FACTORS CONTRIBUTING TO LOW SUPERVISION RATE IN UGU DISTRICT PRIMARY HEALTHCARE CLINICS

by

MKHIZE NTOKOZO CLARICE

A mini dissertation in partial fulfilment of

MASTER OF PUBLIC HEALTH

at the

UNIVERSITY OF FORT HARE

Supervisor: Prof E. Seekoe

2018

Student Number: 201415810

DECLARATION

I NTOKOZO CLARICE MKHIZE hereby declare that this mini dissertation submitted to the University of Fort Hare for degree of Master of Public Health (Coursework) has never been submitted by me for a degree at this or any other university, that this is my own work in design and execution and that all material contained herein has been duly acknowledged.

Signature Date:30/09/2018

Student Number: 201415810

DECLARATION ON PLAGIARISM

I, Ntokozo Clarice Mkhize, student number 201415810, hereby declare that I am fully aware of the University of Fort Hare's policy on plagiarism and I have taken every precaution to comply with the regulations

Signature Date: 30/09/2018

CERTIFICATION

This study entitled “Factors contributing to low supervision rate in Ugu District Primary Healthcare clinics” meets the regulation governing the award of the degree of Masters of the University of Fort Hare and is approved for its contribution to the scientific knowledge and literary presentation.

Supervisor’s Signature_____ Date: 30/09/2018

DEDICATION

This dissertation is dedicated to my mother, Mrs. Christine Ndlovu, who, against all odds contributed to my primary and secondary education which gave me a firm foundation for success.

ACKNOWLEDGEMENTS

I would like to acknowledge the following people for their support and contribution during the pursuit of this study:

- My Lord God Almighty for guidance and strength during this period.
- KwaZulu-Natal Department of Health for affording me an opportunity to study Masters in Public Health.
- My Supervisor, Prof. E. Seekoe for providing guidance and motivation. I also wish to convey my sincere gratitude to Prof. Noddy Jinabhai for providing mentorship and coaching.
- My Albertina Sisulu Executive Leadership Program Mentor, Dr Lungile Ndlovu for valuable contributions and support.
- My deepest gratitude also goes to my family for emotional support, encouragement and prayers without which I could not have completed the programme on schedule.

ABSTRACT

Background

Among the threats, barriers and challenges impeding access to health services in developing countries, Primary Healthcare Supervision was reported as a critical link with complex interventions that are implemented in different ways (Bosch-Capblanch & Garner, 2008:369). Among the objectives of the KwaZulu-Natal Department of Health Policy for PHC Supervision; are increasing the PHC Supervision rate from 60% to 85%; improvement of community participation and inter-sectoral collaboration to achieve improved health services in all health clinics in the Province of KwaZulu-Natal (KZN Department of Health PHC Supervision Policy, 2010:9). However, currently there is no policy guiding the PHC Supervision processes in the province albeit an adapted policy document from the National Health Department and set of supervision tools are used to date. It is therefore critical to examine the strength and weaknesses of the current adapted guidelines for PHC Supervision processes including the reasons for the current low PHC Supervision rate in the province.

Objectives

To (a) identify the factors contributing to the low Supervision Rate in Ugu District PHC clinics and (b) describe the influence of low Supervision rate on service delivery and performance in Ugu District PHC clinics.

Method

The study design was qualitative and descriptive in nature where unstructured interviews were conducted to identify reasons for low supervision rate in Ugu District PHC Clinics. Two groups of participants which comprised of 51 Operational Managers and seven PHC Managers were selected using non-probability purposive technique. Data were analysed using thematic analysis.

Results

Both groups of participants identified high workload, poor planning, low resource allocation and scope of work as factors contributing to low Supervision, while monitoring and evaluation, support and guidance and improved staff relations were identified as benefits of Supervision in Ugu District PHC Clinics.

Conclusion

PHC Supervision is fundamental in providing quality of health services; facilitating a safe and conducive working environment required by legislation for staff members; enabling personnel motivation; ensuring cost effective and appropriate use of resources; undertaking monitoring and evaluation of interventions and planning of health services to respond to community needs (KZN Department of Health KZN PHC Supervision Policy, 2010:1).

Recommendations

The recommendations were outlined in line with the categories that were highlighted as contributory factors to low Supervision Rate in Ugu District PHC facilities. These categories are Wok load, Planning and Resource allocation

Key words: Factor, influence, PHC, supervision, clinics

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS AND ABBREVIATIONS

CCMDD	CENTRALISED CHRONIC MEDICATION DISPENSING AND DISTRIBUTION
CHW	COMMUNITY HEALTH WORKER
DHIS	DISTRICT HEALTH INFORMATION SYSTEM
DHMT	DISTRICT HEALTH MANAGEMENT TEAM
DHS	DISTRICT HEALTH SERVICES
DOH	DEPARTMENT OF HEALTH
HAST	HIV&AIDS, SEXUALLY TRANSMITTED DISEASES AND TUBERCULOSIS
ICRM	IDEAL CLINIC REALIZATION AND MAINTENANCE
ICSM	INTEGRATED CLINICAL SERVICES MANAGEMENT
KZN	KWAZULU-NATAL
M&E	MONITORING AND EVALUATION
MMS	MIDDLE MANAGEMENT SERVICES
NDoH	NATIONAL DEPARTMENT OF HEALTH
OM	OPERATIONAL MANAGERS
PHC	PRIMARY HEALTHCARE
SMS	SENIOR MANAGEMENT SERVICES
UFH	UNIVERSITY OF FORT HARE
WBOT	WARD BASED OUTREACH TEAM
WISN	WORKLOAD INDICATOR OF STAFFING NORMS

