and giving feedback, addressing performance issues, firing supervisees, and ensuring conformance to personnel policies and other internal regulations (Mac-Namara, 2006). Not only gives an immediate feedback but, also gathering suggestions to improve the process (MSH and UNICEF, 1998). Besides, clearly communicated policies and rules, consistent enforcement and application of rules, policies, and honest supervisees evaluations (Zawadsky, 2004).

Feedback means providing the staff with yours response concerning their performance at work. It is central to supervision, feedback lets the supervisees know what they are doing well, where they need improvement, and how they can improve, they recommended to involve supervisees in feedback to make it effective (MSH, 2006).

Good supervisors are good listeners who provide constructive feedback both positive and negative without being judgmental (Mac-Namera, 2006). Feedback is probably the most effective tool for improving communication and Manager should be sure that they being understood (Haimann, 1991). As well supervisors must acquire skills of giving and receiving feedback in an appropriate manner (Ben-Salem, et al, 1996). In medical education feedback has been found to be very important for trainees (Kilminster and Jolly, 2000).

The study conducted in Zimbabwe regarding supervision reports that there is weakness in providing feedback as one-third of supervisors don't observe for enough time before giving feed back and one-half of supervisors give excessive feedback but it was considered as strong point as they provided an accurate information and education to providers (Tavrow, Young-Mikim and Malianga, 2002).

Study conducted in Sweden shows that the supervisors demonstrate commitment and empathy in order to be successful and to understand other and to give positive feedback (Arvidsson and Frindlund, 2005). Document in UK medical education provides postgraduate with guidance. Elements in this guidance include ensuring the safety of the trainee and patient in the course of clinical care, and providing feedback on performance (Kilminster and Jolly, 2000).

2.3.4 Supervision Approach Roles:

An effective supervisor focuses on the planning of programs and team problem solving (MSH, 2006). They can provide technical guidance to staff effectively. When they couple their use of checklists with supportive supervision, they can promote efficient, effective, equitable health care across their organization (MSH and USAID, 2006). Supervisors can use many tools during their supervision, these tools either, reports, checklists, or observation of supervisees performance, these are the more used methods, checklists are considered the more used tool in

between the supervisory tools, as checklists help to organize the work of supervisors to make it regular and reliable. No program can be progressed effectively without checks and balance the supervisor should be supportive instead of using administrative tools (WHO, 2002).

In order to be effective, supervisors need training and support for their activities, as well as clear guidelines and a schedule of supervisory activities that includes all the facilities for which they are responsible. A good supervisor will work with a clinic team to continue monitor activities in the clinic and will serve as an advocate for clinic managers at the regional office (MSH, 2006). Using short checklists enable supervisors to provide guidance on the technical aspects of services, which, results in high-quality primary health care. Supervisees find this objective process motivating, because it helps them to identify and address the highest-priority problems. They know what is expected of them and when they have met those expectations (Rohde, 2006). Observation of activity was recorded as an effective tool of supervision by expert in CS as observing the provider while he/she does job and care of patient (Severinsson and Borgenhammar, 1997). Despite being aware of the importance of checklists to structure supervisory visits, only one third of supervisors in study at Zimbabwe were observed using checklist in their visit and a number of weaknesses in collected checklist were observed (Tavrow, Youn-Mikim and Malianga, 2002).

Also, visiting clinic is important role through it the supervisor can observe supervisees performance. The intensity and frequency of supervisory visits will vary significantly between programs, depending on many factors included, transportation, the period of program if it is new or old one, experience of supervisors, and the tasks performed by the supervisor during the visit. If program is well established, it needs a few visits. It is important to do a regular schedule for visits related to plan and activity of the program. While there are no absolute guidelines, a general rule is to schedule supervisory visits or activities as frequently as

possible, sometimes the visits had disadvantages as used by manager to blame the supervisees (MSH, 2006**)**. Added finding the time for supervision is considered as difficulties for supervisors (Kilminster and Jolly, 2000).

A quantitative study on 260 sample nurses at UK, shows that there is statistical significant differences between number of supervisory sessions as well length of these sessions with effectiveness of supervision as well the supervision were more positively perceive as more sessions were included, and the choice of supervisors. But it doesn't support the type of supervision with the effectiveness of it (Edwared, et al, 2005).

In study at Zimbabwe it is found that the frequency of visits were good, as they 73% of there facilities reported three or more visits within six months for district region**,** it was vary in length and quality of visit too as they found that the majority of supervisors spent their visit in socialization and the notes they wrote not shared with provider a few of them discussing patient issue with provider (Tavrow, Young-Mikim and Malianga, 2002). The more visit are better but the quality of this visit and indication are the best. And interaction between supervisors and supervisees also an important factor.

Supervision sessions ranges from one to one session, group supervision session and peer supervision. Peer supervision can be defined as one to one or group supervision which among and led by peer (Hyrkäs, Koivula, Lehti and Paunonen-Ilmonen, 2003). One to one supervisees, is understood as individual supervision this is properly common in nursing, rather than other disciplines. Group supervision, the clinical supervisor provided supervision a group between four and six supervisees. This is seen as favored in Scandinavian countries (Sloan and Watson, 2002; Sloan and White, 2000). As this is supported by the Swedish study for nurses that 45 of respondents from 49 supervisors were used group supervision in their supervision (Berg and Kisthinios, 2007). Added by Severinsson (1997), other clarification as self

supervision, one to one supervision, provides more opportunity to participate, team supervision the task of more difficult as it needs more knowledge and experience, and differentiate group supervision from Sloan that it occurs within one own discipline (Severinsson and Borgenhammar, 1997).

2.3.5 Communication and Support Roles:

Many authors speak about communication and support as important aspects in organization to achieve the goal. The responsibility of supervisors is acting as a connecting link between the supervisees and the administration, and maintaining a satisfactory working relationships with the heads of all other departments which seen as communicator (Haimann, 1991). To ensure this job satisfaction the supervisors had to be effective communicator (Braddock, 1996), and treating all supervisees with respect (Zawadsky, 2004). As well focusing on external environment, includes communication with other levels of the health system (MSH, 2006).

The function of supervision is to provide and create an environment that permits the supervisee's spontaneity imagination that will support them past their impasse so that they can re-enter the client system to do what they have to do with confidence (Consedine, 2004)

Another benefit of supervision and the staff receive better support, there by reducing stress and burnout and changing recruitment and retention rates (Farrington, 1995). This is supported by Todd, et al, (2005), as he has mentioned a range of supervision benefits for both clinicians and the organization, these benefits are, support to supervisees and improve communication, increase satisfaction and improve work retention (Todd and O'Connor, 2005).

Clinical supervision offers support to the practitioner by providing time and opportunity to reflect and discuss issues arising from clinical practice. Within the supervisory relationship, both supervisors and supervisees are able to recognize their strength and weak points as well

their needs to improve and those they feel confidence (Thomas and Reid, 1995). The supervisor role is to delegate and provide continuous direction and support to the supervisees as they complete their action plan (MacNamera, 2006). Also, to create an atmosphere of teamwork. The meeting should be set friendly, and he/she should encourage participation and discussion. Supervisees will feel more comfortable sharing their problems and concerns if they are confident that they will not be punished for raising them and he/she needs to solve problem (MSH, 2006). Because emotional awareness is extremely important in the supervisory process and the supervisors main character is to share feeling with supervisees (Berggren and Severinsson, 2006).

Good supervisors hold excellent communication skills which they use to build an organized team. They have clear expectations for performance, and are able to express their expectations clearly (MacNamera, 2006). Goorapah (1997) urged that the relationship within supervision should be differentiated between personal and professional issues, he added that a problem will be initiated if the supervisor is the same manager of supervisees as they may fear of penalized (Goorapah, 1997). In order to improve communication, the supervisor must know how to facilitate discussion during meeting and to be a good listener as well he know how to gain access to support when needed. On other hand**,** the supervisor facilitates local problem solving by being supportive of staff action and by being available for discussion with staff if obstacles arise. Supervisors may also play important roles in helping to prioritize the actions that staff had identified (Ben Salem and Beattie, 1996). Yegdich (1999), urged about the importance of support of supervision in reducing burnout for staff (Yegdich, 1999). As in nursing the role of supervisor implies a moral responsibility to support and confirm the supervisees to enable him/her to become the patient's advocate (Johansson, Holm, Lindqvist and Severinsson, 2006). Health professions who receive supervision were found to be more

motivated to professional development, support and improvement in standard (White and Winstanley, 2006). In health organization the supervisors work with supervisees who had an impact on patient as there is an evidence that supervision has a positive effect on patient outcome and that lacks of supervision is harmful for patients. The quality of the relationship between supervisor and trainee is probably the single most important factor for effective supervision. Current supervisory practice in medicine has little empirical or theoretical basis (Kilminster and Jolly, 2000).

Alun (2006), in his review about supervision mentioned the effective relationship between supervisors and supervisees and trust relationship as supervision benefit (Alun, 2006). The following studies shows the importance and benefits of supervision on communication and support. In a study views the staff expectation to their supervision**,** 68% of them felt that supervision support them by reducing stress at work**,** while 23% of them view supervision as increase stress at work (Fowler and Chevannes, 1998).

As reported in study conducted in Zimbabwe the relation between supervisors and provider observed to be relaxed and cooperative, however, all supervisors criticize the provider, they accepted it and reported it as a constructive criticism (Tavrow, Young-Mikim and Malianga, 2002). An evaluative research in England compared a supervised staff with others who got no supervision about the effect of supervision and support on burnout using (MBI) scale, shows statistical significant differences between staff who are supervised and who are not in relation to felling competence and successful achievement. Overall qualitative analysis of the events suggested that there were no differences in types of events or outcomes of support between supervised and non supervised groups. It was the quality of support received that was important (Teasdale, Brocklehurst and Thom**,** 2001).

One important finding in Norway staff satisfaction with their environment and supervision study was a significant correlation between the factor 'independence' and 'relationship with colleagues' as well as between 'collaboration and good communication' and 'work demands' with ($P < 0.05$) (Bégat, Ellefsen and Severinsson, 2005).

A study in England focused on describing of nurse manager and ward sisters perception of the future effect of clinical supervision. The data was collected via empathy story method, and showed the managers had positive long term effect on communication skills, leadership, and self development, self knowledge and coping and they believed that CS had long run supportive measure among worker (Hyraks, Appelqvist-Schmidlechner and Kirstikivima, 2004).

2.3.6 Facilitative Environment Roles:

Supervisors seen as not only a guiding service provision, but also, managing resources and community relations. They help to meet staff needs for support, and logistics (MSH and USAID, 2006). Within a structured professional relationship, supervised clinical practice provides a supportive environment. It encourages a practitioner to accept professional accountability for practice, assume personal responsibility for actions, increase self knowledge, understanding of the client, family and work setting and plan for the effective delivery of care (Alun, 1998).

In a survey study viewing the nurse expectation of supervision supports the benefit of supervision and shows the majority of all respondents (90%) viewed clinical supervision as not being a waste of time, 89% thought that, it would help them focus on and improve patient care, 91% thought it would help them focus on their strengths and 90% thought it would help them focus on their weaknesses (Fowler and Chevannes, 1998).

A study conducted in Saudi Arabia shows that 64.4% of supervisors rating coordination of work as essential role of their duties and control of resources also seen as important role (Jaralla and Khoja, 1998). However, clinical supervision was found to fulfill a variety of functions at different times, to meet individual needs.

2.4 Role of Supervisees

It is important to involve the supervisors and supervisees in this study, as supervision is considered an interrelationship between both. The individual supervisor's behavior is always critically important in influencing supervisees perceptions. Their perception of the supervisor will affect how they perceive the company. A supervisor's best defense against the formation of negative supervisees perceptions is to be visible to supervisees as much as possible and available to them when needed. It is worthwhile for management at all levels to remain constantly aware that, to the perceiver, perception is reality (McConnell, 2005).

A little was written about role or responsibilities of supervisees as they play an important role in the supervision process. In England it is mentioned that the responsibility of supervisees to choose his/her supervisors and to gain access to supervision (Telfored and Wrekin; Shropshire, 2006). Supervisees should be considered as an active partner in supervision relationship and his/her responsibility to know the aim and goal of supervision (Todd and O'Connor, 2005).

2.5 Models of Supervision

Supervision is an interesting and important subject for managers, supervisees and organization regardless if it is a health one or not. Writing about supervision can be traced back only hundred years, not like management and organization which writing on it's traced back thousands of years. However, different models were developed in these short times but they

were less investigated. Controversy over the need of theory in clinical supervision reflects the multi dimensional and complex nature of the concept (Hyrakas, Koivula and Paunonen, 1999). Many of models were developed by different authors, regardless of their differences they all agreed on managerial and personal aspect of supervision. But there is no universal agreement on certain models for clinical supervision (Bégat, Berggren, Ellefesen and Severinsson, 2003). The researcher presented some models which were used in the domains of this study.

2.5.1 Kadushin's Model:

In his discussion of supervision in social work, focused on a variety of techniques to address the administrative, supportive, and educational components of supervision (Gallacher, 1996). Stated the functions of supervision in the following terms: Administrative - the promotion and maintenance of good standards of work, co-ordination of practice with policies of administration, the assurance of an efficient and smooth-running office; Educational - the educational development of each individual worker on the staff in a manner calculated to evoke her fully to realize her possibilities of usefulness; and Supportive - the maintenance of harmonious working relationships (Smith, 2005).

2.5.2 The Adult Learning Model:

The adult learning model of supervision is cyclic. It begins with the supervisee's professional experiences and ends with their new professional experiences, which form the basis of the supervisee's next learning involves a three-stage process through what Van Kessel call : the way of knowing, the way of choosing, and the way of acting (Van Kessel and Han,1993).

2.5.3 Proctor Interactive Model:

Many clinicians have adopted Proctor's (1987) three interactive-function model. As it is the most popular cited supervision model in UK (Sloan and Watson, 2002). Also, more commonly accepted model within nursing in response to the different needs of practitioners working in very different environments (Gordan, 2000).

This model, derived from counseling, can focus on all or any one of three areas at any time. The formative function is concerned with skills development and increasing and updating the supervisee's knowledge; the normative aspect concentrates on managerial issues including the maintenance of professional standards and giving advice to promote high quality care and the restorative function is focused on providing support in an attempt to help supervisees cope better with the pressures of their work and alleviate the stress evoked by doing the job of nursing (Sloan and White, 2000). Aspects of self-interest can be identified in the formative and restorative elements as both centre around individual needs and desires. However, the normative element regulates these by subjecting self-interest to the norms and rules of collective responsibility enshrined within the discourse of the 'autonomous practitioner' (Gilbert, 2001). Proctor's ideas have been influential in nursing as they suggested that clinical supervision has the potential to raise the quality of nursing care (Teasdale, Brocklehurst, and Thom, 2001). The strength of this model lies in the belief in the individual's own ability to increase her/his self-awareness and achieve personal and professional growth by means of the group and the supervisor (Lindrgen, Brullin, Holmlund and Athlin, 2005).

This model combines the different functions of supervisor and demonstrates how it can focus predominately on one or other function at different times. However, the ultimate quality of nursing work demands that the supervisor should always consider them as interrelated and overlapping.

2.5.4 Growth and Support Model:

Is one of the most recent cited models in the literature. By using this model supervisors were able to demonstrate slight changes in job satisfaction and slight reductions in emotional exhaustion for recipients of supervision (Sloan and Watson, 2002). The models can be divided into three types: those that focus on the supervisory relationship, those that describe the functions of the role, and developmental models that focus on the process of the supervisory relationship (Gordan, 2000).

2.5.5 The Integrated Model:

Is a clinical supervision model developed by Philip Rich (1993) after a review of the clinical supervision literature across the disciplines of social work, counseling, clinical psychology, psychotherapy, and human service management. It is a comprehensive model which address the four functions of supervision included; Facilitation, Staff Development, Staff Socialization, and Service Delivery, and six stage cycle of supervision included; Relationship Building; Planning; Observation; Analysis; Conference**;** and Follow up. and primary elements of supervision included, Facilitative Environment, Supervisory relationship, Structural elements, Supervisory skills, Provision of Learning Experiences, and Supervisory Roles (Rich, 1993). Also, in Norway study showed 65.5% of nurses used various supervisory models (Bégat, Berggren, Ellefsen and Severinssson, 2003).

2.6 Effect of Training on Supervision

Training for both supervisors and supervisees are so important in order to maintain high quality work. The supervisors play the most apparent role in training as he should be trained and has skilled to provide training. Many researchers focus on these factors as the majority

agreed about no previous training, or a little for the supervisor about supervision (Mac Namara, 2006). In some underdeveloped country, like Ghana and South Africa, there is no training for supervisors on technical supervision (Combary, et al, 1999; lehmann,et al , 2001), Arab countries as well in a study at Saudi Arabia showed no previous training on supervision and mentioned that the supervision job difficult and demanding (Jarrallah and Khoja, 1998). Even in developed countries supervisors were poorly trained **(**Young-Mi Kim, et al, 2002; Manongi, Marchant and Bygbjerg, 2006).

Some of supervisors had a little training on supervision, as only one or two days preparation for the role of supervision, These are either study days, or time spent with other staff who have tried to implement clinical supervision without any formal training for the role (Gordan, 2000). It rarely to find supervisors trained in management as in Zimbabwe, district-level supervisors are generally registered nurses who have received one year of post-basic training that includes nursing administration (Tavrow, Young-Mikim and Malianga, 2002).

Regardless they had trained on supervision or not, they mainly prompted to supervision position due to their previous skills and experience in their discipline, many were clinicians who made the transition to supervisor after providing direct services most have not received specific instructions and coaching on how to supervise effectively (Robiner and Schofield, 1990; Mac Namara, 2006).

In many instances, staff particularly in Palestine, are promoted to the supervisory level because of their reliability and good work, technical expertise as well, or their residence with an organization. These staffs are then expected to supervise others, often without adequate training or preparation, under the assumption that the same qualities that enabled them to perform well in their previous jobs will apply to the new situation **(**Ben-salem and Beattie, 1996**).** Some authors support that, supervisors should have a previous training on supervision,

staff frequently identify training needs as a problem to be resolved at the site. Supervisors can play a role in planning for training, in gaining access to the necessary resources for training, and, to provide some training if they have the required skills (Ben-salem and Beattie, 1996). A lack of supervisory training can result in missed opportunities for quality improvement (Ben Salem and Beattie, 1996) As supervision needs a significant investment in training and require nurses to take time away from patient care for regular one to one or group discussion of their clinical practice (Teasdale, et al, 2001). Besides that, cost of time and training create a barrier to supervision of clinical personnel (Manongi**,** Marchant and Bygbjerg, 2006).

On midwifery, the supervisors must be experienced and eligible to practice as a midwife and undertake initial and periodic courses of instruction in the duties of a supervisor of midwives (Bennett and Brown, 1996). Kilminster (2000), concentrated on the need of supervisors for training courses not in professional but in supervisory skills also emphasized on the need of supervisees to training or daily training menu. As the supervisors responsibility to provide supervisees with suitable training (Kilminster and Jolly, 2000).

In addition, when there is any training, it is often geared to the inspection model, informing supervisors about what checklists and reports are required in order to quantify results. Unfortunately, data that is collected to satisfy institutional requirements is rarely used by supervisors to help staff at the site level to monitor and evaluate their own activities (Ben-Salem et al, 1996). Another opinion disagree with this role mentioned that teaching is not a part of the basic role of supervision, it may be requested by a supervisees, and supervisor not required to be skilled in teaching. Alternatively, the supervisor may recommend another person who is better positioned to teach the required skills (Fone, 2006).

2.7 Supervision at Primary Health Care

The concept of PHC was defined by the World Health Organization in (1978), as both a level of health service delivery and an approach to health care practice. Primary care the principles of accessible, comprehensive, continuous, and coordinated personal care (Gilchrist, 2002). The declaration of Alma-Ata 1978, identified primary health care as the key for attainment health for all by the year 2000, WHO and UNCEF in this declaration agreed on many principle for attaining this goal (Bryant, 2002). To attain health for all regardless geographical distribution is one principle of PHC, but the comprehensive and equitable care was not fairly distributed to all countries, specially poorly resourced one. Health for all was adopted in all Arab and Islamic countries like United Arab of Emirates (Al-Hosani, 2000), and Libyan Arab Jamahiriya (Abudejaja and Singh, 2000), and Islamic Republic of Iran (Shadpor, 2000).

After assuming the responsibility for the health sector in 1994, the PNA has been working to adopt the principles of PHC declared in Alma-Ata in order to achieve health for all by 2000 (MOH, 1999). However, the Palestinian Authority faced many obstacles mainly economical and political one which prevented them to reach this goal.

PHC is very important as they provide basic and needed services to people base on levels of preventive care such as, immunization, antenatal care, family planning, health education services, dental services and other health services, and curative care such as, first aid, dental care, maternity and child care, laboratory, radiology and medical care. Management is important in order to facilitate these services, and because of distance between clinics it's need supervision position in order to follow up the supervisees as well be contact with them to maintain the PHC goal and strategy. PHC in developed and developing countries in a massive need to supervisory position as supervision is recommended for primary care team in England by their MOH (Francine and Hale, 2001). Supervision is mentioned to be an important tool of

Mother and Child health/PHC integration in Saudi Arabia, beside health provider training (Baldo, et al, 2000).

A study conducted in Zimbabwe about the impact of supervision on stock management and adherence to treatment guidelines in primary health centers as these centers are in rural areas and in need for follow up, and new strategy was introduced based on supervision of PHC providers, they train the district pharmacy staff on supervisory skills. The result of the study showed over all stock improvement was significantly occur as follow up of supervision (Trap, Todd, Moor and Laing, 2001). Another study conducted in Tanzania view lack of supervisory guideline or checklist for their PHC supervisors by their MOH. The study was conducted in multi district health care measuring the quality of supervisor-provider interactions (Tavrow, Young-Mikim and Malianga, 2002). The permanent secretary of MOH in Tanzania mentions that had developed supervisory guidelines in 1999, to meet the need of unifying the primary health care strategy and to allow for overseeing the activity in order to narrow the gap of PHC activities (MOH/ Tanzania, 1999).

Ghana PHC was developed at 1974, while today other healthcare programs were developed like community based distribution (CBD), family planning and mother and child health care (MCH), in the study they explored many performance problems with supervisors, like, reporting, preparing supervisory plan, explaining aim of supervision and technical support, that's why they perform this study in order to see the effect of technical supervision training on these programs (Combary, et al, 1999). In Costa-Rica according to the MOH supervisors must spend one day per month in order to observe the community health workers performance as a result of study on supervision time at PHC indicated that they spent 59% of time less in observing CHW (Valadez, Vargas and Diprete, 1990). In Palestine there are many concern to PHC services improvement through researches and projects. A lot of Public Health School

also were conducted at PHC as it adopted the PHC concept. An assessment was conducted by team from Palestinian MOH and Italy team for MOH services including PHC services one of major problems founded were shortage of human resource and inadequate distribution time management as well lack of managerial link between levels of care (MOH, 2005). MARAM project conducted a study at maternal child health services in PHC including supervision on health care providers, founded that there is a need to supports supervisors system in order to develop health facilities (MARAM, 2003). Individual studies also conducted in PHC for different purpose, one of them about the adherence of PHC physician on drug protocol conduct by (Fattouh, 2005).

2.8 Supervision in other Disciplines

From researcher believe of importance of supervision in all disciplines as a team in PHC, this belief supported by another authors, as they mentioned in their researches about the importance of supervision in multidiscipline, they included that multi professional collaboration is going to play an increasingly important role in health care today as there has been an increase in competition and requirements (Sirola-Karvinen and Hyrkas, 2006). As well CS is one way to improve multidisciplinary teamwork and is considered as innovation way of improving working relationships among professional groups (Thomas and Reid, 1995). So supervision is used in many setting like, administrative, psychological therapy, education and counselor **(**O'Donoghue, 2003). It is a matter of high interest of nurses, researchers, educationalist, and managers **(**Cutcliffe and Hyrkas, 2006). Alun (2006), indicated an ambiguity throughout nursing as regards how supervision should be conducted. Some uncertainties about supervision may stem from its utility in professions. A study in Finland on the effect of supervision on quality of the work showed team work of multidiscipline which

included medical doctors, ward assistance nurses, practical nurses, and secretaries and other staff (Hyrkäs and Paunonen-Ilmonen, 2001). In a study conducted on occupational health supervisors found supervision appears not to be widely practised in occupational health or may not be of a predictable quality (Maynard, 2003). Also most of occupational therapist involved in giving and receiving supervision which is done via formal supervision, performance appraisal and peer review (Fone, 2006).