CHAPTER 1: INTRODUCTION, BACKGROUND AND PROBLEM STATEMENT

1.1 INTRODUCTION AND BACKGROUND

Among the threats, barriers and challenges impeding access to health services in developing countries, Primary Healthcare Supervision was reported as a critical link to complex interventions that are implemented in different ways (Bosch-Capblanch & Garner, 2008:369).

Primary Healthcare Supervision is therefore viewed as a link between the basic health units and policy makers/managers/district at national and local levels in any country, and is considered crucial to ensure improved access to healthcare services. Other research projects have indicated positive effects of PHC Supervision on the quality of healthcare. For example, a positive correlation was found between the experience of the supervisor and reported benefits (Bowles & Young, 1999:958). Supervision was also reported to improve practice and promote relationships with work colleagues (White, Butterworth, Bishop, Carson, Jeacock & Clements, 1998:185).

Kim, Tavrow, Malianga, Simba, Phiri and Gumbo, (2000:1), explored the supervision process in Zimbabwe and identified some strengths of supervision such as rapport and giving feedback. However, in the same study, the authors noted weaknesses including lack of sustained follow up visits, improper checklists, derailing participation, not discussing service standards and not assisting with problem-solving.

In South Africa, the experiences of nurses in supervision in a district heath system in KwaZulu-Natal were explored and the authors found that more than half of the nurses (319 nurses) interviewed, indicated that positive supervision occurs only sometimes or not at all (Uys, Minnaar, Reid & Naidoo, 2004:51). It is important to note that the weak state of the South African Primary Healthcare system has been highlighted (Naledi, Barron & Schneider, 2011:17). This was reflected in the low PHC supervision rate of 62.4% for the year 2013/2014 and similar low figures can be reported for other developing countries. The low supervision rates are mainly due to barriers in the implementation of effective supervision and other factors (Bosch-Capblanch & Garner, 2008: 369; Kim *et al.,* 2000:1).

South Africa has chosen to improve the health service delivery rate and therefore, recently revised its national PHC Supervision Manual (NDOH Primary Healthcare Supervision Manual, 2009:6). Following this development, the KwaZulu-Natal (KZN) Department of Health developed a policy document to improve health services using the District Health System underpinned by the philosophy and structure of an internationally accepted definition of Primary Healthcare (KZN Department of Health PHC Supervision Policy, 2010:9).

Among the objectives of the KwaZulu-Natal Department of Health Policy for PHC Supervision; are increasing the PHC Supervision rate from 60% to 85%;

improvement of community participation and inter-sectoral collaboration to achieve improved health services in all health clinics in the Province of KwaZulu-Natal. (KZN PHC Supervision Policy, 2010: 9). However, currently there is no policy guiding the PHC Supervision processes in the province albeit an adapted policy document from the National Health Department and a set of supervision tools is used to date. It is therefore critical to examine the strength and weaknesses of the current adapted guidelines for PHC Supervision processes, including the reasons for the current low PHC Supervision rate in the province. Therefore, this study seeks to identify and describe the factors contributing to the low PHC Supervision rate in Ugu District PHC Clinics in the province. Taking this into account, this study will explore the plural perspectives and views of PHC managers and operational managers (OMs) with oversight responsibility for 51 healthcare clinics in the Ugu district. Ultimately, through this study's recommendations, the current supervision rate can be improved and will further assist in enhancing quality of care in PHC facilities in the Province of KwaZulu-Natal.

The criteria for primary healthcare supervision to meet the primary healthcare supervisory visit entered on the District Health Information System (DHIS) database are 1).

The visits must be a planned visit to the facility 2). The Red Flag checklist (as adapted by the KZN Province and District) must be used at each visit 3.) An in-depth programme checklist must be used at each visit 4.) An action plan of the innovative and correctional activities must be left at the facility and a copy must be available at primary healthcare supervisor's level 5.) All personnel at the visited facility must have annual work plans and the reports must be updated (KwaZulu-Natal Department of Health PHC Supervision Policy, 2010:15).

1.2 PROBLEM STATEMENT

Low supervision of PHC services is a major challenge to improving the quality of health services in South Africa. The supervision rate is one of the indicators that is measured and monitored on a national and provincial level to assess access to health services (NDOH PHC Facility Supervision Manual, 2009:24).

According to the District Health Information Systems, the PHC Supervision Rate for the year 2013/2014 was 73.7% in South Africa. In 2010, the District Health Barometer reported a wide variation in the PHC facility supervision rate between and within provinces, with some districts scoring less than 40% (Naledi *et al.,* 2011:17). The expected performance, in terms of the prescribed national norm, is 85%. In Ugu District, the PHC Supervision Rate for the year 2013/14 was 65.6% (NDOH District Health Barometer, 2013/2014). The expectation is that all PHC Clinics must be visited by the PHC Supervisor at least once a month to give support and monitor performance on a regular basis to improve health services (KwaZulu-Natal Department of Health PHC Supervision Policy, 2010:10).

Failure of the PHC Managers to conduct supervisory visits monthly impacts negatively on clinic performance. Supervision is viewed as central to recognising capacity, developing human capacity, and in enabling the systems of supply and repair of equipment in health facilities.

Primary Healthcare (PHC) managers are expected to greatly influence quality of care at facility level through their technical and clinical support to healthcare service providers in guiding the provider-client interaction. In addition, they can help in people development processes and supporting community participation in health. Through supervision, the PHC Supervisor can empower and capacitate healthcare providers to achieve expected quality standards thereby increasing their performance when carrying out their duties (KwaZulu-Natal Department of Health PHC Supervision Policy, 2010:5).

Failure to conduct these monthly onsite visits consistently compromises the quality of care rendered to the client and negatively impacts on health outcomes. It is therefore important to stress the need for a critical examination of the strength and weaknesses of the current adapted guidelines for PHC supervision processes to improve the supervision rate in the province.

The National Health Amendment Act of 2013, which provides the legal framework for the establishment of the Office of the Health Standards Compliance (OHSC), was signed into law by the President in September 2013. However, the National Department of Health (NDoH) has observed in many facilities inertias to correct weaknesses in the service delivery platform and in the quality of service provision. Key challenges include apathy amongst health workers and general system failures which perpetuate these weaknesses. The ideal clinic initiative was conceptualized by the Ministry of Health as a blue print for effectively addressing weaknesses and to ensure sustained improvements in the quality of healthcare services delivered at public sector health facilities, starting with clinics. This study intends to describe the factors contributing to the low performance level in PHC supervision ratings in healthcare facilities in Ugu District, KwaZulu-Natal Province.

1.3 AIM OF THE STUDY

The aim of the study is to identify and describe the factors contributing to the low supervision rate in Ugu District PHC Clinics and discuss the influence that low Supervision of PHC Clinics has on service delivery and performance

1.4 RESEARCH QUESTIONS

- What are the factors that contribute to the low supervision rate in Ugu District PHC clinics?
- What is the influence of low Supervision rate on service delivery and performance?

1.5 OBJECTIVES OF THE STUDY

The research questions were responded to by the following objectives:

- To identify the factors contributing to the low Supervision Rate in Ugu District PHC clinics.
- To describe the influence of low supervision rate on service delivery and performance in Ugu District PHC clinics.

1.6 SIGNIFICANCE OF THE STUDY

The findings of the study will assist in enhancing quality of care in PHC facilities through facilitative support supervision as a requirement for compliance with National Care Standards and PHC Reengineering. It will further influence the formulation of strategies and interventions that will improve health outcomes. Findings of the study will further assist the department in improving the District Health Services with specific reference to Primary Healthcare.

1.7 SCOPE OF THE STUDY

The study focused on all PHC Managers and Operational Managers who work in Ugu District. The study was conducted and restricted to Ugu District Municipality, an area with existing health facilities and infrastructure. Furthermore, this study did not attempt to estimate the cost of PHC supervision in the Ugu district nor assess the importance of community members, including patients and other government departments in enhancing health service delivery in the Province of KwaZulu-Natal.

1.8 OPERATIONAL DEFINITIONS OF KEY TERMS AND CONCEPTS

1.8.1 Primary healthcare

PHC is a set of prescribed services, generally falling within the skills base of a professional nurse, midwife, community health worker and emergency medical practitioner (Primary Health Supervision Manual, 2009:11). PHC, in this study, refers to the 51 clinics that provide the promotion of health and prevention of disease as a basis, as well as aspects of curative, rehabilitation and palliative care (NDOH Primary Healthcare Supervision Manual, 2009:11).

1.8.2 Supervision

Supervision is an intervention that is provided by a senior member of a profession to a junior member of the same profession with the aim of enhancing functioning of a junior member. It also ensures monitoring the quality of services offered (Bernard & Goodyear, 1998).

Furthermore, it is a planned, support, coaching and mentoring relationship between the supervisor and supervisee (KZN PHC Supervision Policy, 2010:7). In this study, PHC supervision is the continuous strategy that supports quality PHC services with their full participation, through identification of healthcare needs and healthcare

services gaps, problem solving, resource allocation, people development, planning, monitoring, evaluation, and feedback (KwaZulu–Natal Department of Health PHC Supervision Policy, 2010:10).

1.8.3 Primary Healthcare (PHC) Manager

In this study, the PHC manager or supervisor is a manager whose duty is to oversee and direct the execution of the work in PHC clinics within Ugu District. This manager needs to be in possession of a diploma or degree in health sciences with a minimum of 3 years managerial experience in Primary Healthcare clinics (NDOH Primary Health Supervision Manual, 2009:11).