Others saw that CS recently added a motion for the disciplines of psychiatry, nursing, social work, psychology and occupational therapy to change practice, based on feedback from others on their behavior or intervention and undertake Clinical Supervision from a Supervisor of one's own discipline (White and Winstanley, 2006). Because of supervision importance in UK it is mentioned that within 3 years, by year 2008, a minimum of 90% of all clinical staff including: trained nurses, health care assistants, doctors, therapists, support workers, dentists, dental nurses, nursing auxiliaries and nursery nurses, will undertake regular support supervision sessions of at least one hour every 6 weeks or an equally effective equivalent (Telfored and Wrekin and Shopshire, 2005). In industrial society supervision is one part of management that over see the supervisees, in professional like psychotherapy, in counseling, in social working the supervision was seen as demanding and stressful (Goorapah, 1997).

2.9 Effects of Supervision on Satisfaction

Three components were identified to be included in job satisfaction with supervision, personality, job structure and value, the job structure and value were found to be more influence by supervision. Supervision effects on staff positively as it increases self confidence, ability to reflect problem and controlling the own feeling of stress. On the other hand, others find it as increasing stress as it leads to loss of ordinary time (Severinsson and Borgenhammar,

1997). The supervision program achieved patient, administrative and public satisfaction within democratic learning environment (Yegdich, 1999). A satisfactory Psychological work environment (PWE) empowers staff by offering them freedom to act and an opportunity to influenced (Bégat and Soverinsson, 2006). A study conducted in Norway about nursing satisfaction on their work environment and supervision found that nurses who were supervised are more satisfied than others (Bégat, Ellefsen and Severinsson, 2005). As well 98% of student shows positive expectation from group supervision in a study conducted in Sweden while 2% of them shows negative perception (Lindgren, Brullinm, Holmlund and Athlin, 2005). Also a study conducted in Finland shows that the majority of respondent had intrinsic job satisfaction while a moderate had extrinsic job satisfaction (Hyraks, et al, 2006).

2.10 Difficulties Within Supervision

Supervisors faced many difficulties during their work, some of these difficulties were mentioned in other factors like difficulties with quality, visits, feedback, and training.

The first difficulty is to manage supervision competently and confidently (Butterworth, 1994), this supported by study reviewed the important aspect of supervisors, as supervisees was given 17 items to rank according to priority the first items were rank are that supervisors should be confidential as the most important items (Cutcliffe and Hyrkas, 2006). Supervision could lose its underlying principle of bringing an exchange between practicing professionals in order to enable the development of professional skills, becoming just another management stick used to beat health professions with and to police the profession, It consumes time, effort and commitment from the supervisor and the person supervised (Farrington, 1995). Many staffs have not been trained as supervisors, lack of structure in supervision prevent its effectiveness (Thomas and Reid, 1995). Also, finding time for session and personal communication had

been founded as a problem in clinical supervision, as well lack of supervisory tools like checklist (White and Winstanley, 2006).

2.11 Demographical and organizational Factors of supervisors

There are all personal kinds of supervisors. People aren't predictable, they have moods, illnesses, career expectations, crises in their live, supervisors are expected to deal with these variations (Mac-Namera, 2006). Supervisors asked to cover many sites within a large geographic area may only be able to provide superficial supervision. In reality, much of the supervisor's time is spent on the road, getting from place to place. When, as often occurs, it takes a day to travel to a site and a morning to complete protocol visits with district or site officials, a supervisor may only have a couple of hours to spend actually observing services and talking to staff at the site before she or he must depart. On such a visit, the supervisor may not have an opportunity to talk with different levels of staff or to spend time looking into particular problems (Ben-salem, 1996). The mean number of supervisors per region in Saudi Arabia was 5.7 ± 5.8 supervisors, this wide variation is because of the geographic difference and distribution of personnel between the regions. The mean distance from the farthest health centre was 176 ± 150 km (Jaralla, and Khoja, 1998).

The majority of supervisors were in the middle age (Jouda, 2003; Salah,2005), in Saudi Arabia they were aged between 35 and 45 years (Jarralla, and Khoja 1998).

Gender of supervisors vary from place to another as in Arab countries the majority were male (Jouda,2003; Thabet,2004), in Saudi Arabia all were male (Jarralla, and Khoja 1998), and in Europe countries female supervisors were preferred and also in most African countries (Tavrow, Young-Mikim and Khojs, 1998; Hyrkas,2006). There were variation among studies in relation to previous experience, training on supervision, and professions.

2.12 Supervision in Different Context

International; Clinical supervision is truly an international issue. as it is mentioned in many European countries as, Australia, Finland, the Republic of Ireland, Norway/Sweden, the United Kingdom and the United States. In some studies, they wrote about supervision on Sweden and Norway, collaborate on studies with colleagues from Australia and Japan (Hyrkäs, 2006). And many other American countries like Mexico, As well studies on supervision from African countries like, Ghana, South Africa, Zimbabwe, Kenya, and others not mentioned. That means, the importance of supervision by all it's types in all over the world. Most of studies from these countries were included in the study. Some of these countries were newly create it's supervision system and others were had a supervisory systems since many years, all of them were in need to more researches on supervision.

Arab context; like international concern of supervision, it's also regional concern, As mentioned in study at Saudi Arabia done on primary health supervisors about how they perceive their role, done by (Jarrala and Khoja, 1998) he mentioned that his study was the first study on supervision in Saudi Arabia which found that supervisors positively viewed their roles in PHC. In Sudan a study conducted to explore the adherence to malarial protocols by health care providers and shows a lack of supervision neither direct nor survey supervision was founded (Ahmad and Yousif, 2004). Some studies has briefly mentioned the supervision on some health projects or they mentioned how to educate supervisors for their project as in Egypt project for IMCI with WHO (WHO, 2004). Also, in Bahrain a project for quality improvement in primary health care they mentioned that one of the problems in their project which need engineering is their supervisory system as the supervisors did not provide feedback and didn't work with supervisees to provide job orientation as they solve these problem by training for supervisors and supervisees on job performance (Benjamin, Mandil

and Seaman, 1998). Rather than these studies nothing was found on supervision on Arab context.

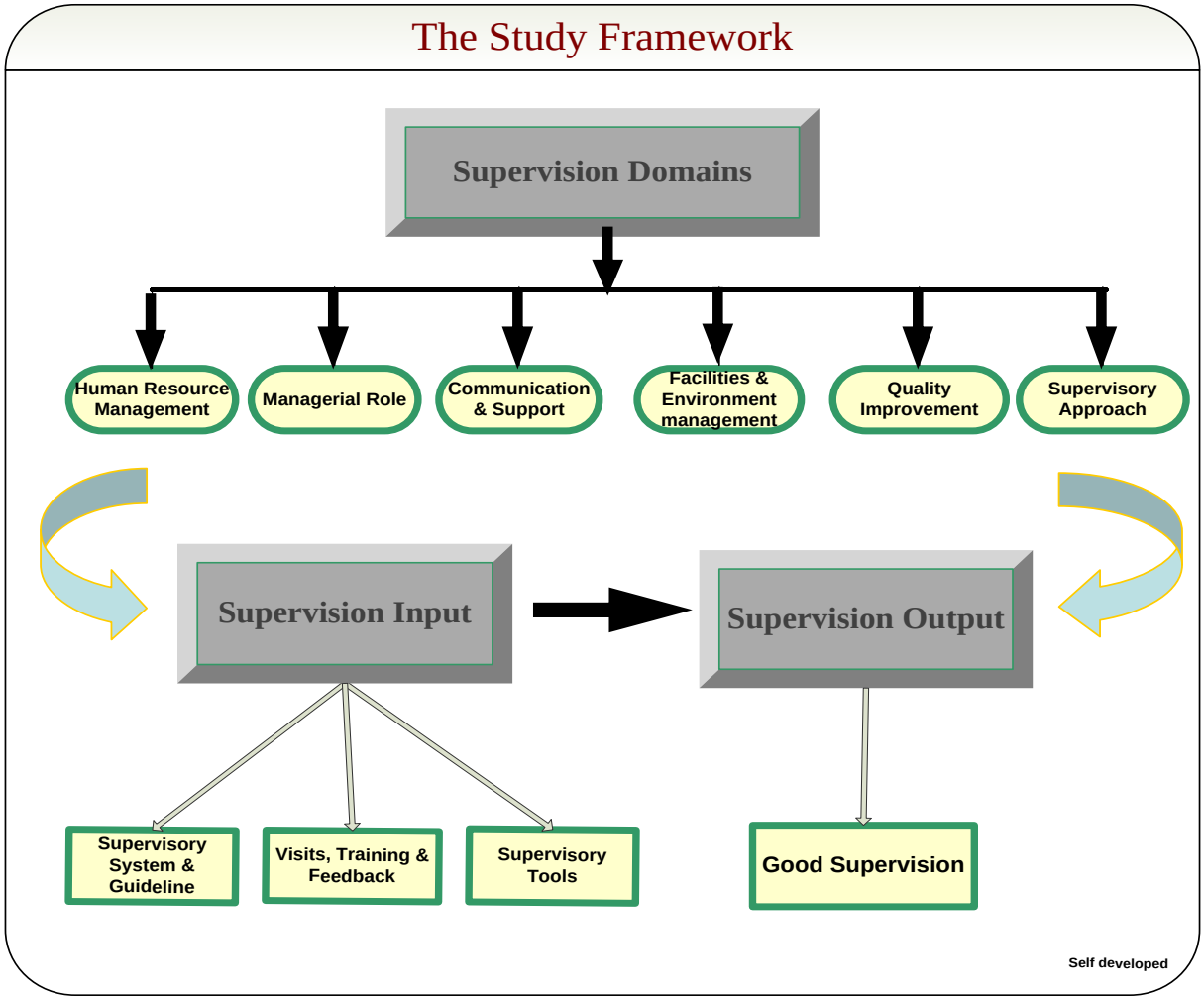
Palestinian context, a study about satisfaction among managers working in Gaza's hospitals, studied the supervision as one variable affect on satisfaction, and found that there was no significant relationship between supervision and levels of managers, and revealed these findings to the nature of Palestinian people as they prefer to hold work without being controlled. However, she found that there is a significant relation between trained manager and level of supervision and she revealed that to the effective of training in management (Thabet, 2004). As well a study conducted at Palestine by MARAM project survey of women and child health and health services, examine the supervision for health facilities on the point of visits and feedback, they found low percentage of regular visits and high percent feedback the health providers received (MARAM, 2003). However, supervision in Palestinian PHC facilities has not been studied, and in need for more evaluation.

In summary the supervision in literature was recently back hundred years ago, many different definitions and various types in various discipline was mentioned and clarify there was different opinion about managerial supervision and clinical supervision, as well the responsibility of supervision which performed by supervisors were well defined in literatures and simply mention in this study. The models which included was various but the resources of these models was few, the chosen models were mainly related to health, the majority was related to nursing as the majority of researches on supervision was focused by nurses more than medicine, administrator and other disciplines Proctor's model was the more mentioned in the literature. As the study conduct at primary health care, so the importance, definitions and other studies at PHC were included in this literature. For importance of supervision in different specialty, the researcher chose to write about supervision in multidiscipline to focus

on all health branches. Quality was the focus of previous researches so researcher found it is a point for discussions, as well training in supervision was found to be important for both supervisors and supervises as the majority of researchers agreed about no as the majority of researchers agreed about no previous training or little were the supervisors got on supervision before they become a supervisors. feedback, visits done by supervisor, effect of supervision on satisfactions and supervisory tools all are included in various literature as mentioned previously in this review, which was founded in Arab and non Arab literature are included. The next chapter will discus the study conceptual frame work.

Chapter 3: Conceptual Framework

The researcher assumption of conceptual framework of supervision at PHC centers illustrated in figure 3.1:



This conceptual framework was developed by the researcher focuses on supervision which is a complex concept that had different definitions and functions, but all these definitions were included three dimensions, the first dimension; is the organization, in this study the organization is the primary health care centers; which is an important component of a comprehensive health care system and is thought to be effective in improving the health for

Palestinian people. The second dimension is the supervisors, who is the link between the high manager and the supervisees, he is a professional practitioner who offer services, he may be a nurse, doctors, administrator, physiotherapist and others. By him/her the organization achieve it's goal. Third dimension is the supervisees, who considers the care provider without him there is no supervision. Also the supervision had six domains illustrated by researcher according to his review to previous literature and to what it may from her view applicable to our Palestinian context. These domains are:

3.1 Managerial Role:

It reflects the supervisor understanding their roles in sharing setting objective, identifying problems and solving it, sharing in decision making on high level as well hiring and firing supervisees, their role in performance appraisal and there responsibility in delegation, organization of work, and if they know the job description of their staff.

3.2 Quality Improvement:

It reflects the supervisors ability to assess staff clinical skills and qualifications, observing staff while they work, provide training for their staff, and recognize the expertise of their staff and match it with the organizational needs, all these help them to reach the organizational goal and provide care with high quality.

3.3 Human Resource Management:

Reflects the ability of supervisors to manage the groups, conduct supervisory visits, managing conflicts, team building, explain staff motivation and promotion, and explain the goal of organization to supervisees, good communication with supervisees and provide them with feedback, understand social context and take supervisee's idea into consideration and provide them with opportunity to developed.

3.4 Facilitative Environment Management:

Reflects the supervisors ability to manage the facilities in order to meet the goals and objectives of organization. These include order of supplies, assess clinic infrastructure and needs of logistics, maintain instrument working, keeps the health facilities clean and functional, and identify the resources needed to accomplish the goals.

3.5 Supervision Approach:

This domain reflects the supervisor ability to do supervisory work as if they do enough visits, criticizes the supervisees positively and discuss problem with them, if they create respective work place, write report and discuss it with supervisees and supervisors.

3.6 Communication and Support:

These items include the support from higher manager and providing support to subordinate, as well listen to them, is the communication channel are clear in the same clinic and between other clinics, and sharing socialization and information in order to promote effective work.

3.7 Organization Factors:

Includes supervisory systems and presence of tools, if the supervisors trained well, doing visit regularly and giving feed back. Experience of supervisors in the organization and its effect on job.

3.8 Demographic Factors:

Includes age, gender, marital status, residency, academic certificate the supervisors got and from where he got it, and main job.

The next chapter discuses how the researcher going on through study methodology.

Chapter 4: Methodology

This chapter addresses issue relating to methodology used to answer the research questions. The chapter includes the study design, the study population, period and place of the study, sample size, sampling method and method of conducting the study. Additionally construction of the questionnaires, as well piloting, ethical consideration, were also included. Then, it presents the ethical consideration and procedure, data collection, and data analysis. Also, it illustrates the validity and reliability of the study instruments. The final step was the eligibility criteria and the limitations of the study.

4.1 Study Design

The study design is cross sectional, descriptive, analytical study. Cross section design is a research design that involves observation of some subset of a population of items all at the same point of time (Trochim, 2006). Usually cheaper, fast in term of time in relative to other design (Gerard, 1999).

4.2 Study Population

The study population consists of two groups:

- The first one was the supervisors who were all staff practicing supervision functions and are registered at governmental sector, primary health care centers, formal and informal supervisor. They were presented by five groups; physicians, nurses, administrators, technicians, and pharmacists. Their total number is 300 between head of departments goes in the channel to the Director General of Primary Health Care centers.

- The second group was supervisees who were working at primary health care center in governmental sector at the time of study. And they presented into 7 groups, the total number was 1728 supervisees (Annex, 6).

4.3 Period of the Study

The study was started in Sep. 2006, after obtaining the approval from Director General of primary health care sector. The pilot study was conducted in March 2007. Data collection started in May 2007 to July 2007. It took all that period because of the political status in the country which was unsafe and the geographical distance between the clinics was an obstacles for data collection. Data entry and cleaning of data was conducted in August 2007, data analysis and writing the report continued till November 20th, 2007.

4.4 Place of the Study

The study was carried out at primary health care centers at governmental sectors in Gaza Strip at the five governorates. The study conducted at 56 clinics including the administrations of PHC directors.

4.5 Sample Size

The researcher used two methods to determine sample size:

- The first was the statistical calculator of the Epi-info to determine a sample size for supervisees, it gave a sample as 200 subjects. Given that the number of supervisees at primary health care at the study time was 1725 supervisees, with percentage of supervision around 20%. They were distributed proportionally (Annex, 6).

- The second method for the supervisor was survey by included all population for their small size, there was 300 supervisor.

4.6 Sampling Method

The researcher used survey technique for all the supervisors. Names were taken from the general administration of primary health care centers. For supervisees, it was proportional systemic random sample technique:

1. Taken the number of each group,
2. Then divided it on the total number of the population to got the proportion of each group,
3. The percentage was divided on the sample size to got the Kth number of each group,
4. The total number of each group was divided by their sample size to reach the systematic method,
5. Then each group was isolated by governorate and then by clinics in each governorate.
6. Started with random number for each group then to the next. Because of difference in number of each group the range between subject were difference.

4.7 Response Rate

The number of respondent from supervisors was 244, represented 81.5% . The number of total respondent from supervisees was 172 with response rate 86%.

4.8 Ethical Consideration

- An official letter was obtained from the Director General of Primary Health Care Centers (Annex, 9)

- Explanatory letter was attached to the questionnaire and provided to participants which included the study title, aim, objectives, and other information needed to made clarification to participants.
- In the interview questionnaire privacy was kept to supervisees.
- The right to participate or not, confidentiality, anonymity was maintained into the explanatory letter (Annex, 3).
- No participant would have experienced a sense of coercion; a sense of fear of not answering.
- Helensky approval was obtained (Annex, 10).

4.9 Construction of Questionnaire

The researcher developed the questionnaires related to study by herself. Draft of questionnaire was done by the researcher, then final modifications were done with supervisor, the questionnaire designed to be clear with no complex terms, double parallel questions was avoided as well there was no duplication in questions. It was translated where it was distributed to the study subjects to facilitate understanding and to ensure credibility of answers.

The questionnaires were sent to expert as mentioned before and a pilot sample was collected to ensure credibility.

The researcher made two questionnaires; one questionnaire for supervisors, which included three sections, the first section included twenty seven items related to personal, work and supervisory information (demographic, basic education, place and years of education,

organization background, experience in work, supervisory duties, number of clinic and supervisees supervised, and other information related to supervision).

The second section; included fifty six items, likert scale, divided into six groups each contain different number of questions (Managerial role contains 12 questions, quality improvement contains 6 questions, human resource management contains 14 questions, facility & environmental management contains 7 questions, supervisory approach contains 9 questions, and communication and Support contains 9 questions).

The third section; contains five open ended questions, included problem faced during supervision work, suggestions to improve supervision work, and personal feeling about supervision duties.

The second questionnaire for supervisees to explore their perceptions about supervision was developed by researcher, also, included three parts; The first part contains twenty questions included personal information (demographical data, basic study, work experience and background, and supervision questions).

The second part general twenty five questions. Included four domains; the first one is: Managerial behavior contains 8 question about Supervisors management behaviors like (appreciate supervisees, provide encouragement and support, knows his job and supervisees quality of work well and providing feedback, and clear guidance), the second domain is communication and support contains 8 questions about (Satisfactory relationship with supervisors and peer, supporting provided by supervisor, listening, understanding, and helping provided by supervisors), the third domain is Fairness contains 4 questions about (equity in treating and fairness in disciplinary actions by supervisors and if supervisors only detected error), the fourth domain is involvement which contains 5 questions about (duties and

responsibilities clearance, effective supervision, involvement in changes and decision making and sufficient training).

The third part was four open ended questions included the suggestion for more improvements, and the supervisees opinion in their supervisor around liked and disliked tasks. The questionnaires arranged in manner to be simple and easy to applied.

The Likert scale used in both questionnaires was contained the following items;

1= strongly disagree, 2= disagree, 3= don't know, 4= agree, 5= strongly agree.

4.10 Pilot Study

A pilot study done before data collection, and after experts evaluation has been done, pilot sample provides the study with many purposes. It gives an idea about response rate, and difficulty or vague questions can be minimized.

Twenty participants were included, ten were supervisors from different specialties, gender, age and different departments, the response rate of the pilot was 70%.

The other ten participants were supervisees, also from different specialties, and different departments, their response rate was 90%.

All of them were provided a clear explanation about study and it's objectives before application. After pilot an individual meeting done to ask the participant about ambiguities and their opinion about the questionnaire. Some changes were done after that, especially for supervisees questionnaire, a face interview was replaced instead of self administered questionnaire. The supervisees who were shared in pilot study were not included in the study.

4.11 Data Collection

Data was collected by the researcher with assistance of three volunteers who got explanation and training about collection and interviewing skills. Due to the geographical distance of clinics and the researcher don’t know the place of all clinics that's why some help from colleague working in the PHC centers were obtained.

The supervisors questionnaire were distributed by asking them to fill the question and giving them an explanation about study and the importance of give a real answers. the questionnaire was enveloped by two envelops, internal envelop without name and external envelop with name and place of clinic due to large number and distance of clinics. The supervisors asked to put the questionnaire into the internal envelop for maintaining privacy and confidentiality. The questionnaire was collected after completing it and checked by researcher for completion.

A face interview questionnaire was done by researcher to the supervisees, because some of them were illiterate. They were given a complete instruction about the study and how they included in it. Privacy and safety during interview were maintained as the interview was done in the place of work, taking into consideration not to interrupt the work, without the presence of their direct supervisors during the interview. The process of data collection took about 3 months.

4.12 Data Entry

Data entry was done by using the SPSS entry model. The questionnaire was coded and entered by researcher, data cleaned by reentering 15% of data randomly and through frequency table.

4.13 Data Analysis

- Data analysis was done by using SPSS program. Starting after collection the data
- Frequency table for the study variable were conducted.
- Description, mean and standard deviation for numeric variable were done,
- Reliability and validity for instrument done.
- Manual analysis for open ended questions were done
- The researcher did not conduct factor analysis due to the domains was created by the researcher and it were not mentioned before in the literature. The researcher interested to see it's effects and the domains may submitted for further study.

4.15 Validity

4.15.1 Face Validity:

As it is important to make people to response more to your questionnaire, the researcher checked the face validity twice time, the first during the pilot study as the participants were asked about the structure of the questions, it's shape, and typing clearance. The second check was through expert persons who gave their opinion in the face validity of questionnaires.

4.15.2 Content Validity:

Content validity is subjective estimation of measurement based on judgment rather than statistical analysis, in order to validate the instrument used. It was done before data collection, by sending the questionnaires with covering letter and paper contain instruction about the study, over all aim, objective, field of study and other relevant information.

The researcher sent the questionnaires to 12 expert from difference backgrounds including nurses, doctors, expert in management, university educationist, and researchers. They were asked to estimate the questionnaires in relation to study, clarity, and completeness of each items. Feedback was obtained from 10 expert and modifications accordingly were done with my supervisor, their opinions were taken in consideration.

4.16 Reliability

The statistical test used for the internal consistency was Cronbachs Alpha coefficient. The reliability for supervisor questionnaire as a whole was 0.94. Cronbachs Alpha was computed for the instruments subscales. Table (4.1) Shows the reliability estimated of the derived factors.

Table 4.1: Sub- Scale Reliability Supervisors Instrument

Factor No.	Factor name	No. of cases	No. of items	Cronbach' Alpha
1-	Managerial Role	210	12	.7915
2-	Quality Improvement	226	6	.7830
3-	Human resource management	192	14	.8747
4-	Facilities and Environment management	218	7	.8206
5-	Supervisory Approach	196	8	.8494
6-	Communication and support	212	9	.7957

The reliability for supervisees questionnaire as a whole was 0.85. Cronbachs Alpha was computed for the instruments subscales. Table (4.2) Shows the reliability estimated of the derived factors.

Table 4.2: Sub- Scale Reliability Supervisees Instrument

Factor No.	Factor name	No. of cases	No. of items	Cronbach' Alpha
1-	Management behavior	168	8	.7722
2-	Communication and support	167	8	.7141
3-	Fairness	167	4	.1451
4-	Involvement	165	5	.5901

4.17 Inclusion and Exclusion Criteria

4.17.1 Inclusion Criteria:

- All staff who was working in primary health care centers as supervisor including internal and external ones, who are supervising at least one supervisees, either official or non official supervisors.
- For supervisees, staff who was working at PHC and available at the time of study.

4.17.2 Exclusion Criteria:

- Staff non available at the time of study, maternity leave, long annual leave, staff abroad.
- Staff who is not formally employed (volunteer staff).