1.8.4 Operational Manager

In this study, the operational manager is a person appointed, delegated or assigned to manage the overall PHC activities and personnel in one local PHC facility. The manager is always referred to as a sister in charge of a clinic/facility. Each PHC clinic has an appointed operational manager, who is responsible for onsite supervision of the quality of care, and management of human resources including management of the staff appraisal system, other resources e.g. pharmaceutical stock, consumables, and clinic outputs, as well as ensuring linkages with community structures and accurate, valid data collection for analysis at local, district and provincial levels. The operations manager is also responsible for local planning of services, liaison, planning, and monitoring within the community (KwaZulu–Natal Department of Health PHC Supervision Policy, 2010:10).

1.8.5 Community participation

In this study, community participation refers to involvement of community members (leaders, NGOs, traditional healers and so forth.) as partners in the planning of health activities, mobilizing communities and resources for health (KwaZulu–Natal Department of Health PHC Supervision Policy, 2010:3)

1.8.6 District

A district refers to a municipality contemplated in section 151(1) of the Constitution and section 12 of the Local Government Municipal Structures Act, 1998 (Act No. 117 of 1998). In the study, the district refers to Ugu District Municipality under which the 51 PHC clinics fall.

1.9 CONCEPTUAL FRAMEWORK

The systems approach was adopted in this study and implemented to illustrate the link between the inputs, process and outputs.

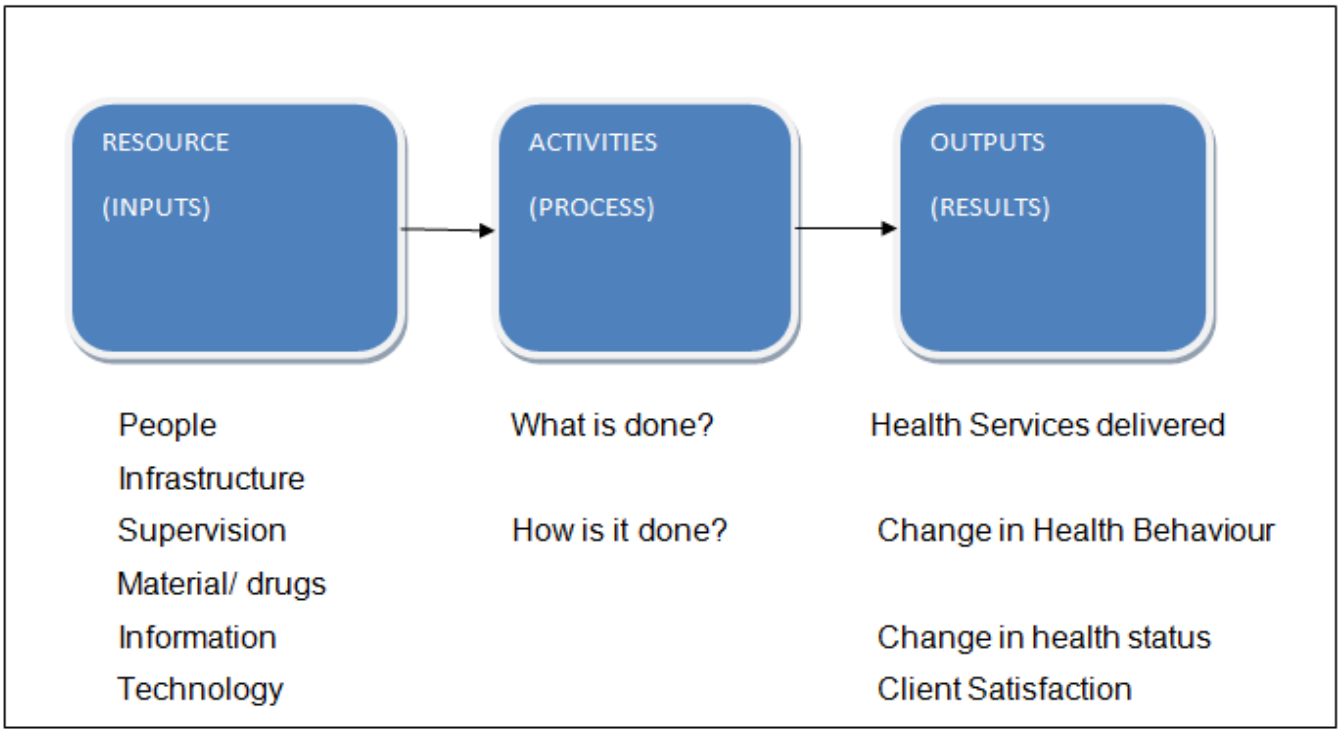

Figure 1.1: *A systems approach: inputs, processes and outcomes. Adapted from Donabedian (1980)*

As reflected in Figure 1.1 above, it is important for PHC managers to understand that processes (activities) are the critical link that transforms inputs (resources) into outputs (results). Therefore, results are dependent on improving processes, as well as inputs, and the importance of the assessment of processes within the Quality Supervision Framework must be emphasised.

Inputs could be resources such as (human or material), drugs, infrastructure, equipment, training and supervision; while activities refer to compliance in terms of technical norms and standards, counselling and couching; and results would mean performance outputs in terms of impact and effect of inputs (NDOH Primary Healthcare Supervision Manual, 2009:29).