4.18 Limitation of the Study

- Time limited and Limited resource like, literature, books and magazine.
- Personal mode and variation between health personnel specialty.
- Geographical distance between clinics was the major complexity.
- Political situation was obstacle, the researcher faced during collection of data.

4.19 Standardization of Measurement and Implementation

It was approved by using the same questionnaire for all supervisors and supervisees, the implementation also was standardized for all supervisors by receiving their questionnaire individually. Interview for all supervisees was performed by the same manner and in the similar circumstances.

Chapter 5: Findings

The study examined the supervision status at primary health care from supervisors and supervisees points of view. It is intended to explore the relationships between demographical variables and supervision domains, as well as to explore the supervisees perceptions toward their supervisors, and to provide recommendations for policy makers in order to improve the supervision status at primary health care centers.

This chapter presents the results of the analysis of the data and the characteristic and distribution of the respondents. Then, it presents some statistical tests to explore the differences between the dependent variables and independent variables. The chapter also explores the relationships between the independent variables for both supervisors and supervisees, such as demographical variables, organizational variables, and supervisory variables.

A. Descriptive Part

A.5.1. Supervisors Part:

A.5.1.1 Demographical Variables:

The figure (5.1) shows the distribution of gender as males respondents represented 82.2%, while females represented 17.8% of total respondents. There is a gap between staff gender in the PHC clinics as males corresponding 62.3% and females 36.8% of total staff with ratio males to females as 1.7-1 (MOH, 2007). Means that the percentage of the female supervisors is not congruent with female representation in the system and it is male dominant. The findings of study is correspondent with a study conducted in Shifa hospital as it shows number

of males three times more than females **(**Jouda, 2003**)**. In the same context a study examined the satisfaction among hospital managers at Gaza Strip found that males mangers was 85.5% while females managers was 14.5% of total respondent (Thabet, 2004). In Saudi Arabia, all supervisors were male **(**Jaralla, 1998**)**. While in Europe the literature shows the female were more represented than male (Hyrkas, 2006). The variation in gender needs more considerations to female recruitment in order to maintain balance.

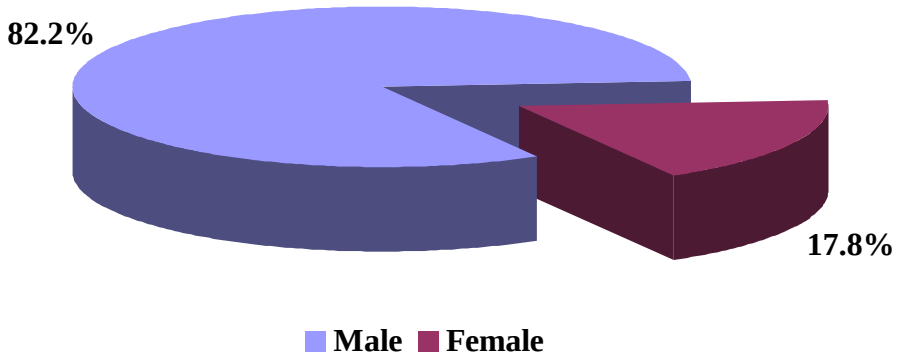


Figure 5.1: Distribution of Supervisors by Gender

Regarding supervisors age, the figure below shows that the highest age group were from 41 to 50 years old, while the lowest age group were the youngest age less than 30 years (mean 45.16, SD 7.75, Range 35). The age of supervisors seems to be young. The findings are nearly similar to Jaralla who found that the majority of the supervisors were aged between 35 and 45 years in his study on supervisors in Saudi Arabia **(**Jaralla, 1998). The majority of supervisors

were young and the manager could benefit of this opportunity and train these young supervisors to improve the system for other long run, figure (5.2).

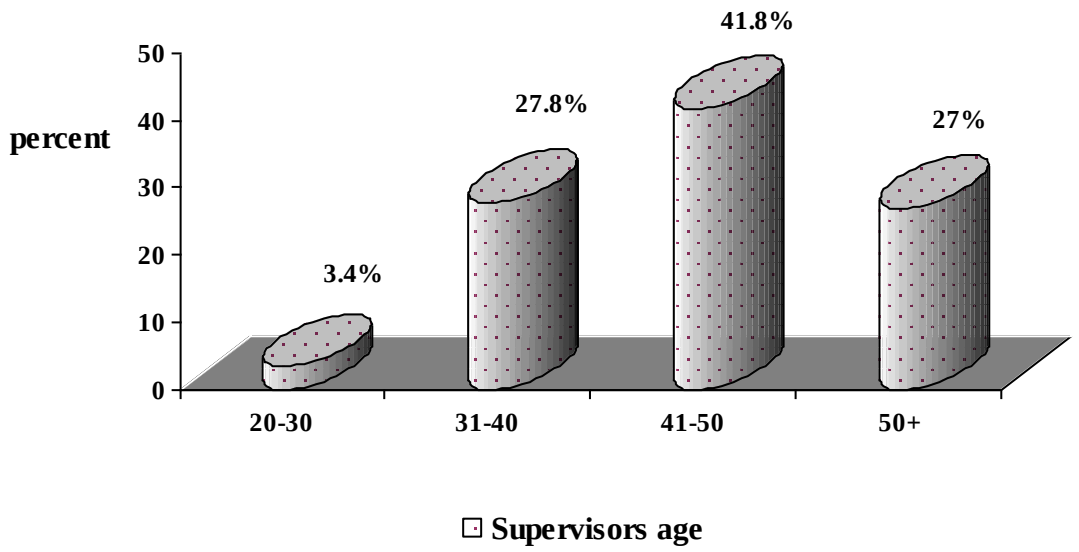


Figure 5.2: Distribution of Supervisors by Age Group

The residency place were distributed to the five governorates in Gaza. Table (5.1) shows that the highest percent was found in Gaza Governorate as represented 30.7% due to location of General Administration of PHC in it, and the lowest percent was found in Rafah Governorate. This distribution is appropriate to the number of clinics in each governorate. Thabet (2004) study supports these findings as reported that the hospital managers were the majority residence at Gaza city. This distribution is corresponding with the population number in Gaza Governorate. The majority of subject were married and represent 95.7%. This is corresponding to the previous literature (Jouda, 2003; Thabet, 2004; Salah, 2005). This may

related to the nature of the Arab customs as people marry early and the divorce is not a common phenomena in Palestinian context (Table, 5.1).

Table 5.1: Distribution of Subjects by Demographic Data

Variable		Frequency	Percent
Residency place	North Governorate	44	18.3%
	Gaza Governorate	74	30.7%
	Mid-Zone Governorate	53	22%
	Khan Younis Governorate	42	17.4%
	Rafah Governorate	28	11.6%
Marital Status	Single	6	2.6%
	Married	225	95.7%
	Widow	4	1.7%
Academic certificate	Tawjehi	15	6.2%
	Diploma	35	14.5%
	Bachelor	146	60.3%
	Master	36	14.9%
	PHD	10	4.1%
Years of education	Less than 15 years	49	20.6%
	16-20 years	163	68.5%
	More than 20 years	26	10.9%
Profession	Physician	69	28.8%
	Nurse	69	28.8%
	Medical Technician	25	10.4%
	Administrator	66	27.5%
	Others	11	4.6%

Allocation of occupation was presented in table (5.1) shows the physician and nurses has the highest and equal percentage and represented 28.8% of respondent. The administrator represents 27.5% as well high. Thabet (2004) study shows similar findings as the percentage of nurses and doctors hospital manager was the highest in between other occupation, while the

administrative occupation not similar as they occupies a few percentage in her study. In Zimbabwe district level supervisors were all nurses (Tavrow, Young-Mikim and Malianga, 2006**)**, and in Saudi Arabia all PHC supervisors were doctors (Jaralla, and Khoja, 1998). Supervisors distribution by occupation is related to the health system policy and there is a need to be reviewed by PHC managers. The majority of supervisors had a bachelor degree and represented 60.3% of respondents. The supervisor who got Tawjehi represented 6.2%, all of them were administrators. These findings are supported by Thabet (2004), study which shows that the majority of hospital manager hold higher degrees, (Table 5.1).

The years of education for the majority of the respondents were 15 years and more as seen in Table 5.1 (Mean 17.03, SD 2.846, Range 20). The majority of subjects hold higher education. This supportive to phenomena that the Palestinian attitude towards education is positive**.** The majority of subjects with master degree were graduated from the School of Public Health.

Table 5. 2: Distribution of Supervisors by Countries of Education

Variable	Frequency	Percent
Palestinian universities	98	44.7%
Arab-Countries Universities	91	41.6%
Non-Arab Country Universities	30	13.7%

In (Table 5.2), the respondents who have university degree got their certificate from different places. Around, half of respondents got their certificate from Palestine while others got their certificates from different countries. Therefore strengthen management system such as syllabus could be integrated into curriculum in the Palestinian universities.

A.5.1.2 Organizational Variables:

Figure 5.3, shows that half of supervisors had 6 to 15 years with their current experience in working. The mean of working experience at the job was 13 years while at organizations it were 11 years. This is supported by study conducted in Zimbabwe the supervisors experience was 5 years average with range of 1 to 18 years (Tavrow, Young-Mikim and Malianga, 2002). Arvidsson and Fridlund (2004), found that the mean years of supervisors experience in supervision was 1-11 years. Recruit supervisors based on their experience need to be discuss with decision makers.

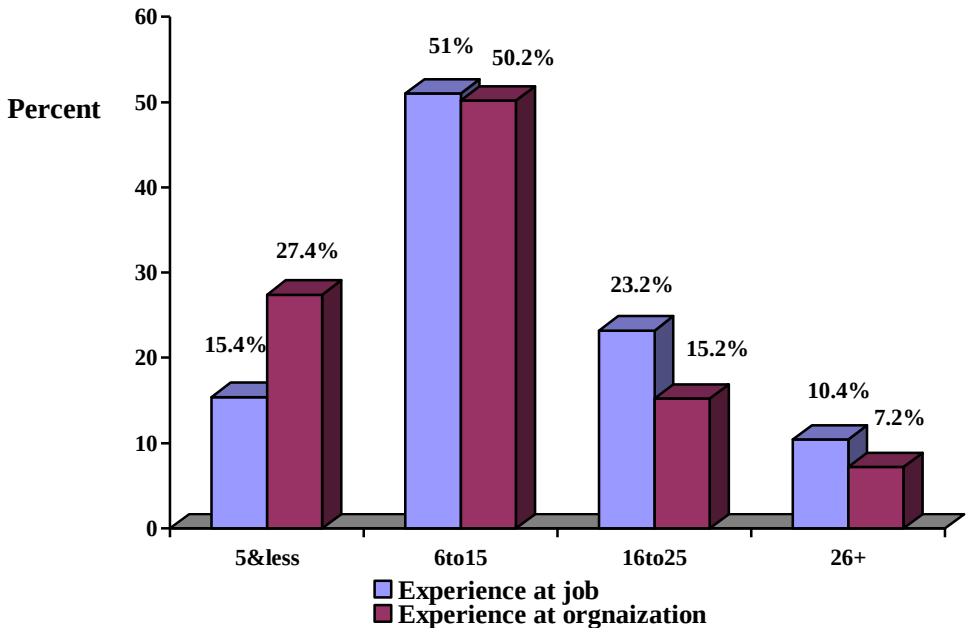


Figure 5.3: Distribution of Supervisors by Years of Experience in Job and Organization

Table 5.3: Distribution of Supervisors by Supervisory Related Variables

Variables		Frequency	Percent
Job Description	Yes	180	76.9%
	No	54	23.1%
Intention to stay	Yes	151	62.9%
	No	89	37.1
Job category	Head of Department	185	75.8%
	Area Supervisors	36	14.8%
	Directors	17	7%
	Deputy Directors	5	2%
	Director General	1	.4%
Reporting Channels	Area Administration	90	40.7%
	Department Directors	57	25.8%
	Nursing Supervisors	42	19%
	Director General	29	13.1%
	Minister of Health	2	.9%
	Clinic Administrator	1	.5%
Document Review	Yes	136	61.3%
	No	86	38.7%
Training Courses	Received	137	59.8%
	Not Received	92	40.2%
Benefits from Supervisory Position	Yes	103	45.4%
	No	124	54.6%
Availability of direct supervisors	Yes	177	79.4%
	No	46	20.6%

The supervisors need a clear guidelines and a schedule of supervisory activities that include all the facilities for which they are responsible (MSH, 2006). These responsibilities are clarified by job descriptions. The majority of supervisors reported in the study having job descriptions, and 23.1% not having job descriptions as shows in table 5.3. One of the requested to improve supervision is the provision of job descriptions as reported by participants in response to the

open ended questions. This finding is corresponding with Thabet (2004). In Zimbabwe and Ghana the supervisors didn't have a guideline to provide them with job description and each one where asked to create his/her own (Combary, et al, 1999; Tavrow, Young-Mikim and Malianga, 2006). The majority of supervisors reported their intention to stay in job until retirement (62.9%). This large percent may be due to the insecurity of the Palestinian live, as they feel more secure with staying in their job, or/and lack of other alternatives (Table, 5.3).

A.5.1.3 Supervision Variables:

The highest percent in the job category was for the head of department "internal supervisors" as represented 75.8% of respondent. Table (5.3) shows the different job category distribution according to PHC structure. 79.4% of respondents agreed that they had a supervisor, while 20.6% of them disagreed. While in PHC organization structure there is chain of command in supervisory positions ranging from internal supervisors to the Director General of PHC.

Regarding the reporting channels table 5.3, shows that there is a systematic reporting while each person reports to the person who is higher rank than him/her, but it also shows some jumping reporting to higher level leaving the intermediate supervisor without being informed. The highest percent was the reporting to area health administrators represented 40.7% of total respondents and the lowest reporting was for the Minister of Health representing .9% of total respondents. The percentage of supervisors received training courses on supervision was 59.8%, and interestingly 39.3% of supervisors who received training are the internal supervisors while only 20.5% of external supervisors received training. This finding is similar to the study conducted by Thabet, 2004. The supervisors in Tanzania not trained on supervision technique **(**Manongi, Marchant and Bygbjerg, 2006**)**. The period of training varies between one week to more than three months, some of supervisors had a training on general

management and a few of them were specialized in management. The researcher claims that the supervisors need more specialized training courses on supervision.

Regarding the benefits they are getting from supervisory position (Table 5.3) shows that45.4% of them reported getting benefits. As supervisors reported in their response to open ended questions, the benefits are material benefit, more commitment and improvement to work, feeling responsible of other and respecting from others. These findings are corresponding with Thabet, 2004. The benefit may motivate the supervisors to be more committed to work, so it is necessary to be included in organization.

Supervisors who supervised only one clinic "internal supervisors" represented 66.5%, while the supervisors who supervised more than 45 clinics represent 4.4% of total respondents (Mean 5, SD 12.341, Range 65), these groups are the directors of PHC departments. The remaining are the supervisors who were in the middle. This huge number of the internal supervisors need to be re structured (Figure 5.4).

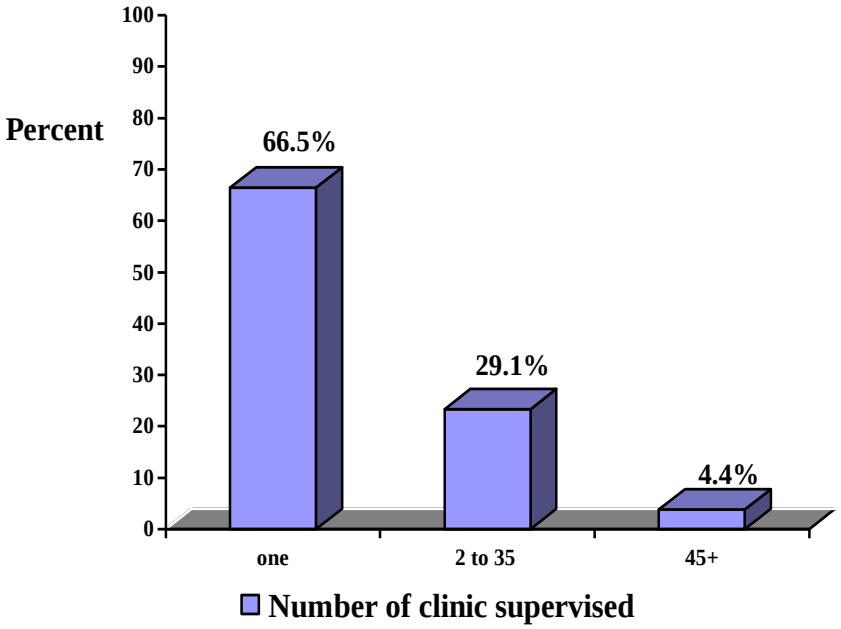


Figure 5.4: Distribution of Supervisors by Number of Clinics They Supervised

The number of supervisees for each supervisor as figure 5.5 shows that, 40.9% of supervisors supervised from 6-20 supervisees. It is not unusual in the span of control at organizational structure for supervisors to supervise 15 to 20 people (Haimann, 1991). The number of supervisees supervised at Sweden for each supervisors ranged from 1-40 with mean number 12 supervisees (Arvidsson and Fridlund, 2004). The system of supervision and the number of supervisees were different from place to another according to many factors included, geographical distance, political situation, economical status, type of supervision they adopted, number of population they served, and many others factors that are related to each place. From above data we conclude that the number of supervisees are close to the recommended literature.

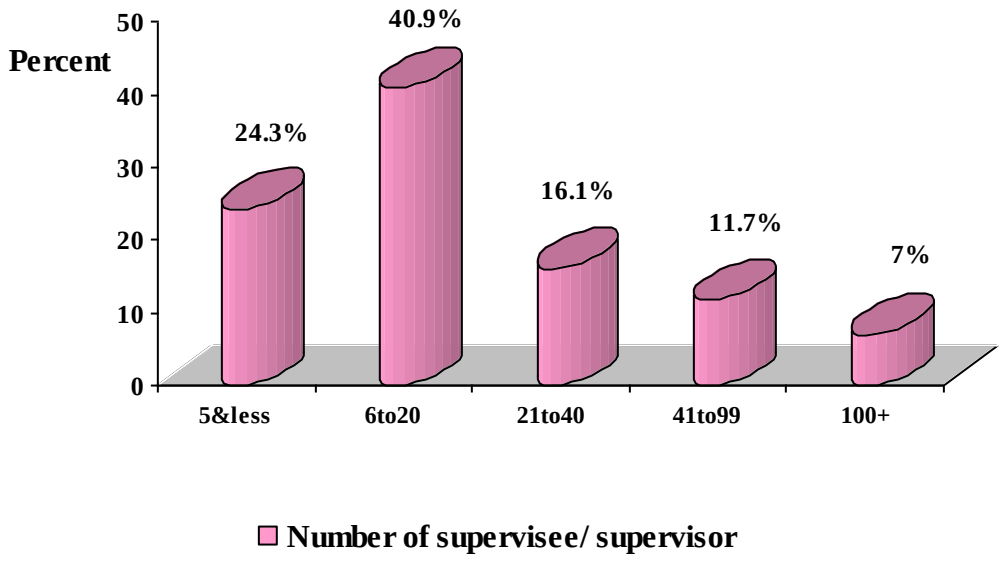


Figure 5.5: Distribution of Supervisors by the Number of Supervisees they Supervised

The frequency and duration of visits to health centers is variable and depends to a large extent on the number of health centers the supervisor is responsible for. Figure (5.6) shows the supervision visits as the majority of supervisors visit their clinics from 6 to 25 visits per month these performed by the external supervisors, the 30 and more visit were performed by the internal supervisors. (Mean 16.25, SD 11.317, Range 44). In Saudi Arabia the majority of supervisors believed that there should be four visits or more per year, and only 11.1% recommended a monthly visit **(**Jaralla and Khoja, 1998**).** These findings help the policy maker to review the visits of supervisors and to determine the reasons, times, and activity done through it as the number of visits is important but the quality of these visits are the most important.

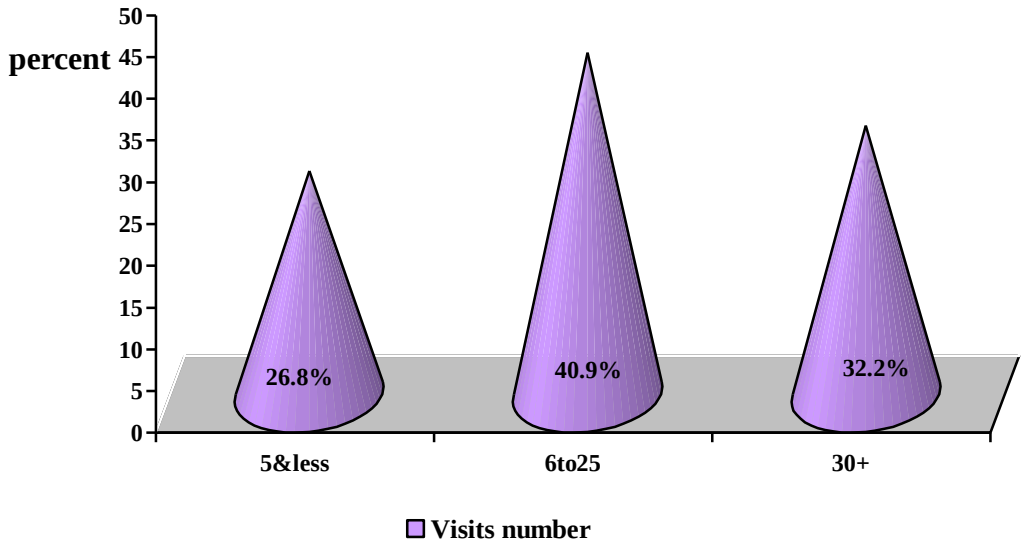


Figure 5.6: Distribution of Supervisors by Number of Visits Done Per Month

Availability of tools for supervision is important to supervisors work as step in improving performance. Figure (5.7) shows that 61.8% of supervisors had a supervisory tool at work, while 62.3% of the respondents don't have supervisory systems. These findings may explained by the lack of clarity of supervisory systems. The supervision in any place requires a written system as it helps both supervisors and supervisees to be in contact with their duties and aware of their performance. The Republic of Tanzania had created it's own supervisory system at 1998 (Tanzania/MOH, 1999). PHC policy makers could get benefits of these findings to create their own supervisory system.

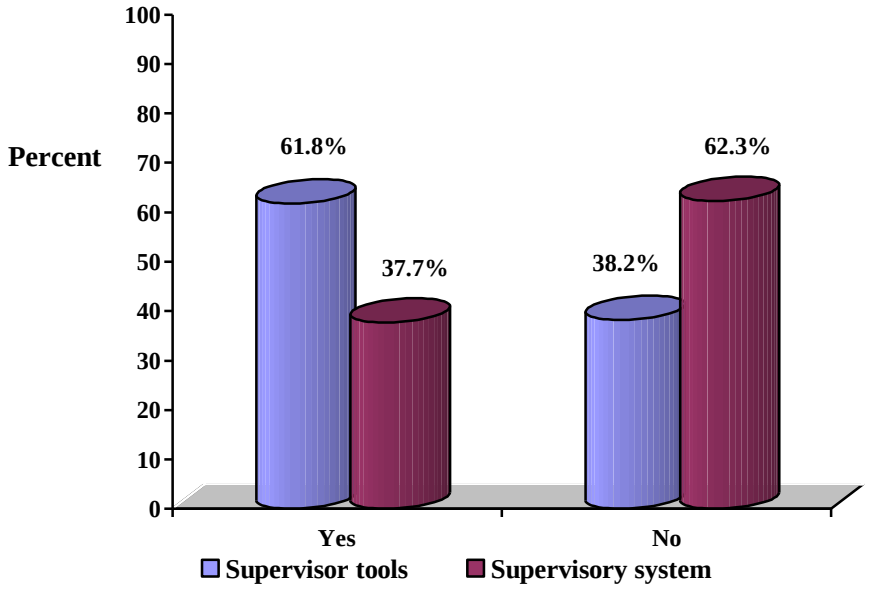


Figure 5.7: Distribution of Supervisors by Having Supervisory System and Tools

Table 5.4 : Distribution of Subject Who Have Report or Checklist Tool

Availability of report			Checklist		Report usage		Had Supervisor	
Var.	**Freq.**	**Perce.**	**Freq.**	**Perce.**	**Freq.**	**Perce.**	**Freq.**	**Perce.**
Yes	141	86%	46	46.5%	109	82%	177	79.4%
No	23	14%	53	53.5%	24	18%	46	20.6%

Report as supervisory tool were available by 86% of respondents, and the percentage of using the reports are high as shows in (Table 5.4). Ninety three point five (93.5%) of supervisors who had report tools using it during their visits. Checklist tool represents 46.5% of respondents. These variations in number of tools explained by variation in the PHC discipline, as they had no unified system. A study conducted in Ghana, found that half of supervisors did not prepare supervision reports and the others wrote it incorrectly (Combary, et al, 1999). In Saudi Arabia, the majority of supervisors use checklists (Jaralla and Khoja, 1998). In Zimbabwe, there is a lack of supervisory guidelines and checklists (Tavrow,Young-Mikim and Malianga, 2006). Which lead us to support the recommendation of creating a formal system for supervisors and concentrate on the importance of checklists in supervision.

Regarding the availability of direct supervisors for the supervisors 79.4% of them agreed that they had a supervisor table (5.4), 61.3% shows that their reports were reviewed with their supervisors. This is consistent with Jaralla study as the percentage of supervisors review plans of actions was (72.6%) and (57.8%) discuss them with staff responsible **(**Jaralla and Khoja, 1998). The review report enhance the relationships between supervisors and supervisees as it maintains the continuous monitoring. More clarifications for the reasons of not reviewing the report need to be focused on.

A.5.2 Supervisees Part

A.5.2.1 Demographical Variables:

Figure 5.8, shows that male represents 54.7% of respondents, and female represents 45.3% of respondents and this is corresponding with male to female ratio in PHC, as male shows higher ratio than female. This needs more concern by MOH managers.

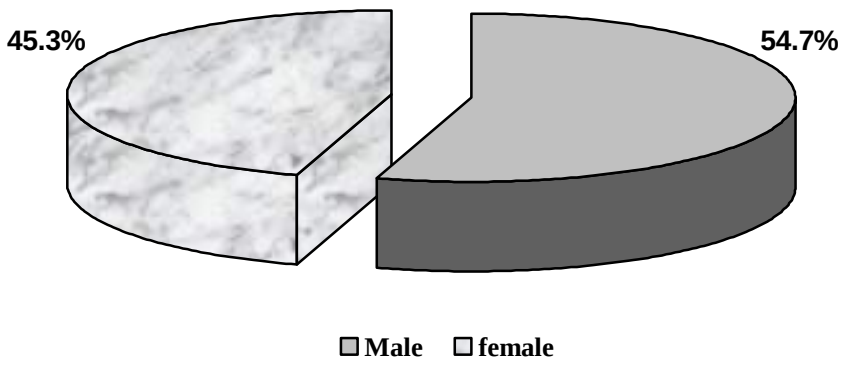


Figure 5.8: Distribution of Supervisees by Gender

Figure (5.9) shows that the majority of respondents were relatively young (63.1% of them are less than 40 years) with Mean 38, SD8.735, Range 38. These young groups could be trained in order to provide quality services for a long time. Correspondingly in Finland, a study shows that the supervisees age ranges from 23 to 60 years, which is nearly to this study (Hyrkäs, 2006). The young population, if not trained could make burden on the system as had to stay long period in the job.

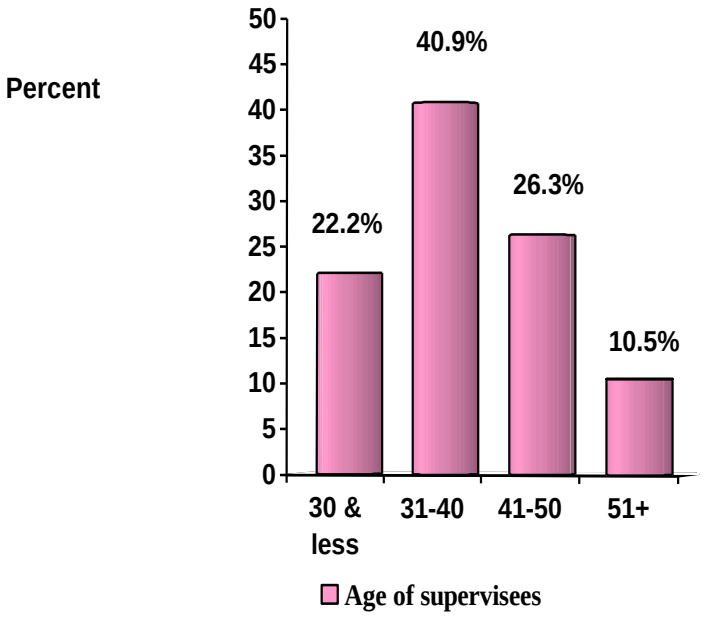


Figure 5.9: Distribution of Supervisees by Age Categories

The study population were distributed at all Gaza Governorates. The respondents higher percentage according to residency place was in Gaza Governorate (34.3%). The relation between residency place and work place shows that the majority of subjects work in the same governorate they live in (Table 5.5). The majority of study population were married and represented 93.6% of respondents. These findings are consistent with supervisors findings mentioned before (Table, 5.5).

The distribution of occupations among subjects as shows in table 5.5, variations in supervisees occupations, with no balance in the distribution as the administrators has the highest percent in between the respondents 30.8%, while the lower percent for support services which included (Technicians, cleaners and drivers). The administrators increase with the annual average of 11.7% in the last five years (MOH, 2005a). This is considered as a burden on the MOH budget. Allocation of job needs to be re-evaluated.

Table 5.5: Distribution of Supervisees by Demographic related Data

Variable		Frequency	Percent
Residency place	Gaza governorate	59	34.3%
	North governorate	36	20.9%
	Mid-Zone governorate	29	16.9%
	Khan Younis governorate	28	16.3%
	Rafah governorate	20	11.6%
Marital Status	Single	9	5.2%
	Married	160	93.6%
	Widows	2	1.2%
Occupations	Physician	39	22.7%
	Nurse	28	16.3%
	Medical technician	40	23.3%
	Administrator	53	30.8%
	Support services	12	7%
Academic certificate	Less than Tawjehi	11	6.4%
	Tawjehi	28	16.3%
	Diploma	50	29.1%
	Bachelor	76	44.2%
	Master	7	4.1%
Years of education	Less than 12 years	29	18.1%
	From 13- 16 years	86	53.8%
	17 years and more	54	28.1%
Place of graduation	Palestinian Universities	144	66.3%
	Arab-Country Universities	33	19.2%
	Non-Arab Country universities	25	14.5%

Regarding the years of education as shows in table 5.5, the majority of respondents had less than 16 years of education (mean=15.3, SD=2.37, Range=11). According to academic certificate, the majority had Diploma degrees and less. This is not corresponding with Jouda (2003) study as the majority of respondents were got degree level (Jouda, 2003). The

researcher claims that the PHC managers need to encourage the supervisees continuous education is supported by this study findings, which shows that the majority of supervisees were not enrolled in continuous education (88.7%) of total respondents. Similar to the supervisors, the majority of supervisees were graduated from Palestinian Universities (66.3%).

A.5.2.2 Organizational Variables:

Regarding the years of experience at the job in PHC centers as table (5.6) shows the highest category were those who worked less than 10 years this could be explained by the expansion of services which tool place after the established of the PNA, (Mean 9.64, SD 7.33, Range 33). The mean years of experience in job in UK found as 14.2 years (Teasdale, Brocklehurst and Thom, 2001). Newly hired staff increase the burden over the health system as they need more training.

Table 5.6: Distribution of Supervisees by Organizational Variables.

Variable		Frequency	Percent
Years of experience	Less than 10 Years	114	66.7%
	From 11-20	41	24%
	21 years and more	16	9.4%
Job description	Available	78	46.2%
	Not Available	91	53.8%
In-service education	Yes	19	11.3%
	No	149	88.7%
Working in department they prefer	Preferable	141	82%
	Not Preferable	31	18%
Interesting in work	Interesting	135	78.9%
	Not interesting	36	21.1%

Staff who had job description represented 46.2% of respondents. This low percent may be related to different occupations which participants had. This finding inconsistent with supervisors findings as the majority of them agree that they had job descriptions. The importance of job description is highly acknowledge in the literature which shows that health workers develop difficulties in work due to insufficient job descriptions (Bégat, Ellefsen and Severinsson, 2005).

Half of participants were engaged in in-service education as table (5.6) shows. The majority of participants who are not enrolled in in-service education were from support services.

The majority of supervised staff are working in their preferable department. While the percentage of who are interesting in practicing job was 78.9% of respondent. The percentage of preference and interested were nearly to each other, that's explained by adaptation of supervisees in their work places (Table, 5.6).

A.5.2.3 Supervisory Variables:

Table 5.7: Distribution of Supervisees by Supervisory Related Variables.

Supervision variables		**Freq.**	**Percent**
Availability of supervisor	Available	162	94.7%
	Not available	9	5.3%
Type of supervisor	Internal supervisor	130	80.2%
	External supervisor	32	19.8%
Reports Review with staff	Reviewed	108	64.3%
	Not reviewed	60	35.7%

The majority of supervisees reported that they had supervisors. According to management structures each supervisees should have a supervisor in a span of control (Haimann, 1991). In a study conducted in UK about evaluation of local clinical supervision on practical nurse 43% of nurses did not know who their local supervisor was, and most of them reported that they would like to have known **(**Francine and Hale, 2001).

Regarding the type of supervision, the supervisees who reported that they had internal supervisors represented 80.2% of respondents. While the subjects who had external supervisor represents 19.8% of total respondent table (5.7). That means, the majority of supervisees are under the direct supervision. In UK, 69% of nurses were allowed to select their supervisors and it could be external or internal supervisor (Teasdale, Brocklehurst and Thom, 2001). While in Palestinian system the supervisors are usually not selected by supervisees.

More than half of supervisees reported that their supervisors reviewed their reports with them. These findings are similar to findings about supervisors as reported before. A study conducted in Tanzania, shows that the supervisees reported that there was little or no on-site supervision from their immediate and external supervisors and complains that they never received any written or oral feedback from their supervisors (Manongi, Marchant and Bygbjerg, 2006). Large number of supervisees reported that their reports are not reviewed, so there is a need to discuss these findings with managers and supervisors and actions need to be taken.

The number of visits varies from one supervisor to another, and the presence of many factors which affects the visits, as mentioned in the literature. Figure (5.10) shows that the visits by supervisors vary from once per month to no visits at all (Mean 4.5, SD 7.28, Range 30). It is

worthy to say that the fourth category which is "other" include different answers from respondents like, irregular visit, and one to two visits each years, and represents 17.7% of responses. It is interesting to mention that 8.5% of supervisees reported no any visit were performed by their supervisors and this shouldn't be ignored. The WHO suggests that the frequency of supervisory remarkably varies from place to another (WHO, 2004) .

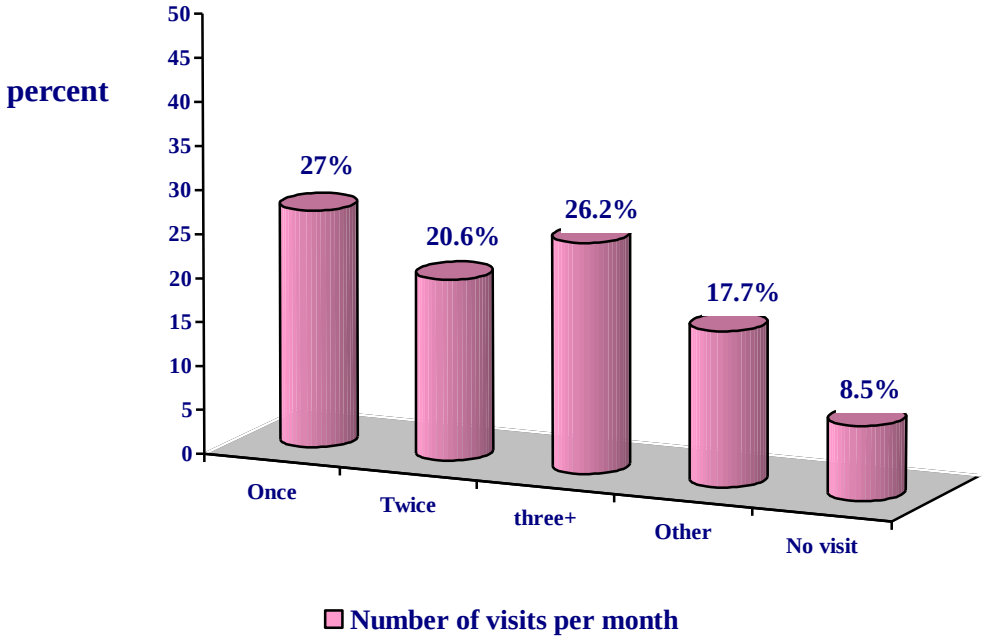


Figure 5.10: Distribution of Supervisees by Supervisors Visits Number

B.5.3.1 Domains of Supervision:

Supervision is a concept that requires many items to consider when being evaluated. It's assessment requires many questions, domains that can't be dealt with separately. The findings reported her are based on the staff perceptions of their roles and functions. It was difficult for researcher to study each items of the likert scale presented in the questionnaires alone. The researcher created a domains for each questionnaire to make it easy and applicable for analysis, these domains were six domains for supervisors and labeled as human resource management, management role**,** supervision approach**,** quality improvement, communication & support and facilities environment management. The supervisors perceive their roles and duties positively as shows in table (5.8). the researcher focuses on the most important items for each domain.

Table 5.8: Distribution of Supervisory Domains as presented by supervisors

Supervisory Domains	Number of Items	Mean	Percent
Human Resource Management	14	3.467	69.3%
Managerial Roles	12	3.583	71.7%
Supervision Approach	9	3.626	72.5%
Communication & Support	9	3.698	73.9%
Facilities Environment Management	7	4.005	80%
Quality Improvement	6	3.884	77%
Overall Perceptions	57	3.711	74.2%

B.5.3.1.1 The Overall Perception:

Refer to summation of the above supervision domains. The percentage of overall perception of domains was 74.2% and it's mean was 3.7 (maximum 5). This means that the supervisors have

a positive perception towards their role but still there is a room for improvement. The table above as well figure (5.11) shows that the mean of supervision domains was range from 3.4-4.005. the mean of overall perception was 3.7 while the percentage of supervision as supervisors perceive it was range from 69.3%-80%. The highest mean as well percentage of supervision was seen at facilities and Environment management, while the lowest was seen at human resource management which reflected poor management system at the organization.

B.5.3.1.2 Human Resource Management:

This domain reflects the performance of supervisors in managing the work groups. The supervisors perceived this domain as the least positive one among the domains (69.3%). This could be explained by the fact that the supervisors are not trained well on human resource management as well there is no clearly defined supervisory system. As related to the most important question about supervisory visits 68.7% agree of preparing themselves before visiting clinic and only 32% of them were inform the staff before visits while this is very low percentage, which needs follow up and more evaluation. In relation to organize meeting 58% of the supervisors agree about this task. The findings are consistent with Jaralla as the coordination of work function was 64.4%, as well the control of personnel as a resource take 59.3% (Jaralla and Khoja, 1998). The supervisors mentioned many of these activities as consuming most of their time. There is a need to clarify this domain for supervisors and train them to perform human resource management more efficiently by giving them training courses or via workshops.

B.5.3.1.3 Managerial Roles:

It reflects the level of understanding of the supervisors to their role as managerial roles. These roles agreed with what mentioned in the chapter 2 by (Haimann, 1991; Mac Namara, 2006). The percentage of this domain was reported as 71.7%, and it is considered as positive but is low in comparing with other domains. This could be explained as the supervisors are not sharing in decision making, hiring and firing the staff and setting objectives for organization. The supervisors reported that, 77% of them were not included in hiring and firing supervisees this may be due to the recruitment policy of MOH. In relation to decision making 41% of them disagree that they were involved in making decision on higher level. However, qualitative data support this explanation as supervisors said "we don't share in decision making", "higher manager interfere in our work", "the organization objective and plan are unclear" "there is decentralization on decision making and we are not included". To improve the management domain consensus workshops are recommended to clarify the role of supervisors, meeting with higher manager to break the bridge between them, as well clear supervisory systems and objectives also recommended. The supervisors in the open ended questions asked for; "increasing the communications between the supervisors and the higher managers", "clarify job descriptions for each supervisees according to their specifications" this is inconsistent with quantitative question as 85% of them agree about knowledge of job description for supervisees, this may explained by having job description but not clear and/or not relevant. "held continuous workshops and training courses", "improve the supervisory skills and give us more delegations". This is inconsistent with was founded in Saudi Arabia supervisors as 42% of them were fully involved in health policy planning, 91.9% of them coordinate of activity, 78.5% solving problems, and 22.2% of them discovering mistakes (Jaralla and Khoja, 1998).

B.5.3.1.4 Supervision Approach:

This domain reflects the supervisors ability to do supervisory work including visits and used reporting during supervisory visits. The level of this domain reported as 72.5% which is considered moderate in relation to other domains but still positive. 81.1% of the supervisors believed that they are doing enough visits, the frequency of visits depends on many factors like, type of program, supervisors jobs, reasons for visit, transportation availability and many others as mentioned in the second chapter. There is a need to focus on the quality of supervisory visits at PHC centers, also many of them were reported they create a positive climate at the work place, discuss problem with their subordinate and 68.4% of them were reported their visits while 68.1% of them discuss report with supervisees and 77.1% report that they review report with their supervisors. These findings need to be recognized by policy makers.

B.5.3.1.5 Communication and Support:

This domain includes the support from higher manager as well providing support to subordinate and other many factors mentioned in questionnaire. Communication and support are very important to achieve the goal of the organization and the supervisors the one who could perform this role as many authors mentioned in their research studies such as (Zawadsky, 2004; Haimann, 1991; Consedine, 2004 and many others) see chapter 2. The supervisors positively perceived and reported for this domain 73.9%. This may be related to Palestinian context as they prefer social interactions, focuses on communication in order to maintain harmony and peaceful between people. However, in the open ended questions the supervisors report that they had little support from higher manager, corresponding with their answers to the same quantitative question around 64.6% of the receive support from their

manager and about 86.1% of them reported that they provide support to their subordinate. There are many problems with communication between them and their higher managers, also they reported that their communications with subordinates are pleasant as they should be. They asked for more support and better communications between them and their managers in response to qualitative questions. Communication is considered as important aspects in work environment as it plays an important role in staff satisfaction. It is recommended for manager to increase their interaction with their staff in order to enhance this part.

B.5.3.1.6 Facilities and Environment Management:

This domain reflects the supervisors ability to manage the facilities in order to meet the goals and objectives of their organization. In spite of, the supervisors complains of equipment deficit and insufficient work environment, this domain reported the highest percentage among other domains 80%. In response to this domain more than 92% of them agreed to do all the procedures (Annex,4). The high score could be related to the fact that this domain deals with tangible issues that is visible and less complicated than other issues. Supervisors major role is to help the staff to meet their needs of supplies (MSH and USAID, 2006). These findings shows the spirit of Palestinian people as they could live in the most difficult situations and able to provide quality work with these difficulties.

B.5.3.1.7 Quality Improvement:

It reflects the supervisors ability to assess staff clinical skills and competencies. The supervisors positively perceived this domain (77%), which is considered as good among the other domains. This is consistent to Jaralla (1998), as the supervisors rating quality improvement as 80% of supervisors functions (Jaralla and Khoja, 1998). However, the

supervisors reported; "follow up the supervisees in their work", "training programs", "education and guidance," "planning", as consuming most of their time. The item related to provide training for supervisees 90% of supervisors agreed of doing that. Many researchers focused on quality care in their researches as mention in (ch.2). Quality is very important in Palestinian context specially quality improvement, it is regarded as a strategic objective in health plans (1999).

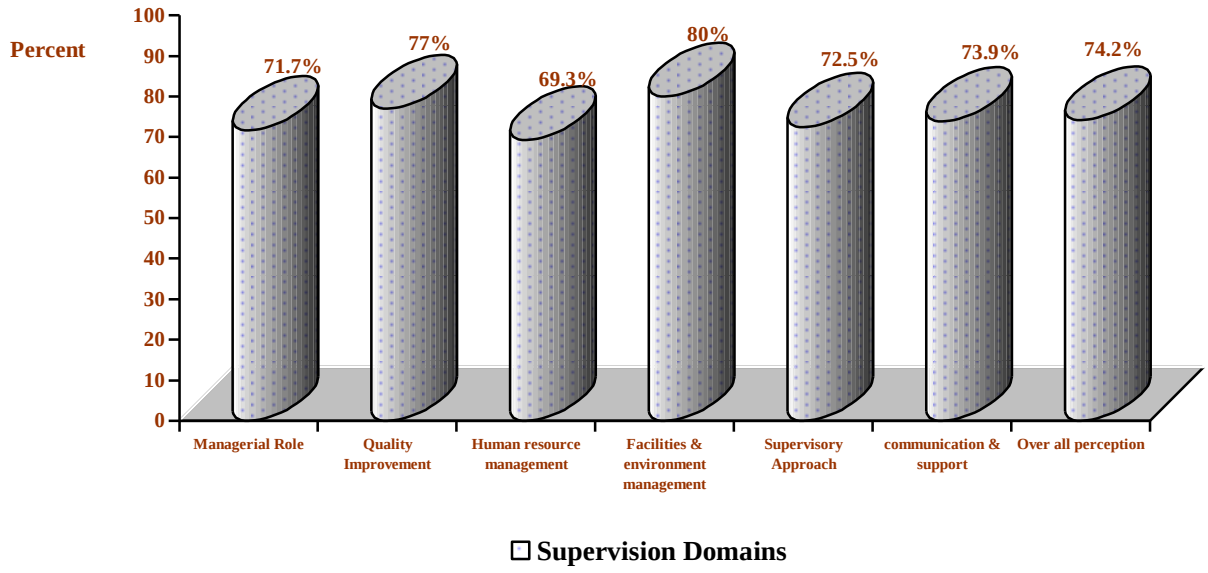


Figure 5.11: Distribution of Supervisory Domains as presented by supervisors by level

B.5.3.2 Supervisees Domains:

The items of supervisees questionnaire were classified by researcher into four categories, management behavior, communication and support, fairness, and involvement. The overall perception is the summation of the four factors above. The table (5.9) and Figure 5.12, show the rang of mean from 3.1-3.5, the highest mean was for communication and support, the lowest mean was for involvement. The supervisees report relatively positive perception towards their supervisors (66.9%) which is consistent with study conducted at Shifa hospital (Jouda, 2003). A study in UK showed that nurses who are supervised reported positive perceptions towards their supervisors (Teasdale, Brocklehurst and Thom, 2001).

Table 5.9: Distribution of Supervisees Domains as Presented by Supervisees

Factors	N0. of items	mean	Percent
Management Behavior	8	3.33	66.6%
Communication and support	8	3.544	70.88%
Involvement	5	3.174	63.4%
Fairness	4	3.203	64.06%
Overall perception	25	3.348	66.9%

B.5.3.2.1 Management Behaviors:

This domain refers how the supervisors deal with their supervisees (Annex, 5). The supervisees show positive perception toward management behavior 66.6%. Particularly the feedback is considered very important to enhance the relationship between supervisors and

supervisees as mentioned in the literature. This is consistent with (Jouda, 2003) who found staff had moderate level of perception toward their supervisors (66.8%). The majority of supervisees mention that, internal supervisors are very supportive and provide them with needed feedback and review report with them, but they complain from the external supervisors as they don't provide them with any support. Knowledge of supervisors for his/her job and the quality of supervisees work are another important items of organizational behaviors. About 76% of them agreed that their supervisors had a good knowledge about the work. This is corresponding with findings from Jouda (2003) studies. Training is very important in improve supervisees performance we need to encourage and support the supervisors to conduct more training.

B.5.3.2.2 Communication and Support:

This domain reflects the staff perceptions towards their supervisors in relation to communication. The supervisees showed positive perceptions toward this domain as they reported the highest percentage which is 70.8% among others. This is proved by qualitative questions as the supervisees reported that they had good relationships with their supervisors and they were respected from them as well they provide them with support during work if they faced any problems. However, they mentioned that their external supervisors had conflicting relationships with them. Jouda (2003) found that the staff perceive the interaction domain which it's items is similar to this domain by 63.5% which is considered as relatively low ranked perception (Jouda, 2003). The good interpersonal relationship is considered healthy for work environment as it increases effective performance (Ben Salem and Beattie, 1996). It is good to invest in social interactions through clinics and workshops that maintain the relationship outside the work environment specially with external supervisors.