In the context of this study, the systems approach is applied as follows:

1.9.1 Resources

The PHC Manager is responsible for ensuring that the resources needed for proper functioning of the PHC are available at all times. Such resources include, but are not limited to supplies, staff needs, information systems and patient needs.

Supervision visits consist of assessment and facilitation (feedback and problem-solving), and planning and monitoring. Assessment and facilitation to improve performance and quality are integrated as much as possible. Many problems are thus addressed immediately through feedback that is supportive and corrective) rather than using longer problem-solving processes. Supervisors address problems at the PHC facility level and at higher levels through follow-up of plans and specific support to resolve problems.

1.9.2 Activities

As part of essential quality standards, a PHC facility supervisor should review plans from the last visit and identify activities to be completed by the next supervisory visit. The supervision checklist and quality improvement (QI) plan provide an opportunity to monitor progress and planned activities for the next period; assess compliance and reinforce skills through feedback; identify problems requiring problem-solving with clinic staff; report results, address problems and then give feedback to clinics; and review clinic resources

1.9.3 Results

For quality standards to result in improved outcomes, the following are essential: organisational and healthcare personnel behaviour change; supervisor and healthcare personnel learning and support, and on-going support from sub-districts and districts (NDOH Primary Healthcare Supervision Manual, 2009:31).

1.10 SUPERVISION

In a study by Bosch-Capblanch & Garner (2008:371), supervision is the process that promotes continuous performance improvement of healthcare workers by managing difficulties encountered by the staff. It includes motivating staff, thus enhancing their performance through education and training. In the health sector, the word “supervision” is accepted as a major issue and priority in the quality of care regardless of how it is understood and defined.

The definition is surrounded in controversy because its meaning seems to depend on the socio-cultural influences of the nation (Butterworth, Carson & White, 1997). For example, in the USA and Japan, the term refers to a ‘superior or novitiate’ type of relationship with a strong management focus and in Germany, nurses refer to it as a growth-promoting and developmental relationship (Butterworth Bishop. & Carson 1996:128). These two definitions seem to depict two separate agendas usually misunderstood by nurses, which is that one is from the nursing profession itself and the other from the policy and management sector.

This assertion was alluded to by Uys *et al.* (2004:50) when they reported on the perception of nurses in a District Health System in KwaZulu-Natal of their supervision responsibility. They highlighted two basic approaches to supervision; namely management supervision and consultative supervision. Some researchers have argued that management supervision may be less effective in nursing as it is seen as regulatory rather than supportive and consultative supervision is seen as supportive and developmental but less common in nursing (Uys *et al.*, 2011:50).

Lyth (2000) in a concept analysis suggested a more consultant-friendly definition of supervision as:

> [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. This process will lead to an increasing awareness of other concepts including accountability and reflective practice (p.728).

This definition is more in line with the value statement on primary healthcare supervision of the KwaZulu-Natal Health Department and will be used for this study (KwaZulu-Natal Department of Health PHC Supervision Policy, 2010:5).

1.10.1 Importance of supervision

The importance of supervision in nursing is well documented in literature. Supervision has been reported to improve practice and promote relationships with work colleagues (White *et al.*, 1998:187), promote rapport and report feedback (Kim *et al.*, 2000:1), provide job-satisfaction and self-esteem (Uys *et al.*, 2011:50), and to help sustain and develop safe and accountable practices (Butterworth & Faugier, 1992:44). In the UK, a pilot study in which nurses were interviewed after a short course in clinical supervision revealed the importance of supervision as it results in improvements in communications, more openness, and better teamwork (Malin, 2000:549). In general, when implemented effectively and efficiently, supervision can promote and improve the quality of care in the PHC system.

1.10.2 Supervision in relation to counselling, coaching and mentoring

The relationship of supervision to counselling, coaching and mentoring especially in business and education, has been recognised as very important and several models have emerged to explain the associated benefits (Ronnestad & Skovholt, 1993:396; Gray, 2007:300; Gray & Jackson, 2012:10).

Supervision is viewed as a relationship between a supervisor and supervisee that should facilitate personal growth and to encourage and enable learning to maximise the supervisee's potential, develop their skills, improve their performance and become the person they want to be (Fisher, 1994:15; Mackenzie, 2004:10). For the supervisor to succeed in supervising the supervisee, he/she needs to be a counsellor, coach and mentor depending on the circumstances and terms of the relationship. As a counsellor, the supervisor should generally address the

supervisee's emotional state and the causes of personal crises and problems, and it involves short-term interventions designed to remedy problems that interfere with the supervisee's job performance (Abiddin, 2006:107).

In general, the term coaching is used interchangeably with counselling and mentoring, however, some authors have differentiated them, wherein mentoring is viewed as a long-term arrangement with a wider perspective but a coaching arrangement may be short-term for the immediate improvement of performance and its focus may be narrow (Abiddin, 2006:107). In summary, supervising can be effective if the supervisor can use any of the approaches (coaching, mentoring or counselling) to improve the performance of the supervisee in the workplace.