B.5.3.2.4 Involvement:

This domain is related to supervisees perceptions of their responsibilities, and sharing in decision making. The supervisees perceived this domain as relatively low among others domains 63.4%**.** This low perception may be explained by the supervisees needs for more training courses particularly in involving others, their approach to include others in decision making. Jouda (2003) study at Shifa hospital shows that the staff reported low level of perception with professional development and empowerment (50.8%). Participation in decision making was an important item in the involvement as 37% of subjects reported that they were not sharing in decision making on their level, and 62% agreed that they were included and given reasons when change in work place done. The last items were if they found the training courses sufficient or not 71% of them found it not enough, consistence with their reporting in open ended questions the needs for more training in their job.

B.4.3.2.3 Fairness:

This domain is related to equity and fairness in the organization. The supervisees show moderate positive perception in relation to this domain as they reported 64.06% percentage in between other domains. Also the majority of them reported that, the fairness is one of the best adjective they like in their supervisors. In relation to the question if the supervisors only detect error 42% of supervisees agree that supervisors only detecting error which is considered high percentage, as the supervisors roles are to coach, train, solve problem and support not only detecting error. According to disciplinary actions, 41% agree that their supervisors were fair when they do it and 37% of them Don't know if there is fairness as all of them reported that

they were never got any disciplinary actions from their supervisors, while the majority of supervisors (93.1%) reported that they critique the supervisees in constructive manner.

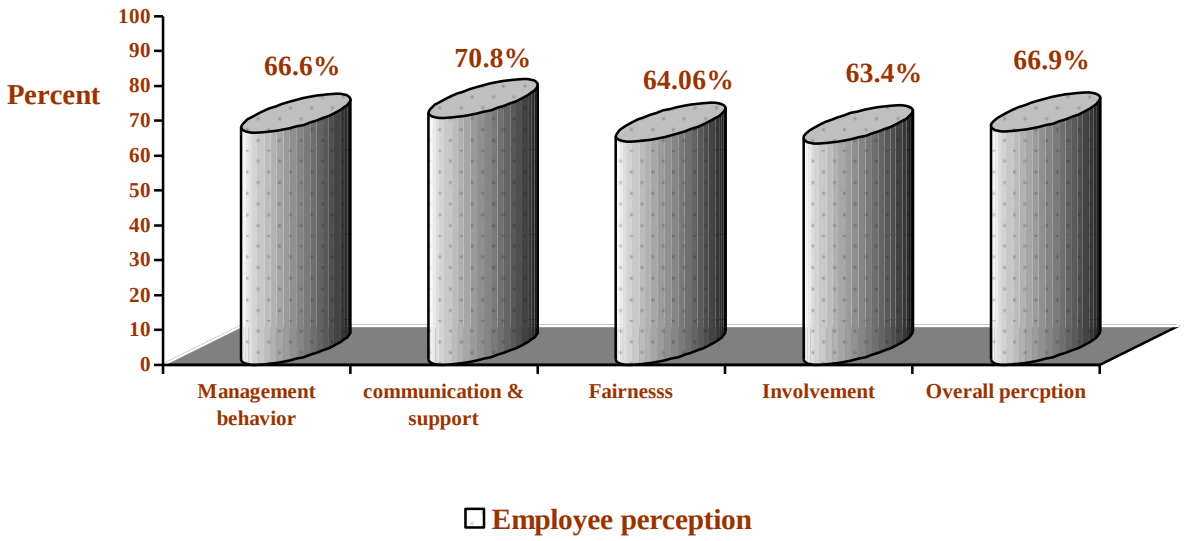


Figure 5.12: Distribution of supervisory domains as perceived by supervisees by level

C.5.4 Inferential Statistic

This part discusses the relationships between the dependent and independent variables for both supervisors and supervisees by using some of statistical tests, and the researcher provides an explanation and opinion regarding the findings of this study. The dependent variable for supervisors was the supervision domains to explore the role and perception of supervisors at PHC, the dependent variable for supervisees was four perception domains. The independents variable for both were, demographical data such as, gender, age residency place, marital status, main job, years of education, place of basic education, Additional, organizational variables such as, years of experience, attending continuous education, interesting in doing work, job description, supervisory related variables which included, for supervisors; job title, number of clinics and supervisees under supervision, number of visits, training on supervision, supervision tools and systems, and reviewing reports by direct supervisors. For supervisees the supervisory variables were; if they had a supervisor, number of visits, and review reports and other variables.

C.5.4.1 Supervisors Part:

C.5.4.1.1 Demographic Characters and supervisory domains:

Regarding age, residency place, marital status, years of education and academic certificate all showed no statistically significant differences in the overall perception (Annexes 7, Tables 1,2,3,4,5).

Table 5.10: Differences in Supervision Domains by Gender

Dependent var. *"Supervision Domains"*	**Ind. var.** *"Gender"*	**N**	**Mean**	**SD**	**t**	**Sig.**
Managerial Role	Male	198	3,6633	.53691	3.007	.003*
	Female	43	3,3895	.56041		
Quality Improvement	Male	198	3,9217	.66638	.823	.411
	Female	43	3,8295	.66517		
Human Resource Management	Male	198	3,5538	.73977	2.802	.005*
	Female	43	3,1877	.92910		
Facilities & Environment Management	Male	198	4,0606	.70973	1.827	.069
	Female	43	3,8339	.85597		
Supervisory Approach	Male	198	3,7077	.91338	2.213	.028*
	Female	43	3,3634	.97659		
Communication & Support	Male	198	3,7626	.74301	2.117	.035*
	Female	43	3,5013	.68809		
Overall perception	Male	198	3.7783	.55281	2.782	.006*
	Female	43	3.5175	.57632		

* Statistically significant

Gender differences with supervision domains (Table, 5.10) using independent t-test which shows that the males and females had statistical significant differences in the mean scores in overall perception (P=.006). Similarly all sub-scale domains were statistical significant differences except quality improvement and facilities & environment management. The study shows that males had more positive perception to all supervision domains than females. This could be explained by the Arabic context where males can practice their roles more freely than females. The findings of the study is consistent with Severinsson (1999) study, which shows differences between female and male nurses in relation to the work environment **(**Severinsson and Kamaker, 1999**)**. But inconsistence with (Thabet, 2004) study at job satisfaction in relation to supervision where she found that there were no statistical significance differences in relation to gender. More concern to female supervisors is needed to be included by the PHC manager.

Table 5.11: Differences in Supervision Domains and Job type

Dependent variable *"Supervision Domains"*	**Indep. Var**. *"Main Job"*	**Sum of Square**	**DF**	**Mean Square**	**F**	**Sig.**
Managerial Role	Between group	4.419	4	1.105	3.340	.011*
	Within group	77.724	235	.331		
	Total	82.143	239			
Quality Improvement	Between group	5.894	4	1.473	3.418	.010*
	Within group	101.303	235	.431		
	Total	107.196	239			
Human Resource Management	Between group	2.561	4	.640	1.021	.397
	Within group	147.359	235	.627		
	Total	149.920	239			
Facilities and Environment Management	Between group	11.480	4	2.870	5.597	.000*
	Within group	120.506	235	.513		
	Total	131.986	239			
Supervisory Approach	Between group	5.390	4	1.347	1.540	.191
	Within group	205.555	235	.875		
	Total	210.945	239			
Communication and Support	Between group	2.752	4	.688	1.257	.288
	Within group	128.655	235	.547		
	Total	131.407	239			
Overall perception	Between group	3.978	4	.995	3.154	.015*
	Within group	74.100	235	.315		
	Total	78.079	239			

*The sub-scale group mean (Physician 3.7025,Nurses 3.8480, medical technicians 3.4885, Administrators 3.7771, others 3.3782)

One way ANOVA used to examine the supervision domains by occupation of participants (table, 5.11) shows that there were differences in the overall perceptions of domains with statistical significant (P=.015). The respondents shows difference statistical significance in managerial role, quality improvement, and facilities & environment management. No statistical significant different in human resource management, supervisory approach, and communication & support were reported. Scheffe test shows that nurses had more positive perception, then administrator, physician, and the medical technician consequently. This could be explained by the basic training of participant on supervision more in nursing than other

occupations. Also, supervision is more clear in nursing job that's why nurses more positively than other jobs. These findings are inconsistence with (Thabet, 2004), study which shows no significant differences between occupation and job satisfaction among hospital managers. In contrary, the findings are consistent with a study conducted in Finland which showed statistical significant differences between supervisors occupation in relation to supervision effects on satisfaction, while the higher mean found at occupational therapists but other occupations and nurses showed the lowest mean **(**Hyrkäs, 2006**)**. The study findings could help the manager to develop training on supervision for other jobs which elicited lower level in their perception.

Table 5.12: Differences in Supervision Domains by Country of Education Category

Dep. Variable *"Supervision Domains"*	**Independ. Var.** "Contry of education"	**Sum of Square**	**DF**	**Mean Square**	**F**	**Sig.**
Managerial Role	Between group	.472	2	.236	.663	.516
	Within group	76.861	216	.356		
	Total	77.333	218			
Quality Improvement	Between group	2.922	2	1.461	3.336	.037*
	Within group	94.611	216	.438		
	Total	97.533	218			
Human Resource Management	Between group	1.285	2	.642	1.086	.340
	Within group	127.831	216	.592		
	Total	129.116	218			
Facilities and Environment Management	Between group	3.186	2	1.593	3.022	.051*
	Within group	113.870	216	.527		
	Total	117.056	218			
Supervisory Approach	Between group	3.447	2	1.724	2.055	.131
	Within group	181.173	216	.839		
	Total	184.620	218			
Communication and Support	Between group	2.144	2	1.072	2.052	.131
	Within group	112.835	216	.522		
	Total	114.979	218			
Overall perception	Between group	1.893	2	.946	3.02	.051*
	Within group	67.608	216	.313		
	Total	69.500	218			

***The mean (Palestine 3.8335, Arab country 3.6720, Non-Arab country 3.5958)**.

Regarding the country of university education, respondent shows (table, 5.12) statistical significant differences in overall perception (P=.051). The respondents who got their training from Non Arab countries showed higher statistical significant differences in quality improvement (P=.037) and facilities & environment management (P=.051) compared with Palestinian and Arab countries. This reflects the organizational culture of the Non Arab organizations as they have different systems and utilize supervision more effectively. This is consistent with (Jouda, 2003) findings that staff who studied at Non Arab countries shows significant relation with moral and commitment than staff who studied at Arab and Palestinian universities. Concerns should be made for those who graduated from Palestine and Arab countries in relation to the supervision domains. Palestinian universities need to includes management and supervision in the curriculum of their professions.

C.5.4.1.2 Organizational Variables and supervisory domains:

Regarding job descriptions, years of experience at job and organization, all showed no statistical significant differences in overall perception with a little variations in the sub-scale domains (Annex 7, Tables 6,7,8).

An independent t-test was used to compare the mean of the supervision domains scores in regard the intention to stay or to leave the PHC. It shows that the mean scores of the staff who had intention to stay in PHC were higher than the mean of the supervisors who aren't interested to stay in PHC in most of the domains. Managerial role domain shows differences between groups with statistically significant (P=.011), and human resource management domain is statistically significance (P=.004). The overall perception shows relatively significant (P=.077). This agrees with the tasks that the supervisors mostly preferred to do as

reported in the open ended questions including, organizing and follow up the work, providing training and education to supervisees. But inconsistence with other tasks the supervisors preferred including, communication and support, delegation, quality improvement, and coordination of work. The majority of supervisors in Saudi Arabia study (88.9%) were happy working as supervisors which aid in their positive perception to their supervision (Jaralla and Khoja, 2006). This finding could help manager to motivate the supervisors who want to stay and the others who don't want to stay, considering staff preference and allowing autonomy is an important factors in improving work climate and performance (Annex 7, table 9).

5.4.1.3 Supervision Variables and supervisory domains:

Regarding availability of supervisors, availability of report, checklist and using report and visit numbers in comparing with supervision domains, the study didn't reveal in this regard statistical significant differences (Annex 7, Table 10,11,12,13,14).

Table 5.13: Differences in Supervision Domains by Supervision Type.

Dependent var. *"Supervision Domains"*	**Indp. var.** *"Type of supervision"*	**N**	**Mean**	**SD**	**t**	**Sig.**
Managerial Role	Internal	183	3.5952	.57212	-.152	.880
	External	60	3.6083	.61855		
Quality Improvement	Internal	183	3.8743	.67440	-1.070	.286
	External	60	3.9806	.64593		
Human Resource Management	Internal	183	3.4251	.82906	-1.977	.049*
	External	60	3.6560	.63118		
Facilities &Environment Management	Internal	183	4.0531	.69927	1.156	.249
	External	60	3.9262	.84638		
Supervisory Approach	Internal	183	3.5178	.97805	-4.446	.000*
	External	60	4.0167	.66482		
Communication and Support	Internal	183	3.6588	.77095	-2.042	.042*
	External	60	3.8815	.60231		

Overall perception	Internal	183	3.6874	.58035	-1.872	.062
	External	60	3.8449	.51742		

An independent t-test was used to compare supervision domains by the type of supervision. Table (5.13) shows small variations in the mean scores between group in the overall perception were reported with statistically significant differences in Human resource management, & in supervisory approach and communication and support. These finding could be explained by the close observation of internal supervisors may affect in there perception to supervision domains. These finding inconsistence with (Thabet, 2004) study which showed that there were no differences between level of hospital managers and supervision. A written supervisory system could help the supervisors to perceive their role more positively.

Table 5.14: Differences in Supervision Domains and Receiving Training Courses on Supervision

Dependent var. *"Supervision Domains"*	**Ind. var.** *"Training courses"*	**N**	**Mean**	**SD**	**t**	**Sig.**
Managerial Role	Yes	137	3.7105	.50001	3.458	.001*
	No	92	3.4321	.65453		
Quality Improvement	Yes	137	3.9477	.60794	1.358	.176
	No	92	3.8188	.76142		
Human Resource Management	Yes	137	3.5772	.74498	2.165	.032*
	No	92	3.3416	.50001		
Facilities & Environment Management	Yes	137	4.0115	.76345	-.829	.408
	No	92	4.0885	.56147		
Supervisory Approach	Yes	137	3.7920	.87267	2.637	.009*
	No	92	3.4728	.93446		
Communication and Support	Yes	137	3.7989	.60191	1.671	.096
	No	92	3.6449	.79019		
Overall perception	Yes	137	3.8063	.51452	2.271	.024 *
	No	92	3.6331	.59732		

Regarding training on supervision, the mean was relatively near in all domains in table (5.14), the higher mean was observed in the facilities and environment management domain with no statistically significance, followed by quality improvement, and the communication and support domain shows no statistically significance. The overall and other domains shows statistically significant. The respondent who had training courses had positive perception toward supervision domains. It could be explained by those who trained on supervision were more oriented to their roles than others without training. This finding consistent with (Thabet, 2004; Hyrkas, Appelqvist-Schmidlechner and Hataja, 2006**)**.

It's worthy to say that the majority of supervisors asked about training courses and in-service education in the open ended questions, and they mentioned that one of the most tasks they like as a supervisors was the training and work shops. These findings may flag the need to focus on training specially on supervision activities.

Table 5.15: Differences in Supervision Domains and Availability of Supervisory Tools

Dependent var. *"Supervision domains"*	**Ind. var.** *"Supervisor tool"*	**N**	**Mean**	**SD**	**t**	**Sig.**
Managerial Role	Yes	131	3.7201	.48691	2.716	.007*
	No	81	3.5093	.58452		
Quality Improvement	Yes	131	4.0140	.57810	2.297	.023*
	No	81	3.7840	.77837		
Human Resource Management	Yes	131	3.6287	.65510	2.238	.027*
	No	81	3.3660	.92240		
Facilities & Environment Management	Yes	131	4.0763	.67363	.553	.581
	No	81	4.0212	.75495		
Supervisory Approach	Yes	131	3.8645	.86506	3.698	.000*
	No	81	3.3997	.92732		
Communication and Support	Yes	131	3.8244	.65863	1.656	.099
	No	81	3.6612	.75643		
Overall perception	Yes	131	3.8547	.48164	2.883	.005 *
	No	81	3.6235	.61424		

An independent t-test was used to compare the means of the supervision domains in relation to the availability of supervisory tools. Table (5.15) shows that there is statistically significance differences between supervisors who had supervisory tools with there who don't, in managerial role domain (P=0.007), quality improvement domain (P=0.023), human resource management domain (P=0.027), supervisory approach domain (P=0.000), and the overall perception domains (P=0.005). Other domains which were facilities & Environment management had higher mean score with similar mean in between the group and communication & support had relatively similar mean score like others domains, both domains with no statistically significant differences. This may be explained as the presence of supervisory tool was so important for professional work as they showed statistical significant differences in the majority of domains except communication and support which informal ways play an important role, especially in our organization.

It is worthy to say that while answering the open ended questions some of supervisors complain of absence of supervisory tool and instrument, and there supervisors doesn't take their report into consideration. This finding help the manager to focus on supervisor tools as an important in doing an effective and quality work. Good decision are not enough, tools and means are important as well.

Table 5.16: Differences in Supervision Domains and the Availability of Supervision System

Dependent var. *"Supervision Domains"*	**Indep. var.** *"Supervisory system"*	**N**	**Mean**	**SD**	**t**	**Sig.**
Managerial Role	Yes	86	3.8159	.46321	4.826	.000*
	No	142	3.4771	.58776		
Quality Improvement	Yes	86	4.0446	.48333	2.852	.005*
	No	142	3.8122	.74611		
Human Resource Management	Yes	86	3.6869	.71556	2.990	.003*
	No	142	3.3763	.78601		
Facilities & Environment Management	Yes	86	4.1346	.57909	1.479	.141
	No	142	4.0080	.65272		
Supervisory Approach	Yes	86	3.8895	.86654	2.872	.004*
	No	142	3.5449	.88505		
Communication and Support	Yes	86	3.8605	.60863	2.102	.037*
	No	142	3.6682	.70335		
Overall perception	Yes	86	3.9053	.49297	3.609	.000*
	No	142	3.6478	.53906		

Regarding the availability of supervisory systems, an independent t-test was performed comparing by supervision domains. The table (5.16) shows a difference in mean scores between the groups with statistically significant, the overall perception of the domains shows P=0.000. Only the facilities & environment management domain shows the highest mean scores with small difference between group and no statistically significant (P=0.141). In spite of few supervisors who agreed about presence of supervisory system, it was observed that

there were a statistical significant differences between supervisors who had supervisory system with others who don't. That's could be explained by the presence of systems helps supervisors to be more positive to their supervision role. This could help the manager of PHC to review the current system and to create a system for supervisors who don't have clear supervisory systems.

Table 5.17: Differences in Supervision Domains and Reviewing Reports

Dependent var. *"Supervision Domains"*	**Indep. var.** *"Review document"*	**N**	**Mean**	**SD**	**t**	**Sig.**
Managerial Role	Yes	136	3.6814	.52723	2.539	.012*
	No	86	3.4826	.62819		
Quality Improvement	Yes	136	4.0282	.54416	3.055	.003*
	No	86	3.7345	.77938		
Human Resource Management	Yes	136	3.4905	.83366	-.187	.852
	No	86	3.5108	.70791		
Facilities & Environment Management	Yes	136	4.0641	.76957	.399	.690
	No	86	4.0266	.51322		
Supervisory Approach	Yes	136	3.8226	.87050	2.828	.005*
	No	86	3.4869	.84715		
Communication and Support	Yes	136	3.7859	.64670	1.303	.194
	No	86	3.6628	.74418		
Overall perception	Yes	136	3.8121	.53170	2.172	.031*
	No	86	3.6507	.55132		

An independent t-test comparing between reviewing of documents/reports and supervision domains. Table (5.17) shows that the supervisors who their document were reviewed by their higher supervisors had higher mean scores than others, with statistically significant differences in managerial role (P =.012), quality improvement (P=.001), supervisory approach (P=.005), and the overall perception of domains (P=.031). Other domains had different mean scores with no statistically significant differences between groups. However, supervisors in the open ended question reporting that their reports were not taken into consideration by their higher

managers as well they complain of centralization of work and didn't got support from their higher managers. These findings support one of the most important duties of the supervisors which is to assist the subordinates in doing their duties.

Table 5.18: Differences in Supervision Domains Regarding Clinics Number

Dependent variable *"Supervision Domains"*	**Indep. Var**. *"Number of clinic"*	**Sum of Square**	**DF**	**Mean Square**	**F**	**Sig.**
Managerial Role	Between group	4.053	2	2.026	6.299	.002*
	Within group	72.060	224	.322		
	Total	76.113	226			
Quality Improvement	Between group	.593	2	.296	.692	.502
	Within group	95.982	224	.428		
	Total	96.575	226			
Human Resource Management	Between group	5.595	2	2.798	4.895	.008*
	Within group	128.012	224	.571		
	Total	133.607	226			
Facilities &Environment Management	Between group	3.596	2	1.798	3.291	.039*
	Within group	122.399	224	.546		
	Total	125.996	226			
Supervisory approach	Between group	17.670	2	8.835	12.045	.000*
	Within group	164.310	224	.734		
	Total	181.980	226			
Communication & Support	Between group	6.269	2	3.134	6.220	.002*
	Within group	112.876	224	.504		
	Total	119.144	226			
Overall perception	Between group	3.917	2	1.958	6.554	.002*
	Within group	66.933	224	.299		
	Total	70.850	226			

* the mean (One clinic 3.6828, From 2-35 clinics 3.8160, 45 clinics and more 4.2930).

To examine the effect of clinics number per supervisor on supervision domains, one way ANOVA was used and showed statistically significance differences for all domains (P=0.002),

except quality improvement domain which shows no statistically significant differences (P=.270), and facilities & environment management relatively significant (P=.06). From the data we conclude that there is a relation between number of clinics supervised by a supervisor and supervision domains, when the number of clinic is higher the supervisors perception are more positive. This could be explained by the supervisors who supervised high number of clinics had broad thinking, and more understanding for their roles as a supervisors. Focusing on the supervisors who supervised a few number of clinics and clarification of the role of supervision to them are needed.

Table 5.19: Differences in Supervision Domains and Supervisees Number

Dependent variable *"Supervision Domains"*	**Indep. Var.** *"Supervisees number"*	**Sum of Square**	**DF**	**Mean Square**	**F**	**Sig.**
Managerial Role	Between group	2.598	4	.649	1.965	.101
	Within group	74.372	225	.331		
	Total	76.970	229			
Quality Improvement	Between group	3.215	4	.804	1.820	.126
	Within group	99.389	225	.442		
	Total	102.604	229			
Human Resource Management	Between group	4.785	4	1.196	1.940	.105
	Within group	138.779	225	.617		
	Total	143.564	229			
Facilities & Environment Management	Between group	3.961	4	.990	1.792	.131
	Within group	124.379	225	.553		
	Total	128.341	229			
Supervisory approach	Between group	10.628	4	2.657	3.202	.014*
	Within group	186.716	225	.830		
	Total	197.344	229			
Communication & Support	Between group	2.063	4	.516	.993	.412
	Within group	116.832	225	.519		
	Total	118.896	229			
Overall perception	Between group	3.648	4	.912	2.957	.021*
	Within group	69.383	225	.308		
	Total	73.031	229			

*the mean (less than five 3.5627, from 6-20- 3.7268, from 21-40- 3.8452, from 41-99- 3.6526, from 100 and more 4.0319).

Differences of supervisees number per supervisor by supervision domains was examined by using one way ANOVA. The table (5.19) shows that the overall perception of domains with different mean scores and statistically significant differences (P=.021). The highest mean scores was to the supervisors supervised the highest number of supervisees. Supervisory approach domain shows statistically significant (P=.014), the remaining domains were not statistically significant. This explained as the increase number of supervisees under supervision the perception be more positive which is corresponding with number of clinics with the same explanation. This is inconsistent with what Hyrkäs (2006) found in relation to number of supervisees, the lowest number had the higher mean with significant differences. It's worthy to say that the majority of supervisors complain of number of supervisees deficit in PHC mainly nurses and doctors, in their response to open ended question. The supervisors with low number of supervisees needs to be trained on supervisory activities, as well there is a need to focus on and clarify the role of supervisor by their level.

Table 5.20: Differences in Supervision Domains and Benefit of Supervision

Dependent var. *"Supervision Domains"*	**Indep. var.** *"Benefit from supervision"*	**N**	**Mean**	**SD**	**t**	**Sig.**
Managerial Role	Yes	103	3.7460	.51375	3.381	.001*
	No	142	3.5040	.55510		
Quality Improvement	Yes	103	4.0356	.57907	2.429	.016*
	No	142	3.8253	.70257		
Human Resource Management	Yes	103	3.6123	.73646	1.936	.054*
	No	142	3.4136	.79713		
Facilities & Environment Management	Yes	103	4.0610	.80951	.381	.704
	No	142	4.0253	.60088		
Supervisory approach	Yes	103	3.8325	.88865	2.178	.030*
	No	142	3.5796	.85604		
Communication and Support	Yes	103	3.8188	.68440	1.532	.127
	No	142	3.6765	.70672		

Overall perception	Yes	103	3.8510	.55920	2.515	.013*
	No	142	3.6707	.51911		

An independent t-test comparing benefit from supervision by supervision domains. Table 5.20, showed variations between groups mean scores with statistical significant differences. The overall perception mean scores differ between group with statistically significant differences (P=0.013), the supervisors who got benefit from there supervision shows positive perception then others, not all sub-group are statistically significance differences as the table shows. Facility & environment management domain the higher mean scores and communication and support which are not statistical significant. These findings could be explained by the positive relationships between the benefits they got from supervision and the supervision domains. As the supervisors who got benefits were more positively perceive the supervision. The benefits can improve the supervision perception, that's why it is important to focus on it and to increase it as possible.

Suggestions reported by supervisors to improve supervisory tasks in an open ended question were too many because of that the researcher categorized them into groups and reported as supervisor priorities which included, improve supervisors education by increasing workshops, training courses in management and other disciplines, as well they asked about fairness in training especially abroad courses, and availability of in-service education as well helping them to increase their knowledge. This is supported by study at Saudi Arabia which found that more than 90% of the supervisors said they would like to receive formal training in supervision and increasing the frequency of visits (54.1%). Increasing the number of supervisors was suggested by (25.9%) of respondents. Giving more incentives was mentioned by very few (3.7%) **(**Jaralla and Khoja, 1998**).** Availability of job descriptions will help them

to know their roles and others will know their role, This will help them to be more official, availability of tools which facilitate work and availability of computerized system at clinics as this will help them to communicate with their supervisors and others clinic more easily, as they complain of deficit in number of visit and follow up from their manager they recommended to their higher manager always to be in contact, and more visits by higher managers were recommended. As well they complain of absence of reward and incentive system at PHC they asked for availability of reward and punishment system as well availability of better appraisal system. As reported in Zimbabwe study supervisors praise their supervisees and this a praise was related to facility level (Tavrow, Young-Mikim and Malianga, 2006), and give the supervisor revenue for their supervision. Participation in decision making will make them more responsible for the decisions. Availability of clear plan, protocols, and system for supervision with different specialties the supervisory system will help them to follow the same steps and be more systematic and responsible of their work. As they complain of absence of support from their manager they recommended to provide them with support and treating supervisors far away from their political affiliations. Help them to find fair and fast solution for problem they faced at work place. Finally they ask to put suitable person in suitable position.

C.5.5.2 Supervisees Part:

C.5.5.2 Demographic Characters and Supervisees Domains:

Different tests were used to examine the relationships of demographical data and supervisees domains, in order to explore the effects of various demographical variables on supervisees perceptions about their supervisors. Regarding gender, age, residency place, marital status, academic certificate, years of education, and continuous education variables all found with no statistical significant differences with supervisees perceptions (Annex 8, Table 1,2,3,4,5,6,7).

Table 5.21: Differences in Supervisees Domains and Occupations

Dependent variable *"Supervisees Domains"*	**Indep. Var**. *"occupation"*	**Sum of Square**	**DF**	**Mean Square**	**F**	**Sig.**
Management Behavior	Between group	6.109	4	1.527	3.122	.017*
	Within group	81.705	167	.489		
	Total	87.814	171			
Communication and support	Between group	1.448	4	.362	1.184	.320
	Within group	51.042	167	.306		
	Total	52.490	171			
Fairness	Between group	2.888	4	.722	1.286	.277
	Within group	93.739	167	.561		
	Total	96.628	171			
Involvement	Between group	4.529	4	1.132	2.834	.026*
	Within group	66.718	167	.400		
	Total	71.247	171			
Overall perception	Between group	2.527	4	.632	2.205	.071
	Within group	47.844	167	.286		
	Total	50.370	171			

*The mean (Physician 3.2349, Nurses 3.5743, Medical Technicians 3.3550, Administrators 3.2725, Support services 3.5033).

One way ANOVA was used to examine the differences between the staff perception towards supervision and their occupation. The table (5.21) shows the relatively statistical significant differences in overall perception, nurses show relatively positive perception in overall

perception and in involvement perception domain (P=.026). While the management behaviors show statistical significant differences (P=.017), the support services showed positive perception to this domain. The physician had negative perception towards their supervisors. This could be explained as the more professional the job the more difficult to be satisfied. Hyrkäs 2006, study on supervisees which were all nurses and its specialists, shows statistical significant differences with occupation of supervisees and the effect of supervision on their satisfaction**.** As well a study done in UK showed that the nurses with low degree had positive significant to support from there supervisor than higher degrees (Teasdale, Brocklehurst and Thom, 2001). The findings may help the supervisors to focus more on the high level supervisees and to share them in decisions, as this may increase their satisfaction as well effect on their perceptions.

C.5.5.2.2 Organizational Factors:

One way ANOVA used to examine years of experience in organization and independent t-test to examine job description in examining differences with supervisees domains, all found with no statistical significant differences (Annex 8, Tables 8,9). The in-service education and it's effects on the supervisees perception was examined by using independent t-test. The findings show no statistical significant differences in overall perceptions and sub-scale domains, except the involvement domain which shows, the supervisees who were enrolled in in-service education had positive perception than who do not (P=.011). These findings could be due to lack of satisfaction response to supervisees about these workshops as they asked for more training and education in response to the open ended questions. Which guide the manager to increase the period and quality of these workshops (Annex 8, Table 10).

Table 5.22: Differences in Supervisees Domains and working in Preferable Department

Dependent var. ***"Supervisees domains"***	**Indep. var.** "preferable department"	**N**	**Mean**	**SD**	**t**	**Sig.**
Management behavior	Yes	141	3.4096	.67911	3.037	.003*
	No	31	2.9879	.79014		
Communication and support	Yes	141	3.5975	.54896	2.735	.007*
	No	31	3.3024	.51919		
Fairness	Yes	141	3.2429	.75767	1.472	.143
	No	31	3.0242	.70815		
Involvement	Yes	141	3.2000	.65159	1.109	.269
	No	31	3.0581	.61361		
Overall perception	Yes	141	3.4011	.53146	2.772	.006*
	No	31	3.1084	.53697		

Table (5.22) shows that, the supervisees who worked at their preferable departments had positive perception with statistical significant differences in overall perception and showed variation in sub-scale domains. The management behavior (P value .003), and communication and support domain (P value .007) both with statistical significant differences. While the other two domains show no significant differences. This finding could be explained by the level of adaptation which had an effect on the supervisees perceptions so the result could help the manager of PHC to recruit persons at the place they regard as preferable work place and this might affect on the productivity and quality of care.

An independent t-test used to examine the perceptions of supervisees by their interesting in the work. The table (5.23) shows variation in mean scores and the supervisees who were interested in the work had higher mean scores in all domains and in the overall perception domains with statistical significant differences (P=.000). However, the supervisees who were interesting in their work showed positive perceptions.

Table 5.23: Differences in Supervisees Domains and interesting in work

Dependent var. *"Supervisees domains"*	**Indep. var. "interesting in work"**	**N**	**Mean**	**SD**	**t**	**Sig.**
Management behavior	Yes	135	3.4565	.66921	4.652	.000*
	No	36	2.8646	.71237		
Communication and support	Yes	135	3.6481	.51294	5.089	.000*
	No	36	3.1528	.54125		
Fairness	Yes	135	3.2778	.73914	2.544	.012*
	No	36	2.9236	.75313		
Involvement	Yes	135	3.2815	.60658	4.416	.000*
	No	36	2.7722	.64525		
Overall perception	Yes	135	3.4542	.49671	5.349	.001*
	No	36	2.9478	.53459		

Interested in the work could be related to supervisors communications as in response for open ended question for the adjective of supervisors they dislike; some of the supervisors personal characters which include modesty, nervousness, shyness, unclearness, sophisticated, and administrative characters included, not decision makers, unable to make solution, centralization of decision, and deficit of number of visit. This finding could help manager to redesign staff according to their preference in work and to know what makes their work more interesting to them and to focus on it.

C.5.5.2.3 Supervisory Factors:

An independent t-test was used to examine the differences between perception domains and presence of a supervisor. The table (5.24) shows that supervisees who had been supervised had higher mean score with statistical significant differences in overall perception and other domains (P=0.017), except fairness and involvement which were not statistical significant. That means, the supervisees who had supervisors had positive perception towards their supervisor that's may be due to direct contact with the supervisors which make the

Table 5.24: Differences in Supervisees Domains and the Availability of Supervisor

Dependent var. ***"Supervisees domains"***	**Indep. var.** "Had supervisor"	**N**	**Mean**	**SD**	**t**	**Sig.**
Management behavior	Yes	162	3.3673	.71417	2.432	.016*
	No	9	2.7778	.56173		
Communication and support	Yes	162	3.5671	.54230	2.203	.029*
	No	9	3.1528	.67540		
Fairness	Yes	162	3.2315	.71397	1.087	.307
	No	9	2.7778	1.24024		
Involvement	Yes	162	3.1877	.65586	1.148	.253
	No	9	2.9333	.42426		
Overall perception	Yes	162	3.3736	.53480	2.422	.017*
	No	9	2.9289	.56348		

communication and makes contact more easy. This is consistent with a study about the effect of clinical supervision in moral sensitivity which found that nurses who had supervision rated higher moral sensitivity than who are not (Severinsson and Kamaker, 1999). Also, it is consistent with Kevin (2001), study about burnout showed that the supervised nurses reported great feeling competences and low sick leave days with no statistical significant differences. This finding support the importance of supervisors in the work place and the PHC manager should enhance the role of supervisors.

Table 5.25: Differences in Supervisees Perception Domains With Type of Supervisors

Dependent var. *"Supervisees domains"*	**Indep. var.** *"type of supervisors"*	**N**	**Mean**	**SD**	**t**	**Sig.**
Management behavior	Internal	130	3.4144	.73549	2.613	.010*
	external	32	3.0508	.56159		
Communication and support	Internal	130	3.6058	.54972	2.335	.021*
	external	32	3.3516	.55941		
Fairness	Internal	130	3.2385	.72126	.908	.365
	external	32	3.1094	.71543		
Involvement	Internal	130	3.2154	.67726	1.438	.152
	external	32	3.0313	.51333		
Overall	Internal	130	3.4077	.54557	2.411	.017*

perception	external	32	3.1525	.49612		

The table (5.25) consistent with the above one and proved it by using independent t-test to compare the differences between the perception towards supervision by the type of supervisors. It shows differences between mean scores with statistical significant differences in overall perception (P=.017). The management behavior show mean differences with statistical significant differences between groups (P=.010). The communication and support shows statistical significant differences (P=.021). The supervisees who had internal supervisors shows positive perception. These findings should be taken into consideration to increase the quality and productivity of work. In study for Kevin at UK only one type of supervisor was shown significantly to affect factor scores, with manager supervisors consistently resulting more positive factor scores than peer supervisors (Kevin, 2001). The finding in this study supported by supervisees respond to open question and showed the adjective of their supervisors they like which included; good personal characters, good communicator, allow them to participate in decisions, provide them with constructive critique, good listener, not discriminator, support and satisfy them, and provide them with good instructions. This support the presence of internal supervisors in increasing quality of work and at the same time there is a need to explored why the indirect supervisors effect negatively on supervisees.

Table 5.26: Differences in Supervisees Perception Domains with Reviewing Reports

Dependent var. *"Supervisees Domains"*	**Indep. var.** *"Review reports"*	**N**	**Mean**	**SD**	**t**	**Sig.**
Management behavior	Yes	108	3.5787	.60096	6.245	.000*
	No	60	2.8938	.72187		
Communication and support	Yes	108	3.6910	.49632	4.756	.000*
	No	60	3.2875	.57825		
Fairness	Yes	108	3.3380	.68981	2.974	.003*
	No	60	2.9833	.82450		
Involvement	Yes	108	3.3241	.61369	4.027	.000*
	No	60	2.9200	.64013		
Overall perception	Yes	108	3.5252	.46346	5.766	.000*
	No	60	3.0393	.55379		

An independent t-test used to examine the perception towards supervision and the effect of reviewing report by their supervisors. Table (5.26) shows significant variation between mean scores of groups with statistical significant differences for overall perception (P=.000). Also, all other domains were statistical significant differences. That's could be explained as the supervisees who their supervisors review their reports with them had positive perception towards supervision and this finding help us to concentrate on this point and enhance the supervisor to use and review reports.

In response to open ended question the supervisees reported that the supervisors should help them to improve their skills as: Increasing number and quality of workshops, training and directions as well fairness in distribution of the training courses, it's worthy to remind the reader that the percentage of supervisees who received in-service education at PHC centers was 55.6% of total respondent, most of them reported that they had one workshop and it was

for orientation to the new supervisees for their rights as governmental supervisees. Application of reward and punishment systems which seems as absence and if present it is not applicable fairly. Better communication between supervisor and supervisees. Technological development of clinics as the clinics suffer from absence of simple technology which is needed for communication between clinics such as computer system, internet, and fax machines. Providing support and understanding to supervisees. Providing the supervisees with good appraisal system. Availability of clear job description. Participation in decision making as well in choosing supervisors. Not treating the supervisees according to their political affiliation this is similar to the complain of supervisees working at Shifa hospital in study done by (Jouda, 2003) and other studies for nurses perception towards their association they asked to be far away from political interference (Salah, 2005). Finally they added, Availability of good health protection, uniform, and better work environment. Their answers were corresponding to supervisor's one.As well many other recommendations we couldn't mention them all because they are very much to include.

In the next chapter, the researcher presents the conclusion of this study, then the suggested recommendations to improve the supervision status at PHC sector. Also, the suggested recommendations for the policy makers which help the supervisors and supervisees is presented in the next chapter.

Chapter 5: Conclusion and Recommendation

Conclusion

In order to assess the status of supervision at Palestinian primary health care sector, a descriptive analytical study was conducted at Gaza primary health care centers in MOH, to assess the supervisors perception to their roles and supervisees perceptions towards their supervisors. The sample was collected from PHC staff, the supervisors were all included and the supervisee were randomly selected. Questionnaires tool were used in order to test the staff perception. Triangulation of data was used in order to ensure credibility of the results. The response rate of supervisors was 81.5 %, and for supervisees it was 86% both responses rate are considered high. The study result might help to improve the supervision at primary health care by tries to answer to what extent the primary health care staff perceive the supervision.

The findings of the study showed that male participants was higher than female participants in the two groups and this finding was corresponding with male to female ratio in the PHC staff. The majority of supervisors and supervisees were in the middle age. Physician and nurses represented the highest percent of supervisors respondents, and for supervisees occupation, the administrators represented the highest percentage. Half of respondents from both groups got their basic education from Palestinian universities. Half of supervisors and supervisees were attended training courses. Large number of them had intention to stay in PHC until retirement this may due to the insecurity they feel with their live. There was variations in availability of job descriptions between supervisors and supervisees. The majority of staff had internal supervisors and little more than half of them their report had been reviewed by their supervisors. There are two type of supervisors, the internal supervisors who are performing

daily visits for the clinic and the external supervisors perform different range of visits but less number of visits than the internal supervisors.

The title of job was reported as 75.8% of respondent were head of departments. According to supervisory tool 61.8% of them had supervisory tools, 57.8% use reports as supervisory tools, 82% of them use this tool during supervision and 46.5% of supervisory tools were checklist, which is mentioned as an important supervisory tools in the literature. The presence of supervisory system were constituted 38.2% while 62.3% of supervisors reported that they had no supervisory system this is a problem which is in need for solving by the policy makers. 45.4% of supervisors agreed that they got benefit from supervision which is range from material to moral benefits.

Six supervisory domains were created by the researcher and including, managerial role, quality improvement, human resource management, facilities and Environment management, supervisory approach, and communication and support. The overall perception of supervisors towards their supervision was reported as 74.2%. The supervisors reported the highest level of perception with facilities and environment management (80%). The study showed that the supervisors performed their duties by using the required facilities to operate clinic. A number of respondents reported a deficit in facilities and environment that operate the clinics.

The most important supervisory activities were visits as the majority of supervisors reported that they provide enough visits to clinics they supervised while they had faced many problems associated with visits. Other important aspects of supervisory activity was the report as half of the supervisors mentioned that they used and discuss reports with subordinate while more than half of them discuss report with their supervisors.

The study found that the majority of supervisors were not included in hiring and firing supervisees and don't share in decision making on higher level. They were not included in putting goal for the organization.

The overall perception of supervisees towards their supervisors domains were reported to be positive as 66.9%. the domains was created by researcher, including, general management domain, communication and support domain, fairness domain, and involvement domain. The supervisees reported the highest perception level to communication and support as they reported (70.8%). Further training needed to satisfy supervisees needs that may improve the staff perception towards their supervisors.

Some demographical variables showed statistical significant differences effect on supervision domains at PHC and showed effect on supervisees perceptions to their supervisors, Gender showed that male perceived their supervisor role more positively than female with statistical significant differences. Education showed that supervisors with higher degree perceive the supervision more negatively than other with no significant. Occupation of participant showed statistical significant differences as nurses were positively perceived their supervision. The respondent studies in Non Arab countries were perceived supervision more positively.

Regarding the supervisory factors, The type of supervision (internal or external) was found that the internal supervisors were positively perceive supervision than the external supervisors. The supervisors who had training courses on supervision were found to be statistical significant differences. The study showed that the supervisors who had supervisory tools were perceived supervisory more positive than others who don't had tools with statistical significant differences. The supervisors who had report tools were found no effect on supervision domains with those who don't had report. But those who used report and had checklist were found to be statistical significant. The study showed the supervisors who had supervisory

system statistical significant differences and positive perceive supervision than those who don't had. The supervisors who their report reviewed by their managers were statistical significant differences this prove the importance of report revision. The supervisors who supervised higher number of clinics and supervisees were positive perceived supervision with statistical significant differences. The supervisors who visit clinic more than 30 visits per month and who got benefit from supervision were found to perceive their role more positively.

The supervisee demographic variables such as gender, age, marital status and residency showed no statistical significant differences. The participants with less than Tawjehi degree more positive perceive the supervision among others with no statistical significant differences. The nurses showed the higher positive perception towards their supervisors. The lowest years of education had the highest perception towards their supervisors with no statistical significant differences. Also those who had enrolled in continuous education and in-service education showed positive perception with no statistical significant differences. Related to organizational factors the study showed there was no effect of years of experience and presence of job description on supervisees perception towards their supervisors. While the supervisees who worked in the department they prefer, showed positive relation with statistical significant differences. Also, the supervisees who were interested in doing their job showed high positive perception towards their supervisors. The supervisees who had internal supervisor showed positive relation. The supervisees who their supervisors reviewed report with them showed high positive perception in all domains with statistic significant differences. But visit number showed no effect on supervisees perception.

Both supervisors and supervisee at PHC sectors were positively perceived the supervision, with differences in some domains. They agreed on the importance of visits and training.

Recommendation

The study provided the researcher with a chance to make a number of recommendations that based on the study findings and can be achieved within PHC at MOH. These recommendation are:

- Although the supervisors and supervisees were reported moderately positively perceive the supervision at primary health care, their perception could be improved further by addressing the factors constructs identified in the study, which could be considered as a construct model-frame for staff perception of supervision.
- Policy makers and managers from all managerial levels are required to consider the identified constructs of the supervision perception and to develop appropriate strategies that meet their staff expectations toward supervision.
- External supervisors and high levels managers could manage their people and organizations better by showing more commitment to their staff and work related issues, they need to show concern to their people by asking them what they need.
- Supervisors need to revise their supervisory roles, they need to acknowledge their responsibilities to motivate staff and improve development by encouragement, removing barriers, training and empowering the supervisees. Special training skills for supervisors should be introduced that focuses on supervisory activity.
- To reduce the ambiguity and role conflicts dominating in Palestinian health organization supervisors need to develop supervisory system with clear guideline and tools, rule and regulations and job description that provide them with clearance duties and responsibilities.

- Strengthening supervision will require a variety of job-aid, including manual for supervisors and guide for training of supervisors.
- To improve staff perception about supervision, the supervisors should work closely with their subordinate and involve them in supervisory planning. Creating a trusting climate that considered sharing in decisions and vision as adopted policy.
- To satisfy supervisees supervisors need to be educator, role model, supporter, suggesting strategies specially in Palestinian situation which need the supervisors who are decision makers and able to face challenges.
- As the study showed the women not presented in supervision position like in other countries, we recommended to enhance their participation in this position by adopting a policy of recruiting more women and giving them chance to participate in decisions.

Area for Further Research

- Further study is needed to include other health organization in Palestine to assess and compare the staff opinion in related to supervision
- There is a need to create a unified guideline with other health organization in Palestine. So it needs to be studied.
- Further study to include more supervisees in order to achieve more results.

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Annexes

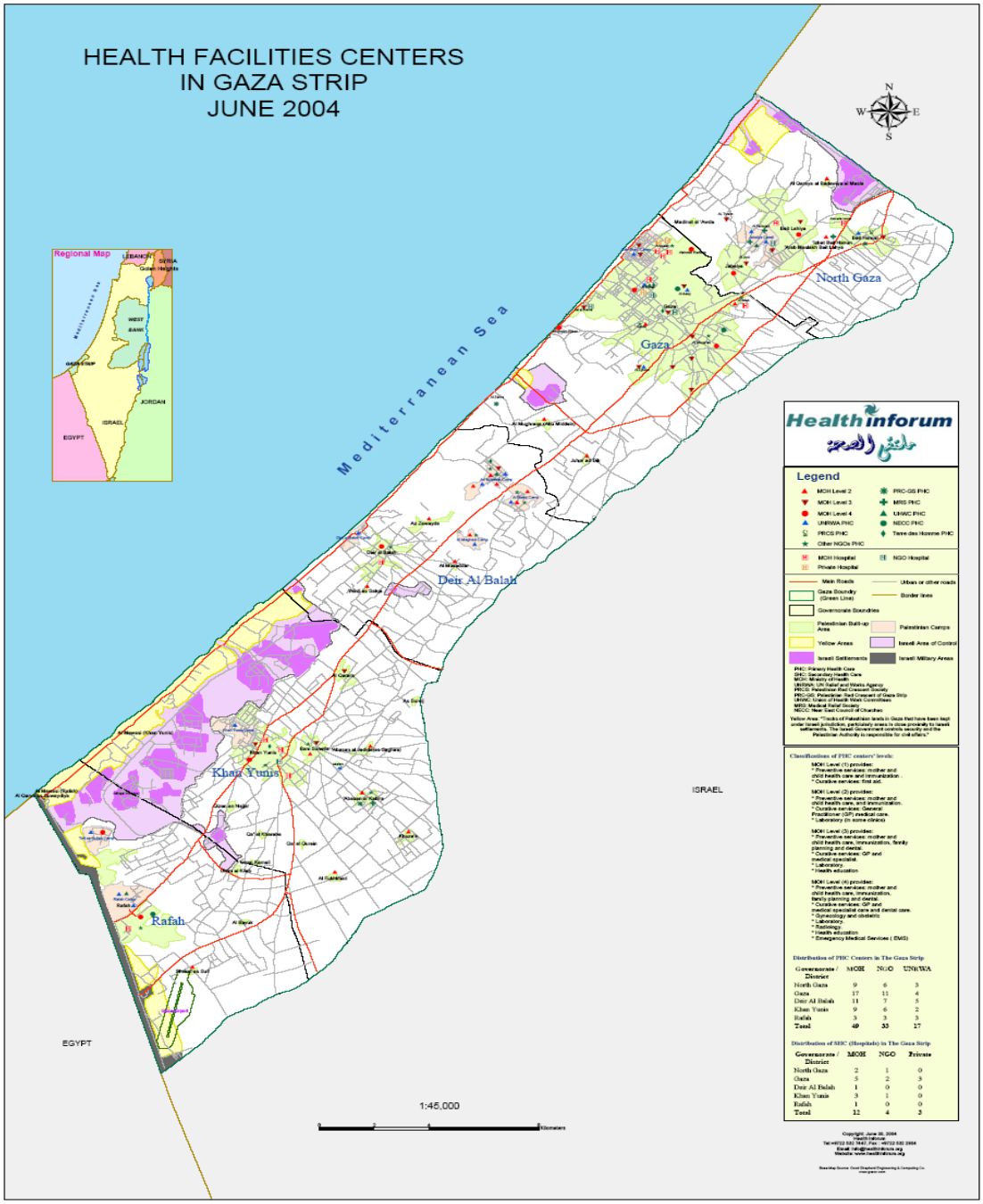
Annex1

Map of Palestine

Adopted from State Information Services

Annex 2

Map of Distributing Health Facilities Centers in Gaza Strip



Adopted from MOH Website.