1.10.3 Supervision within the PHC context

Supervision within the PHC context can best be described as clinical supervision. According to the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, clinical supervision is defined as a necessary process based on a clinically focused professional relationship between the practitioner and supervisor. This relationship involves the supervisor using their clinical knowledge and experience to assist colleagues with the development of their clinical skills, knowledge and values to promote and maintain high standards and innovation in clinical practice (Butterworth & Faugier 1992:48; Butterworth *et al.,* 1997:232). In the PHC system, supervision can, where appropriate, be augmented by networking with colleagues from other clinical professions.

PHC supervision is fundamental in providing quality healthcare services; facilitating a safe and conducive working environment required by legislation for staff members; enabling personnel motivation; ensuring cost effective and appropriate use of resources; undertaking monitoring and evaluation of interventions and planning of health services to respond to community needs (KwaZulu-Natal Department of Health PHC Supervision Policy, 2010:5).

As shown in Figure 1.2, the average PHC supervision rate in South Africa in the year 2013/14 was 73.3%. Limpopo (LP) had the highest supervision rate at 92.8%, with Northern Cape (NC) having the lowest rate at 41.8%, which was well below the national average of 73.7%. It was further noted with concern that the PHC supervision rate in KwaZulu-Natal (KZN) was the second lowest at 62.4% (NDOH District Health Barometer, 2013/14).

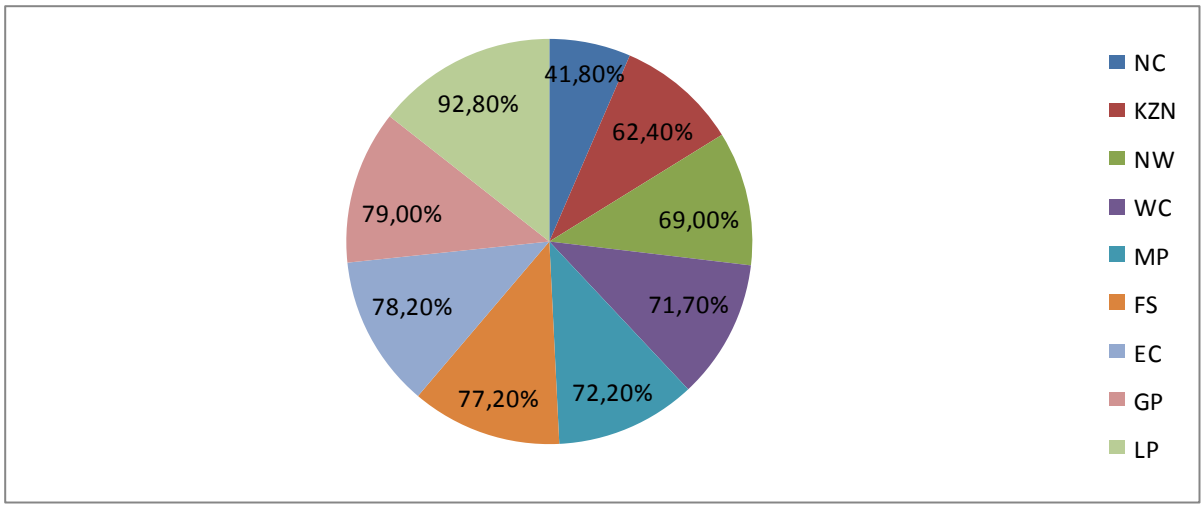

Figure 1.2 *PHC Supervision visit rate by province in South Africa 2013/14*

The performance in figure 1.3 indicates that in KZN, only 3 out of 11 districts have achieved a PHC supervision rate above the national average of 73.7%. Ugu District in particular, had a PHC supervision rate of 65.9%. Though the NHI pilot districts (Umgungundlovu, Umzinyathi and Amajuba) have been receiving more health systems strengthening interventions, all of them performed poorly in 2013/14 (NDOH District Health Barometer, 2013/14).