Annex 3

Explanatory Letter

- I' am Maysoun Turban, has been enrolled in master program in public health at all Quds university.
- The title of my study is:

Status of Supervision at Primary Health Sector at the Palestinian MOH-Gaza

- The aim of the study is to explore the positive relation and to improve the negative point.
- Dear collage, you are selected randomly to participate in this study and I'm looking foreword to your participation in filling this questionnaire.
- It takes you about 20 minutes to complete it. Your participation is voluntary, you have the right to refuse to answer questions, you have the right not to participate.
- I would like to assure you that the information will be confidential and the questionnaire will be coded.
- The information will be used for scientific purpose.
- The questionnaire will help in identifying the supervision status at primary health care center, the degree significance of perception toward supervision and in the development of supervisor so I hope you will give accurate answers.
- I appreciate your cooperation.

Thank you for your cooperation.

Annex 4[a]

Questionnaire (1)

For Supervisor

Personal information:

1. **Sex:** Male Female

2. **Age:** years.

3. **Residency place:** Gaza Governorate North Governorate

   Mid-Zone Governorate Khan Younis Governorate Rafah Governorate

4. **Marital Status:** Single Married Divorced Widows

5. **Occupation:** Physician Nurse Technician Support services
   Other / specify

6. **Period of relative education:**

7. **The last academic certificate you have got:** Less than Tawjehi Tawjehi

   Diploma Bachelor Master PHD

8. **Place of your last academic certificate:** Country_____
   University_____

Organizational factors:

9. **Place of work:** Name of clinic _____ Governorate _____

10. **Present job (position):** _____

11. **Years of experience a the present job** | | |

12. **How long did you work in this organization?** | | |

Supervisory Data:

13. **How many clinics you supervised?**

14. **How many supervisees you supervised?**

15. **To whom did you report?** _____

16. **How many supervisory visits you do per month?** ☐☐

17. **When was your last supervisory visit?** Day Month Year

18. **Did you receive any training courses on supervision?** Yes ☐ No ☐
    If yes: what is the period of your training
    _____

19. **Do you have a job description?** Yes ☐ No ☐

20. **Do you have a supervisor?** Yes ☐ No ☐

21. **Do you have a supervisory tools?** Yes ☐ No ☐
    If yes is it?
    Checklist
    Report Others/ specify _____

22. **Do you have a written supervisory system/format?** Yes No

23. **Do you use a supervisory report/format?** Yes ☐ No ☐

24. **Does your supervisor review documents with you?** Yes ☐ No ☐

25. **Which task takes most of your time?** _____

26. **Do you receive benefit for your supervision?** Yes No
    If yes clarify the benefit _____

27. **Are you interested to stay in your job until retirement?** Yes ☐ No ☐

(SD) Strongly disagree (D) Disagree (DK) Don't Know (A) Agree (SA) Strongly agree

No.	Items	SD	D	DK	A	SA
MANAGERIAL ROLE						
28.	You understand the role and responsibilities of a supervisor effectively.					
29.	You share in setting objectives for organization.					
30.	Your responsibility is to coordinate work inside the					

	clinic.					
31.	You able to identify relevant work problems.					
32.	You solve problems on the field effectively.					
33.	You involved in decision making at high level.					
34.	You involved in hiring and firing of your staff.					
35.	You do Performance appraisal regularly.					
36.	You discus performance appraisal with your staff.					
37.	You allowed to delegate responsibilities for supervisees.					
38.	You organize the work flow in an effective manner.					
39.	You know the job description of staff members.					
QUALITY IMPROVEMENT						
40.	You assess your staff clinical skills					
41.	You deploy your staff according to their qualification					
42.	You observe supervisees or health provider while they are doing work					
43.	You involved in in-services education for your supervisees					
44.	You provide a guidance and training for your supervisees					
45.	You match the supervisee's expertise with organization needs.					
HUMAN RESOURCE MANAGEMENT/STAFFING						
46.	You regularly organize a group meeting.					
47.	You prepare your self prior to the supervisory visits.					
48.	You inform the supervisees by your visit before it's date.					
49.	You manage a conflict in organization if present.					
50.	You build teams work in your organization.					
51.	You explain the goal and objective of organization to the supervisees.					

52.	You work to improve staff motivation in your organization.					
53.	You appreciate your supervisees when they did a good task immediately after they finish the task.					
54.	You facilitate supervisees promotion process.					
55.	Your communication with your subordinate is effective					
56.	You provide constructive feedback for your supervisees					
57.	You understand social and culture dynamics in the work place					
58.	You take staff ideas and suggestions into account					
59.	You provide opportunities for staff career development					
FACILITIES AND ENVIRONMENT MANAGEMENT						
60.	You order and reorder supplies and equipment					
61	You assess the clinic infrastructure (physical setting, equipment)					
62.	You maintain instrument working effectively					
63.	You have a system for the disposal of equipment					
64.	You have procedures to keep health facilities clean and functional					
65.	You assess needs in term of logistics and support					
66.	You identify the resources needed to accomplish goals.					
SUPERVISORY APPROACH						
67.	You do enough visit to the clinics which follow you					
68.	You use supervisory checklist					
69.	You criticize the staff in constructive way					
70.	You discus problems with your supervisees					
71.	You create a respective work place.					

72.	You write reports about your supervision visits					
73.	You discuss the report with your supervisees					
74.	You discuss the report with your supervisor					
75.	You demonstrates how job and task are interrelated					
COMMUNICATION AND SUPPORT						
76.	You have enough support from your manager					
77.	You provide support to all supervisees.					
78.	You carefully listen to supervisee's personal problems.					
79.	Your organizational communication channel are clear.					
80.	You facilitate communication between various clinics					
81.	You share social activities with your staff					
82.	You establish open communication with supervisees and provide feedback					
83.	You use information technology for effective office communication					
84.	You listen actively to verbal and non-verbal messages that came from your supervisees.					

85. Mention some of the problems which you encounter in the execution of your job as a supervisor?

86.What are your suggestions to improve your supervision skills?

87.What are the most task of supervision do you like as a supervisor?

88.What are the most task of supervision do you dislike as a supervisor?

89.Did you have any comments?

Thank you for your co-operation,,,

Annex 4[b]

استبانة رقم (1)

معلومات شخصية:

1. **الجنس:** ☐ أنثى ☐ ذكر
2. **العمر:** ☐☐ سنة
3. **السكن:** ☐ محافظة غزة ☐ محافظة الشمال ☐ المحافظة الوسطى
   ☐ محافظة خانيونس ☐ محافظة رفح ☐
4. **الحالة الاجتماعية:** ☐ عزب ☐ متزوج ☐ مطلق ☐ أرمل
5. **المهنة:** ☐ طبيب ☐ ممرض ☐ مهن طبية ☐ إداري
   غير ذلك / وضح_____
6. **عدد سنوات الدراسة :** ☐☐ سنة
7. **آخر شهادة حصلت عليها:** ☐ أقل من توجيهي ☐ توجيهي ☐ دبلوم
   ☐ بكالوريوس ☐ ماجستير ☐ دكتوراه
8. **المكان الذي تخرجت منه:** الجامعة _____ البلد _____

معلومات عن المؤسسة:

9. **مكان العمل:** اسم العيادة: _____ المحافظة: _____
10. **المهنة الحالية (المسمى الوظيفي):** _____
11. **سنوات الخبرة في هذه المهنة:** _____
12. **مدة العمل في هذه المؤسسة:** _____

معلومات عن الإشراف:

13. **كم عدد العيادات التي تشرف عليها:** ☐☐
14. **كم عدد الموظفين الذين تشرف عليهم:** ☐☐
15. **لمن ترفع التقرير:** _____
16. **كم عدد الزيارات الإشرافية التي تقوم بها في الشهر:** ☐☐

17. **متى كانت أخر زيارة:** اليوم ☐ الشهر ☐ السنة ☐

18. **هل تلقيت أي دورات تدريبية عن الإشراف؟** نعم ☐ لا ☐

إذا كانت الإجابة نعم فكم مدتها؟ _____

19. **هل لديك وصف وظيفي؟** نعم ☐ لا ☐

20. **هل لديك مشرف؟** نعم ☐ لا ☐

21. **هل لك أدوات للإشراف؟** نعم ☐ لا ☐

إذا كانت الإجابة نعم فهل هي:

تقارير نعم ☐ لا ☐

Checklist (قائمة فحص) نعم ☐ لا ☐

أخرى / وضح _____

22. **هل عندك نظام إشراف مكتوب؟** نعم ☐ لا ☐

23. **هل تستعمل تقارير للإشراف ؟** _____

24. **هل يراجع مشرفك التقارير معك؟** نعم ☐ لا ☐

25. **أي مهام تأخذ معظم وقتك؟** _____

26. **هل تجني فائدة من وراء الإشراف؟** نعم ☐ لا ☐

إذا كانت الإجابة نعم فما هي؟ _____

27. **هل تود أن تبقى في وظيفتك حتى التقاعد؟** نعم ☐ لا ☐

م.	البنـــــود	لا أوافق مطلقاً	لا أوافق	لا أدري	أوافق	أوافق مطلقاً
	الإدارة العامة					
28.	تتفهم دورك ومسئولياتك كمشرف بكفاءة.					
29.	تشارك في وضع الأهداف للمؤسسة.					
30.	مسئوليتك تنسيق العمل داخل العيادة.					
31.	تستطيع أن تتعرف على المشاكل التي تخص العمل.					
32.	تستطيع حل المشاكل الخاصة بالعمل بكفاءة.					
33.	تشارك في عملية صنع القرار على مستويات عالية.					
34.	تشارك في عملية التوظيف وترقيم قيد الموظفين.					

م.	البنـــــود	لا أوافق مطلقاً	لا أوافق	لا أدري	أوافق	أوافق مطلقاً
.35	تقوم بعملية التقويم بانتظام.					
.36	تناقش التقويم مع الموظفين					
.37	يسمح لك بإيعاز المسئوليات على الموظفين .					
.38	تنظم تسلسل العمل بكفاءة.					
.39	تعرف الوصف الوظيفي لكل الموظفين					
	جودة العمل					
.40	تستطيع تقويم مهارات الموظفين العملية					
.41	تقوم بتفويض العمل على الموظفين حسب كفاءاتهم.					
.42	تقوم بمراقبة الموظفين في أثناء قيامهم بعملهم.					
.43	تشارك في عملية التعليم الداخلي للموظفين.					
.44	تقوم بعملية التوجيه والتدريب للموظفين عند اللزوم.					
.45	تربط بين خبرة الموظفين واحتياجات المؤسسة.					
	إدارة الموارد البشرية					
.46	أقوم بإدارة اللقاءات بين المجموعات بانتظام.					
.47	تجهز نفسك مسبقاً قبل القيام بزيارة إشرافية.					
.48	تخبر الموظفين بالزيارة قبل موعدها.					
.49	تستطيع أن تدير النزاعات داخل المؤسسة.					
.50	تنمي عمل الفريق داخل المؤسسة.					
.51	تشرح الأهداف العامة والخاصة بالمؤسسة للموظفين.					
.52	تقوم بتحسين الحوافز لدى الموظفين في المؤسسة.					
.53	أتعامل مع الموظفين بشكل جيد.					
.54	تثمن عمل الموظفين مباشرة بعد قيامهم بالمهام.					
.55	تسرع من ترقية الموظفين					
.56	تقوم بإعطاء الموظفين تغذية راجعة عن عملهم.					
.57	تتفهم النواحي الاجتماعية والثقافية في داخل المؤسسة.					
.58	تقدر مقترحات الموظفين و أفكارهم وتأخذها بالحسبان.					
.59	تعطي الفرصة للتطوير الوظيفي.					

	إدارة الإمكانيات والأدوات					
60.	تطلب الموارد والأدوات.					
61.	تفحص إمكانيات العيادة من (أدوات وأماكن)					
62.	تحافظ على الأجهزة فعالة.					
63.	لديك إجراءات للتخلص من المخلفات.					
64.	لديك إجراءات للمحافظة على العيادة نظيفة.					
65.	تقيم الاحتياجات اللازمة للعيادة.					
66.	تحدد الموارد اللازمة لتحقيق الهدف.					
	تنسيق الإجراءات الإشرافية					
67.	تقوم بزيارات كافية للعيادة التي تشرف عليها.					
68.	تستخدم أداة للإشراف.					
69.	تقوم بنقد الموظفين بشكل بناء.					
70.	تناقش المشاكل مع الموظفين.					
71.	تنشئ جو احترام داخل المؤسسة.					
72.	تقوم بكتابة تقارير الزيارات الإشرافية.					
73.	تناقش التقارير مع الموظفين.					
74.	تناقش التقارير مع المشرفين.					
75.	توضح كيفية تداخل الوظيفة مع المهام.					
	طريقة التواصل والدعم					
76.	لديك دعم كافٍ من المسئولين عليك.					
77.	تمنح الدعم الكافي لكل الموظفين.					
78.	تستمع بعناية لمشاكل موظفيك الخاصة.					
79.	طرق التواصل في داخل المؤسسة واضحة.					
80.	تقوم بتسهيل التواصل بين العيادات.					
81.	تشارك في الأنشطة الاجتماعية مع الموظفين.					
82.	تتواصل مع الموظفين بشكل مفتوح وتعطيهم تغذية راجعة.					
83.	تستخدم التكنولوجيا لتسهيل التواصل.					
84.	تستمع للموظفين وتفسر الرسائل المقروءة وغير المقروءة.					

85. اذكر بعض المشاكل التي تواجهها خلال عملك كمشرف؟

_____

_____

_____

_____

86. اذكر مقترحات لتحسين المهارات الإشرافية؟

_____

_____

_____

_____

78. ما هي أكثر المهام التي تحبها كمشرف؟

_____

_____

_____

_____

79. ما هي أكثر المهام التي لا تحبها كمشرف؟

_____

_____

80. هل لديك ملاحظات أخرى؟

_____

_____

وشكراً لتعاونكم،،،

Annex 5[a]

Questionnaire 2

For supervisees

Personal information:

1.	**Sex:**	Male		Female		

2.	**Age:**			year.		

3.	**Residency place:**		Gaza Governorate		North Governorate		
	Mid-Zone Governorate		Khan Younis Governorate		Rafah Governorate		

4.	**Marital Status:**	Single		Married		Divorced		Widows	

5.	**Occupation:**	Physician		Nurse		Technician		Support services	

6.	**Period of relative education:**		

7.	**The last academic certificate you have got:**			PHD		Master			
	Bachelor		Diploma		Tawjehi		Less than Tawjehi		

8. Place of your last academic certificate: Country_____
Uniersity_____

Organizational data:

9.	**Place of work:**	Name of clinic	_____	Governorate

10. Present job (position): _____

11. Years of experience at the present job | | |

12. Do you work in your preferable department? Yes ☐ No ☐

13. Have you been enrolled in continues education programs in the last three years: Yes ☐ No ☐
If yes what is the period of continues program? _____

14. Do you know your supervisor? Yes ☐ No ☐

15. Does your supervisor review medical records/reports with you? Yes ☐ No ☐

16. **How many visit did he does to your clinic per month?** ☐☐

17. **When was the last visit?** _____

18. **Do you have a clear job description?** Yes ☐ No ☐

19. **Were you enrolled in in-service training in you organization?** Yes ☐ No ☐

20. **Are you interested in doing your work?** Yes ☐ No ☐

(SD) Strongly disagree (D) Disagree (DK) Don't Know (A) Agree (SA) Strongly agree

No.	Items	S.D	D	DK	A	S.A
	MANAGEMENT BEHAVIOR					
21.	My supervisor encourages and assists me in improving my skills so I have the opportunity to improve.					
22.	My supervisor knows whether or not I am doing a good job.					
23.	My supervisor knows his job well.					
24.	My supervisor gives clear, exact, and easily understood instructions about my work.					
25.	I have got a suitable guidance and supervision from my supervisor.					
26.	I get conflicting orders because of too many supervisors.					
27.	My supervisor provides feedback to me.					
28.	I don't get appreciation from my supervisor					
	COMMUNICATION AND SUPPORT					
29.	My relationship with my supervisors are as pleasant as they should be					
30.	I have a satisfactory relations with my peers					
31.	My supervisor carefully listens to my opinions and problem					
32.	I had a satisfactory introduction to and explanation of my new job before I started working					

No.	Items	S.D	D	DK	A	S.A
33.	My supervisor understand my difficulties.					
34.	My supervisor doesn't support me when I have a problem at work					
35.	I can appeal to a higher authority if my immediate supervisor decides a point against me.					
36.	My supervisor helps me to progress in my work.					
	FAIRNESS					
37.	There is no equity and there is discrimination from my supervisor					
38.	My supervisor only detects my errors.					
39.	My supervisor is fair in any disciplinary action that is taken.					
40.	When my supervisor criticizes me or my work, it is done in a friendly and helpful manner.					
	INVOLMENT					
41.	When change is made in my work, I am usually get the reason for it.					
42.	My duties and responsibilities are very clear to me.					
43.	I am not sharing in decision making.					
44.	The supervision I receive helps me to work more effective.					
45.	I find the in-service training and education sufficient					

46.What do you think the supervisor should do to help you in performing your tasks?

47.What are the most characters or task you like in your supervisor?

48.What are the most characters or task you dislike in your supervisor?

49.Give any additional comments ?

Thanks you for your co-operation,,,

Annex 5[b]

استبيان رقم (2)

معلومات شخصية:

1. **الجنس:** ☐ أنثى ☐ ذكر
2. **العمر:** ☐☐ سنة
3. **السكن:** ☐ محافظة غزة ☐ محافظة الشمال ☐ المحافظة الوسطى
   ☐ محافظة خانيونس ☐ محافظة رفح ☐
4. **الحالة الاجتماعية:** ☐ عزب ☐ متزوج ☐ مطلق ☐ أرمل
5. **المهنة:** ☐ طبيب ☐ ممرض ☐ مهنة طبية ☐ إداري
   غير ذلك / وضح_____
6. **سنوات الدراسة التخصصية:** ☐☐ سنة
7. **آخر شهادة حصلت عليها:** ☐ أقل من توجيهي ☐ توجيهي ☐ دبلوم
   ☐ بكالوريوس ☐ ماجستير ☐ دكتوراه
8. **المكان الذي تخرجت منه:** الجامعة _____ الدولة _____

معلومات عن المؤسسة:

9. **مكان العمل:** اسم العيادة: _____ المحافظة: _____
10. **المهنة الحالية (المسمى الوظيفي):** _____
11. **سنوات الخبرة في هذه المهنة:** _____
12. **هل تعمل في قسمك المفضل؟** ☐ نعم ☐ لا
13. **هل اشتركت في برنامج تكميلي في أخر ثلاث سنوات؟** ☐ نعم ☐ لا
    إذا كانت الإجابة نعم، فما هي المدة التي درست فيها _____
14. **هل لديك مشرف؟** ☐ نعم ☐ لا
15. **هل مشرفك يراجع معك السجلات الطبية والتقارير؟** ☐ نعم ☐ لا
16. **كم عدد المرات التي يزورك بها في الشهر:** ☐☐

17. **متى كانت أخر زيارة:** _____

18. **هل لديك وصف وظيفي واضح؟** ☐ نعم ☐ لا

19. **هل اشتركت في تدريب في داخل المؤسسة؟** ☐ نعم ☐ لا

20. **هل أنت مستمتع في عملك؟** ☐ نعم ☐ لا

م.	البنـــــود	لا أوافق مطلقاً	لا أوافق	لا أدري	أوافق	أوافق مطلقاً
21.	تلقيت مقدمة وتوضيح عن طبيعة عملك قبل أن تبدأ به بشكل مرضٍ.					
22.	علاقتك مع المشرف جيدة .					
23.	علاقتك مع زملائك جيدة .					
24.	لا تتلقى المدح من مشرفك.					
25.	لا يوجد عدالة ويوجد تمييز من قبل مشرفك.					
26.	مشرفك لا يساندك عند وجود مشكلة في العمل.					
27.	مشرفك يستمع إلى آرائك ومشكلاتك بعناية.					
28.	مشرفك يشجعك ويساندك في تحسين مهاراتك لتتقدم.					
29.	مشرفك يعرف مدى جودة عملك.					
30.	مشرفك يعرف عمله جيداً.					
31.	واجباتك ومسئولياتك واضحة لك.					
32.	يساعدك مشرفك للتقدم في عملك.					
33.	يعطيك مشرفك ملاحظات واضحة ومحددة وسهلة عن عملك.					
34.	الإشراف الذي تتلقاه يساعدك في عملك بكفاءة.					
35.	يعطيك المشرف تغذية راجعة في عملك.					
36.	المشرف فقط يفحص أخطائك.					
37.	المشرف عادل في القرارات العقابية التي يتخذها.					
38.	عندما ينتقدك المشرف يكون ذلك بشكل جيد ومساعد.					
39.	عند حدوث تغيير في عملك يعطيك أسبابا لذلك.					
40.	المشرف يتفهم سلوكك تجاه أخطائك.					

م.	البنـــــــود	لا أوافق مطلقاً	لا أوافق	لا أدري	أوافق	أوافق مطلقاً
41.	لديك المجال لتشكو المشرف إذا قرر أن يقف ضدك لمن هو أعلى منه.					
42.	لا تشارك في صنع القرار.					
43.	هناك صراع في الأدوار من كثرة المشرفين.					
44.	تتلقى توجيهات مناسبة من قبل مشرفك.					
45.	التدريبات التي تتلقاها كافية.					

46. ماذا تعتقد أن المشرف يجب أن يعمل ليساعدك في تحسين أدائك؟

_____

_____

47. ما أكثر الصفات التي تحبها في مشرفك؟

_____

_____

_____

48. ما أكثر الصفات التي لا تحبها في مشرفك؟

_____

_____

_____

49. هل لديك مقترحات أخرى؟

_____

_____

وشكراً لتعاونكم،،،

Annex 6

Table 1:Distribution of clinics by level and no. with governorate

Clinic Name	Level II	Level III	Level IV	Total
North Governorate	**4**	**5**	**1**	**10**
Gaza Governorate	**5**	**8**	**2**	**15**
Mid-Zone Governorate	**13**	**2**	**1**	**16**
Khan-Younis Governorate	**7**	**2**	**2**	**11**
Rafah Governorate	**1**	**2**	**1**	**4**
Total	**30**	**19**	**7**	**56**

Adopted from annual report (MOH, 2006).
There is no clinic in level I in Gaza Strip.
The classification of levels are:

- Primary health care, level one: the clinic that has a community health worker and a nurse reports to duty all week working days and is visited twice per week by a physician.
- Primary health care, level two: the physician and a full time nurse works in the clinic all the week days.
- Primary health care, level three: physicians and nurses work all the week days at the clinic provide basic lab services, ultrasound, X-ray, dental care and emergency for 12 hours daily.
- Primary health care, level four: the facility/clinic has a full time physicians, nurses, lab services, ultrasound, X-ray, family planning and emergency for 24 hours daily in addition to some specialty services. (Adopted from Fattouh, 2005)

Table 2: Shows the number of PHC supervisees per occupation, and Proportional study sample

Occupation	Total No.	Sample no.	Percent
Physician	248	30	14.35%
Nurses	319	37	18.46%
Pharmacists	196	21	11.34%
Medical Technicians	303	35	17.53%
Administrators	475	55	27.49%
Dentists	101	12	6%
Lab Technicians	78	10	4.5%

Annex 7

Table 1:one- way ANOVA comparing supervision domains scores regarding age.

Dependent variable	Independ. Var.	Sum of Square	DF	Mean Square	F	Sig.
Managerial role	Between group	1.715	3	.572	1.892	.132
	Within group	70.379	233	.302		
	Total	72.094	236			
Quality improvement	Between group	.682	3	.227	.502	.681
	Within group	105.387	233	.452		
	Total	106.069	236			
Human resource management	Between group	1.904	3	.635	1.020	.385
	Within group	144.950	233	.622		
	Total	146.854	236			
Facilities & Environment management	Between group	.394	3	.131	.268	.849
	Within group	114.254	233	.490		
	Total	114.648	236			
Supervision Approach	Between group	2.634	3	.878	1.022	.384
	Within group	200.228	233	.859		
	Total	202.862	236			
Communication & support	Between group	.495	3	.165	.309	.819
	Within group	124.395	233	.534		
	Total	124.890	236			
Overall perception	Between group	.222	3	.074	.234	.873
	Within group	73.609	233	.316		
	Total	73.831	236			

Table 2:one- way ANOVA comparing supervision domains scores by Residency place

Dependent variable	Independ. Var.	Sum of Square	DF	Mean Square	F	Sig.
Managerial role	Between group	1.853	4	.463	1.363	.248
	Within group	80.221	236	.340		
	Total	82.074	240			
Quality improvement	Between group	2.226	4	.556	1.260	.286
	Within group	104.205	236	.442		
	Total	106.430	240			
Human resource management	Between group	6.370	4	1.592	2.605	.037*
	Within group	144.278	236	.611		
	Total	150.648	240			
Facilities & Environment management	Between group	1.378	4	.344	.628	.643
	Within group	129.479	236	.549		
	Total	130.857	240			
Supervision Approach	Between group	1.253	4	.313	.353	.842
	Within group	209.359	236	.887		
	Total	210.612	240			
Communication & support	Between group	1.797	4	.449	.817	.515
	Within group	129.679	236	.549		
	Total	131.47	240			
Overall perception	Between group	.957	4	.239	.732	.571
	Within group	77.173	236	.327		
	Total	78.130	240			

Table 3:one- way ANOVA comparing supervision domains by Marital status

Dependent variable	Independ. Var.	Sum of Square	DF	Mean Square	F	Sig.
Managerial role	Between group	.744	2	.372	1.079	.342
	Within group	80.051	232	.345		
	Total	80.795	234			
Quality improvement	Between group	1.359	2	.679	1.517	.222
	Within group	103.895	232	.448		
	Total	105.254	234			
Human resource management	Between group	.729	2	.365	.566	.568
	Within group	149.349	232	.644		
	Total	150.079	234			
Facilities & Environment management	Between group	.570	2	.285	.510	.601
	Within group	129.760	232	.559		
	Total	130.331	234			
Supervision Approach	Between group	1.266	2	.633	.717	.489
	Within group	204.717	232	.882		
	Total	205.983	234			
Communication & support	Between group	1.979	2	.989	1.794	.169
	Within group	127.985	232	.552		
	Total	129.964	234			
Overall perception	Between group	.661	2	.331	.992	.372
	Within group	77.305	232	.333		
	Total	77.966	234			

Table 4:one- way ANOVA comparing supervision domains by education years.

Dependent variable	Independ. Var.	Sum of Square	DF	Mean Square	F	Sig.
Managerial role	Between group	.395	2	.198	.572	.565
	Within group	81.225	235	.346		
	Total	81.620	237			
Quality improvement	Between group	.527	2	.263	.582	.559
	Within group	106.322	235	.452		
	Total	106.849	237			
Human resource management	Between group	3.074	2	1.537	2.449	.089
	Within group	147.490	235	.628		
	Total	150.564	237			
Facilities & Environment management	Between group	.022	2	.011	.019	.98
	Within group	131.605	235	.560		
	Total	131.626	237			
Supervision Approach	Between group	1.737	2	.869	.987	.374
	Within group	206.884	235	.880		
	Total	208.622	237			
Communication & support	Between group	.890	2	.445	.899	.408
	Within group	116.262	235	.495		
	Total	117.152	237			

Overall perception	Between group	.434	2	.217	.664	.516
	Within group	76.799	235	.327		
	Total	77.233	237	.217		

Table 5:one- way ANOVA comparing supervision domains scores regarding Academic certificate

Dependent variable	Independ. Var.	Sum of Square	DF	Mean Square	F	Sig.
Managerial role	Between group	1.162	4	.290	.858	.490
	Within group	80.268	237	.339		
	Total	81.430	241			
Quality improvement	Between group	1.745	4	.436	.992	.412
	Within group	104.187	237	.440		
	Total	105.933	241			
Human resource management	Between group	5.871	4	1.468	2.454	.047*
	Within group	141.741	237	.598		
	Total	147.612	241			
Facilities & Environment management	Between group	.750	4	.187	.340	.851
	Within group	130.693	237	.551		
	Total	131.443	241			
Supervision Approach	Between group	7.359	4	1.840	2.186	.071
	Within group	199.461	237	.842		
	Total	206.820	241			
Communication & support	Between group	3.159	4	.790	1.536	.192
	Within group	121.858	237	.514		
	Total	125.017	241			
Overall perception	Between group	1.755	4	.439	1.407	.232
	Within group	73.906	237	.312		
	Total	75.661	241			

Table 6:Independent t-test for available of job description by supervision domains

Dependent var.	Independent var. Job description	N	Mean	SD	t	Sig.
Managerial Role	Yes	180	3.6292	.58392	1.846	.066
	No	54	3.4630	.56743		
Quality Improvement	Yes	180	3.8963	.66062	.041	.967
	No	54	3.8920	.71752		
Human resource management	Yes	180	3.5194	.76652	1.313	.190
	No	54	3.3598	.83817		
Facilities & Environment management	Yes	180	4.0008	.76395	-.786	.433
	No	54	4.0899	.60818		
Supervision Approach	Yes	180	3.6042	1.01236	-1.398	.164

	No	54	3.7593	.59768		
Communication & support	Yes	180	3.6975	.78092	-.988	.325
	No	54	3.7840	.47993		
Overall perception	Yes	180	3.7246	.58516	-.001	.999
	No	54	3.7246	.47889		

Table 7:One- way ANOVA comparing supervision domains scores by Experience in the organization

Dependent variable	Independ. Var.	Sum of Square	DF	Mean Square	F	Sig.
Managerial role	Between group	3.180	3	1.060	3.226	.023*
	Within group	76.568	233	.329		
	Total	79.749	236			
Quality improvement	Between group	1.780	3	.593	1.323	.267
	Within group	104.468	233	.448		
	Total	106.248	236			
Human resource management	Between group	3.639	3	1.213	2.142	.096
	Within group	131.971	233	.566		
	Total	135.610	236			
Facilities & Environment management	Between group	.961	3	.320	.572	.634
	Within group	130.573	233	.560		
	Total	131.535	236			
Supervision Approach	Between group	.754	3	.251	.316	.814
	Within group	185.195	233	.795		
	Total	185.949	236			
Communication & support	Between group	.347	3	.116	.230	.876
	Within group	117.168	233	.503		
	Total	117.514	236			
Overall perception	Between group	1.264	3	.421	1.368	.253
	Within group	71.736	233	.308		
	Total	73.000	236			

Table 8: one- way ANOVA comparing supervision domains scores regarding years in supervisory position

Dependent variable	Independ. Var.	Sum of Square	DF	Mean Square	F	Sig.
Managerial role	Between group	.164	3	.055	.159	.924
	Within group	81.500	237	.344		
	Total	81.664	240			
Quality improvement	Between group	1.390	3	.463	1.032	.379
	Within group	106.431	237	.449		
	Total	107.821	240			
Human resource management	Between group	1.142	3	.381	.603	.614
	Within group	149.725	237	.632		
	Total	150.867	240			
Facilities & Environment management	Between group	.947	3	.316	.571	.635
	Within group	131.013	237	.553		
	Total	131.959	240			

Supervision Approach	Between group	.437	3	.146	.164	.921
	Within group	210.619	237	.889		
	Total	211.056	240			
Communication & support	Between group	.154	3	.051	.092	.964
	Within group	131.552	237	.555		
	Total	131.706	240			
Overall perception	Between group	.283	3	.094	.287	.835
	Within group	77.888	237	.329		
	Total	78.171	240			

Table 9:Independent t-test comparing interested to stay in job or not with supervision domains

Dependent var.	Independent var. Interested to stay	N	Mean	SD	T	Sig.
Managerial Role	Yes	151	3.6722	.55081	2.574	.011 *
	No	89	3.4738	.61835		
Quality Improvement	Yes	151	3.9558	.65960	1.795	.074
	No	89	3.7959	.67875		
Human resource management	Yes	151	3.5937	.75405	2.913	.004 *
	No	89	3.2897	.82462		
Facilities & Environment management	Yes	151	3.9962	.80372	-.671	.503
	No	89	4.0626	.61707		
Supervision Approach	Yes	151	3.6813	.93982	.895	.372
	No	89	3.5688	.94185		
Communication & support	Yes	151	3.7520	.78813	1.037	.301
	No	89	3.6492	.65540		
Overall perception	Yes	151	3.7752	.57790	1.777	.077
	No	89	3.6400	.55458		

Table 10:Independent t-test comparing Supervision domains by availability of supervisor

Dependent var.	Independent var. Had supervisor	N	Mean	SD	t	Sig.
Managerial Role	Yes	177	3.6144	.54208	.389	.698
	No	46	3.5797	.52791		
Quality Improvement	Yes	177	3.9105	.67420	.891	.374
	No	46	3.8116	.65979		
Human resource management	Yes	177	3.4548	.83148	-.332	.740
	No	46	3.4984	.62823		
Facilities & Environment Management	Yes	177	4.0048	.77620	-.824	.411
	No	46	4.1056	.56779		
Supervision Approach	Yes	177	3.6377	.94918	.188	.851

	No	46	3.6087	.87504		
Communication & support	Yes	177	3.7232	.71765	1.049	.296
	No	46	3.5966	.77277		
Overall perception	Yes	177	3.7242	.57787	.261	.795
	No	46	3.7001	.47973		

Table 11: Independent t-test comparing the presence of reporting tools or absence with supervision domains

Dependent var.	Indep. var.	N	Mean	SD	t	Sig.
Managerial Role	Yes	141	3.7004	.49411	1.398	.164
	No	23	3.5435	.52876		
Quality Improvement	Yes	141	4.0142	.56886	1.184	.238
	No	23	3.8623	.57877		
Human resource management	Yes	141	3.6231	.64332	.983	.327
	No	23	3.4720	.89519		
Facilities & Environment management	Yes	141	4.0669	.65656	-.760	.448
	No	23	4.1739	.38030		
Supervision Approach	Yes	141	3.8901	.82287	1.587	.114
	No	23	3.6087	.51718		
Communication & support	Yes	141	3.8377	.63863	.471	.638
	No	23	3.7729	.39707		
Overall perception	Yes	141	3.8554	.46714	1.131	.260
	No	23	3.7389	.39398		

Table 12: Independent t-test comparing the availability of checklist by supervision domains

Dependent var.	Indep. var.	N	Mean	SD	t	Sig.
Managerial Role	Yes	46	3.7264	.54424	.661	.510
	No	53	3.6541	.54189		
Quality Improvement	Yes	46	4.1522	.51379	1.327	.187
	No	53	3.9906	.67258		
Human resource management	Yes	46	3.7391	.47457	1.519	.132
	No	53	3.5445	.78161		
Facilities & Environment management	Yes	46	4.0590	.72128	-1.021	.310
	No	53	4.1833	.47988		
Supervision Approach	Yes	46	4.0734	.50317	3.932	.000*
	No	53	3.4811	.95430		
Communication & support	Yes	46	3.9275	.45555	1.514	.133

	No	53	3.7526	.65830		
Overall perception	Yes	46	3.9463	.41348	1.840	.069
	No	53	3.7677	.53370		

Table 13:Independent t-test comparing the use of report with supervision domains

Dependent var.	Independent var.	N	Mean	SD	t	Sig.
Managerial Role	Yes	109	3.6636	.51219	-.382	.703
	No	24	3.7083	.54948		
Quality Improvement	Yes	109	4.0061	.54335	-.060	.952
	No	24	4.0139	.68967		
Human resource management	Yes	109	3.5655	.68857	.902	.369
	No	24	3.4167	.90832		
Facilities & Environment management	Yes	109	4.0904	.58148	1.235	.219
	No	24	3.9048	.97226		
Supervision Approach	Yes	109	3.8670	.77229	2.089	.039*
	No	24	3.4792	1.02990		
Communication & support	Yes	109	3.8206	.57891	-.094	.925
	No	24	3.8333	.68258		
Overall perception	Yes	109	3.8355	.45680	.974	.332
	No	24	3.7260	.66066		

Table 14: one- way ANOVA comparing supervision domains scores regarding Visit no.

Dependent variable	Independ. Var.	Sum of Square	DF	Mean Square	F	Sig.
Managerial role	Between group	1.460	2	.730	2.060	.131
	Within group	51.737	146	.354		
	Total	53.197	148			
Quality improvement	Between group	.441	2	.221	.559	.573
	Within group	57.644	146	.395		
	Total	58.085	148			
Human resource management	Between group	2.027	2	1.014	2.580	.079
	Within group	57.374	146	.393		
	Total	59.402	148			
Facilities & Environment	Between group	.096	2	.048	.096	.908
	Within group	73.022	146	.500		

management	Total	73.118	148			
Supervision Approach	Between group	4.838	2	2.419	4.276	.016*
	Within group	82.581	146	.566		
	Total	87.418	148			
Communication & support	Between group	1.633	2	.817	2.459	.089
	Within group	48.498	146	.332		
	Total	50.131	148			
Overall perception	Between group	1.149	2	.575	2.263	.108
	Within group	37.080	146	.254		
	Total	38.230	148			

Annex 8

Table 1: One way ANOVA comparing supervisees perception domains with age category

Dependent variable	Independ. Var.	Sum of Square	DF	Mean Square	F	Sig.
Management Behavior	Between group	.700	3	.233	.447	.720
	Within group	87.071	167	.521		
	Total	87.770	170			
Communication and support	Between group	.714	3	.238	.769	.513
	Within group	51.689	167	.310		
	Total	52.403	170			
Fairness	Between group	.630	3	.210	.366	.777
	Within group	95.791	167	.574		
	Total	96.421	170			
Involvement	Between group	1.902	3	.634	1.530	.209
	Within group	69.204	167	.414		
	Total	71.106	170			
Overall perception	Between group	.810	3	.270	.912	.437
	Within group	49.464	167	.296		
	Total	50.275	170			

Table 2:Independent t-test comparing supervisees perception domains with their gender

Dependent var.	Independent var. gender	N	Mean	SD	t	Sig.
Management behavior	Male	94	3.3564	.66193	.457	.648
	Female	78	3.3061	.78092		
Communication and support	Male	94	3.5452	.54435	.023	.982
	Female	78	3.5433	.56903		
Fairness	Male	94	3.1835	.78731	-.382	.703
	Female	78	3.2276	.71075		
Involvement	Male	94	3.1532	.63613	-.472	.637
	Female	78	3.2000	.65979		
Overall perception	Male	94	3.3485	.52606	.004	.997
	Female	78	3.3482	.56562		

Table 3: One way ANOVA comparing supervisees perception domains by Residency place.

Dependent variable	In depend. Var.	Sum of Square	DF	Mean Square	F	Sig.

Management Behavior	Between group	.487	4	.122	.233	.920
	Within group	87.327	167	.523		
	Total	87.814	171			
Communication and support	Between group	1.075	4	.269	.873	.482
	Within group	51.415	167	.308		
	Total	52.490	171			
Fairness	Between group	.733	4	.183	.319	.865
	Within group	95.895	167	.574		
	Total	96.628	171			
Involvement	Between group	.660	4	.165	.390	.815
	Within group	70.588	167	.423		
	Total	71.247	171			
Overall perception	Between group	.377	4	.094	.315	.868
	Within group	49.994	167	.299		
	Total	50.370	171			

Table 4: One way ANOVA comparing supervisees supervision perception domains with marital status.

Dependent variable	In depend. Var.	Sum of Square	DF	Mean Square	F	Sig.
Management Behavior	Between group	1.603	2	.801	1.589	.207
	Within group	84.742	168	.504		
	Total	86.345	170			
Communication and support	Between group	1.561	2	.780	2.681	.071*
	Within group	48.903	168	.291		
	Total	50.464	170			
Fairness	Between group	.705	2	.353	.621	.539
	Within group	95.425	168	.568		
	Total	96.130	170			
Involvement	Between group	1.971	2	.986	2.395	.094
	Within group	69.135	168	.412		
	Total	71.106	170			
Overall perception	Between group	1.283	2	.642	2.245	.109
	Within group	48.023	168	.286		
	Total	49.307	170			

Table 5: One way ANOVA comparing supervisees supervision perception domains with academic certificate.

Dependent variable	Independ. Var.	Sum of Square	DF	MeanSquare	F	Sig.
Management Behavior	Between group	3.690	4	.922	1.831	.125
	Within group	84.124	167	.504		
	Total	87.814	171			
Communication and support	Between group	1.583	4	.396	1.298	.273
	Within group	50.907	167	.305		
	Total	52.490	171			
Fairness	Between group	2.014	4	.503	.889	.472
	Within group	94.614	167	.567		
	Total	96.628	171			
Involvement	Between group	3.308	4	.827	2.033	.092
	Within group	67.940	167	.407		
	Total	71.247	171			
Overall perception	Between group	1.903	4	.476	1.640	.167
	Within group	48.467	167	.290		
	Total	50.370	171			

Table 6:One way ANOVA comparing supervisees supervision perception domains with period of education.

Dependent variable	In depend. Var.	Sum of Square	DF	Mean Square	F	Sig.
Management Behavior	Between group	1.785	2	.892	1.705	.185
	Within group	82.148	157	.523		
	Total	83.933	159			
Communication and support	Between group	.947	2	.473	1.510	.224
	Within group	49.217	157	.313		
	Total	50.164	159			
Fairness	Between group	.701	2	.351	.623	.538
	Within group	88.392	157	.563		
	Total	89.093	159			
Involvement	Between group	1.626	2	.813	1.900	.153
	Within group	67.205	157	.428		
	Total	68.831	159			
Overall perception	Between group	1.176	2	.588	1.971	.143
	Within group	46.827	157	.298		
	Total	48.003	159			

Table 7:Independent t-test comparing supervisees perception domains with enrolled in continuous education

Dependent var.	Independent var.	N	Mean	SD	t	Sig.
Management behavior	Yes	19	3.2632	.77381	-.509	.611
	No	149	3.3523	.71247		
Communication and support	Yes	19	3.5132	.41853	-.254	.800
	No	149	3.5478	.57459		
Fairness	Yes	19	3.3421	.73225	.889	.375
	No	149	3.1779	.76134		
Involvement	Yes	19	3.3158	.48678	1.017	.310
	No	149	3.1544	.66865		
Overall perception	Yes	19	3.3663	.48337	.142	.887
	No	149	3.3474	.55587		

Table 8:One way ANOVA comparing supervisees supervision perception domains with experience at the organization

Dependent variable	In depend. Var.	Sum of Square	DF	Mean Square	F	Sig.
Management Behavior	Between group	.819	2	.409	.791	.455
	Within group	86.910	168	.517		
	Total	87.729	170			
Communication and support	Between group	.339	2	.169	.546	.580
	Within group	52.145	168	.310		
	Total	52.484	170			
Fairness	Between group	.252	2	.126	.220	.803
	Within group	96.334	168	.573		
	Total	96.586	170			
Involvement	Between group	.628	2	.314	.749	.474
	Within group	70.478	168	.420		
	Total	71.106	170			
Overall perception	Between group	.425	2	.212	.714	.491
	Within group	49.946	168	.297		
	Total	50.370	170			

Table 9: Independent t-test comparing supervisees perception domains with job description

Dependent var.	Independent var. job description	N	Mean	SD	t	Sig.
Management behavior	Yes	78	3.3413	.67410	.303	.762
	No	91	3.3077	.75721		
Communication and support	Yes	78	3.5673	.51428	.557	.578
	No	91	3.5192	.59451		
Fairness	Yes	78	3.1731	.79702	-.447	.655
	No	91	3.2253	.72078		
Involvement	Yes	78	3.2615	.63762	1.724	.086
	No	91	3.0901	.64997		
Overall perception	Yes	78	3.3708	.51949	.619	.537
	No	91	3.3187	.56724		

Table 10: Independent t-test comparing supervisees perception domains with enrolled at in-service training

Dependent var.	Independent var.	N	Mean	SD	t	Sig.
Management behavior	Yes	95	3.3697	.70520	.638	.524
	No	76	3.2993	.73174		
Communication and support	Yes	95	3.5868	.54244	.951	.343
	No	76	3.5066	.55599		
Fairness	Yes	95	3.1868	.75879	-.289	.773
	No	76	3.2204	.75163		
Involvement	Yes	95	3.2905	.68836	2.572	.011*
	No	76	3.0395	.55907		
Overall perception	Yes	95	3.3941	.55367	1.118	.265
	No	76	3.3011	.52441		

Table 11: One way ANOVA comparing supervisees supervision perception domains with number of visits.

Dependent variable	In depend. Var.	Sum of Square	DF	Mean Square	F	Sig.
Management Behavior	Between group	2.785	6	.464	.906	.493
	Within group	68.640	134	.512		
	Total	71.424	140			
Communication and support	Between group	2.414	6	.402	1.325	.250
	Within group	40.699	134	.304		
	Total	43.113	140			
Fairness	Between group	2.639	6	.440	.821	.555
	Within group	71.763	134	.536		
	Total	74.402	140			
Involvement	Between group	4.635	6	.773	1.695	.127
	Within group	61.082	134	.456		
	Total	65.717	140			
Overall perception	Between group	2.505	6	.418	1.381	.227
	Within group	40.512	134	.302		
	Total	43.017	140			

Annex 9

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وزارة الصحة

كليـة الصحـة العامـة

School of Public Health

القدس - فلسطين

جامعة القدس

2006/10/31

الأخ/ د. علي قويدر المحترم

مدير عام الرعاية الأولية -وزارة الضحة

تحية طيبة وبعد،،،

الموضوع: مساعدة الطالبة ميسون تربان

تقوم الطالبة المذكورة أعلاه بإجراء بحث بعنوان:

"Status of supervision at primary health care at Palestinian ministry of health"

كمتطلب للحصول على درجة الماجستير في الصحة العامة-مسار إدارة صحية علماً بأن الطالبة قد حصلت على موافقة لجنة هلسنكي لأخلاقيات البحوث و ستكون المعلومات متوفرة لدى الباحثة فقط. و عليه نرجو التكرم للإيعاز لمن ترونه مناسب لتسهيل مهمة الطالبة في جمع البيانات الخاصة.

موافقتكم دعماً للمسيرة الأكاديمية

و تفضلوا بقبول فائق الاحترام ،،،

د. سوزان شعشاعه

عميد كلية الصحة العامة المساعد

نسخة: الملف

كلية الصحة العامة / غزة
رقم الصادر: ١٢٢
تاريخ الصادر: ٢٠٠٦/١٠/٣١

Annex 10

Palestinian National Authority
Ministry of Health
Helsinki Committee

السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

Date: 25 / 6 /2006

التاريخ: 25/ 6/2006

Mrs./ Maysoun Turban

I would like to inform you that the committee has discussed your application about:

السيدة: ميسون تربان

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

Status of Supervision in Primary Health Care Sector at the Palestinian Ministry of Health - Gaza.

In its meeting on June 2006
and decided the Following:-
To approve the above mention research study.

و ذلك في جلستها المنعقدة لشهر يونيو 2006
و قد قررت ما يلي:-
الموافقة على البحث المذكور عاليه.

Signature
توقيع

Member
عضو

Member
عضو

Chairperson

Ministry of Health
Halsinki Committee

Conditions:-

- Valid for 2 years from the date of approval to start.
- It is necessary to notify the committee in any change in the admitted study protocol.
- The committee appreciate receiving one copy of your final research when it is completed.

Gaza Etwam -- Telefax 972-7-2878166

Palestinian National Authority
Ministry of Health
Helsinki Committee

السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

التاريخ: 2006/6/26
الرقم: 12/06

السيد/ة ..... المحترم

تحية طيبة وبعد:

الموضوع: قرار لجنة هلسنكي

مرفق طيه قرار لجنة هلسنكي للبحوث الصحية بخصوص بحثكم المقدم بعنوان:

Status of Supervision in primary health care Secbor at the palestinian Ministry of health - Gaza.

واقبلوا التحية

منسق اللجنة

د.سوزان شعشاعة