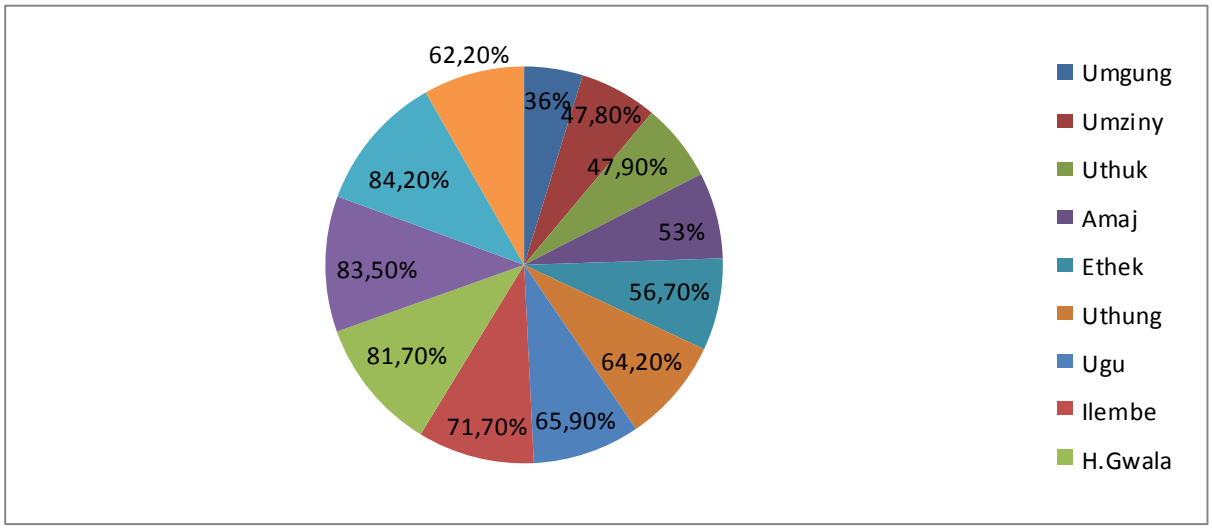

Figure 1.3 *PHC Supervisory visit rate by KZN districts, 2013/14*

1.11 CONCLUSION

In this chapter, the researcher presented the overview of the study which encompassed the introduction, background and problem statement of the study. The researcher further discussed the conceptual framework that is applicable to the study. The next chapter will focus on the literature pertaining to this study.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, the literature review in conceptualising the concept of supervision will be discussed.

2.2 FINDINGS FROM LITERATURE REVIEW

In developing countries, PHC supervision was reported as a critical link to develop complex interventions to mitigate the threats, barriers and challenges impeding access to health services (Bosch-Capblanch & Garner, 2008:369). Kim *et al.* (2000:1, explored the supervision process in Zimbabwe and identified a few strengths of supervision such as rapport and giving feedback. However, in the same study, the authors noted weaknesses including lack of sustained follow up visits, improper checklists, derailing participation, not discussing service standards and not assisting with problem-solving.

In South Africa, the experiences of nurses on supervision in a district heath system in KwaZulu-Natal were explored. The authors found that more than half of them (319 nurses) interviewed, indicated that positive supervision only happens sometimes or not at all (Uys, *et al.,* 2004:51). It is important to note that the weak state of the South African Primary Healthcare system has been highlighted (Naledi, *et al*, 2011:17).

This was also reflected in the low PHC Supervision Rate of 62.4% for the year 2013/2014 and similar low figures can be reported for other developing countries, mainly due to barriers in the implementation of effective supervision and other factors (Bosch-Capblanch & Garner, 2008:369).

South Africa has chosen to improve the health service delivery rate and therefore, recently revised its national PHC Supervision Manual (Primary Healthcare Supervision Manual, 2009:6).

In a concept analysis, Lyth (2000:728) suggested a more consultant-friendly definition of supervision as “a support mechanism for practicing professionals within which they can share clinical, organizational, developmental and emotional experiences with another professional.” He further indicated that such experiences are achievable in a secure, confidential environment to enhance knowledge and skills.

Different authors support the viewpoint that for the supervisor to successfully supervise the supervisee, he/she needs to be a counsellor, coach and mentor depending on the circumstances and terms of the relationship. As a counsellor, the supervisor should generally address the supervisee’s emotional state and the causes of personal crises and problems. This further involves short-term interventions designed to remedy problems that interfere with the supervisee’s job performance (Abiddin, 2006:107). In summary, supervising can be effective if the

supervisor can use each of the approaches (coaching, mentoring or counselling) to improve the performance of the supervisee in the workplace.

2.3 SYSTEMS-SPECIFIC FACTORS - LOW PHC SUPERVISION

2.3.1 Poor time management and priority setting

As will be discussed in the analyses section the results of the study revealed that there were too many unscheduled meetings and workshops coordinated at district level that the PHC manager is expected to attend.

The study by Nkosi, Horwood, C., Vermaak, K., Cosser, C. & Haskins (2009:13) confirmed that most clinics and supervisors reported that visits were not scheduled in advance. Supervisors said they were not scheduling the visits because often they had to cancel due to other commitments. Most supervisors felt clearer guidelines regarding supervisory visits were needed, and senior management needed to be more supportive and enable them to perform their supervisory functions.

2.3.2 Low resource allocation

Shortage of staff and the unavailability of transport to conduct supervision was an issue that emerged throughout the interviews. In support of this, Nkosi *et al.* (2009:12) concurs that transport was reported to be one of the reasons why supervisory visits were sometimes missed with 32% of the supervisors reporting having missed more than one visit in the past month for this reason. Only 32% of the supervisors said they had dedicated transport to conduct supervisory visits. The majority said they used carpools or travelled with other colleagues, and there was a general feeling expressed by the majority of supervisors that they need dedicated vehicles, to be able to visit their clinics anytime they wish to. Furthermore, the fact that supervisors are not able to visit their clinics regularly undermines the concept of clinical supervision, which requires face-to-face interaction.

As supported by Kitenge and Govender (2013:3) the majority of the PHC professional nurses (more than 50%) expressed the opinion that the challenges faced in monitoring the RTHC were staff shortages, lack of equipment, a work overload and unequal distribution of professional nurses on duty per shift, with the degree of understaffing ranging from moderate to severe.

2.4 POSITIVE CONTRIBUTION OF PHC SUPERVISION

2.4.1 Identification of gaps in performance to ensure service delivery improvement

The modern approach to supervision emphasises quality improvement and is regarded as one of most important support systems for effective, high quality healthcare services (Tavrow, Kim, & Malianga, 2002:57). Clinical supervision entails assessment of skills, where the supervisor observes patient care, identifies gaps in knowledge and/or skills of the healthcare workers, and acts to improve skills and

performance of healthcare providers. Directly observed practice is beneficial to the healthcare providers as instant feedback is received (Smith, 1996:16). Most clinic-based managers often lack skills and the authority to manage and address service delivery challenges, hence the importance of regular supervisory visits by sub-district based, or external clinic supervisors (Marquez & Kean, 2002:1).

On the contrary, a study by Bosch-Capblanch *et al.* (2011:19), showed that while supervision involved regular visits and played a role in performance and motivation, joint problem solving and feedback were minimal. Such models of supervision can have negative repercussions on staff retention, job satisfaction, motivation and job performance (McAuliffe, Daly, Kamwendo, Masanja, Sidat & de Pinho, 2013:5).

Fatti, Rundare, Pududu and Mothibi (2013:2) describe that supervision can increase motivation by showing nurses the results of their work and thus, act as a positive affirmation of work well done. Communication between supervisor and supervisee was described as a crucial factor for excellent quality supervision. Bradley and Igras (2005) found two-way communication to be a critical factor in staff motivation, and an important mechanism to create team spirit by ensuring staff could express their opinions and make suggestions.

2.4.2 Support and guidance

Supportive supervision can promote quality improvements by strengthening relationships within the system, identifying and solving problems, and maximizing resource allocation (Chambers & Long, 1995). The study by Manzi, Magge, Hedt-Gauthier, Michaelis, Cyamatare, Nyirazinyoye, Hirschhorn and Ntaganira (2014) concurs with the above author, suggesting that mentoring skills of active listening and relationship building improves morale, confidence, and self-esteem of both the mentor and healthcare workers.

As stated in the PHC Supervision Manual (2009:33), most feedback involves a combination of supportive and corrective feedback. Giving feedback is probably the most important quality improvement skill for a supervisor to have.

2.5 IMPACT OF FAILURE TO SUPERVISE CLINICS

2.5.1 Lack of monitoring and evaluation

The performance management system refers to the mechanisms and processes used towards identifying those behaviours and activities that produce actual results and attending to them. The main aim is to identify and remedy the gaps between the actual results versus the desired outcome (Ijeoma, Nzewi &. Sibanda 2013:170).

2.6 PRESENTATION OF NEW FINDINGS

2.6.1 Training and skills development

Although none of the participants of the study mentioned lack of supervisory capacity and training as reasons for failure to conduct monthly supervisory visits to clinics,

many studies that have been conducted revealed this as a major gap. This is confirmed by the findings below:

In his paper, 'Training Programme for Rural Primary Care Nurse Practitioners in South Africa', Reid (2002:1) points out, that in South Africa, the role of support and supervision of PHC workers was given to professional nurses who were not adequately trained for the job. The article describes a programme that was designed to support and develop PHC coordinators in Pietermaritzburg district (now Umgungundlovu) in KwaZulu-Natal in 2000. Evaluation at the end of the programme showed that there was improvement in the supervisory process, supervisors had more understanding of their roles, and their self-confidence and problem-solving skills were improved (Reid, 2002:7).

A study conducted by Gwele and Makhanya, (cited in Lehman 2001:6), in one district in KwaZulu-Natal, found that in the supervisory process, the frequency and duration had been improved by training of supervisors. There are major challenges to supervision, including supervisors' lack of skills, lack of useful assessment tools, lack of transport, and supervisors are often burdened with administrative duties. Supervisors are often not supported by their superiors, who may prioritise other activities over supervisory visits (Rowe, de Savigny, Lanata & Victora, 2005:1030).

Supervision therefore, needs to be improved so that supervisors can contribute to quality improvement. To achieve this, supervisors need to be trained in supportive supervision so that the clinic supervisor obtains the skills to act as a facilitator, trainer and coach (Marquez & Kean, 2002:24). Supervisors also require support from their superiors and as resources to increase the time they spend with health workers (Rowe *et al.,* 2005:1030).

Supervisors are rarely prepared to be supervisors. Whether the CHW supervisors are district health officers or primary care nurses, they are usually not trained in supervision and therefore, they cannot provide the kinds of support CHWs need. Supervisors need skills in counselling, problem solving and quality improvement. Supervision tools and checklists, when they exist, are often overly complex, long, and not practical aids for supervisors or for CHWs (Crigler, Gergen & Perry 2013:8).

2.7 CONCLUSION

This chapter dealt with the concept of supervision giving different viewpoints from various authors. It also explored existing literature on the factors that have an impact on the supervision of clinics. While supervision remains key to enhancing the performance of the supervisee, capacitating the supervisor to effectively conduct supportive supervision is critical.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

The previous chapter presented the introduction, background and problem statement. This chapter will focus on the research methodology. The methodology will be discussed in terms of the research design, study setting, data collection, data analysis, trust worthiness and ethical considerations

3.2 RESEARCH DESIGN

The research design followed in this study was qualitative and descriptive in nature. A research design is an overall plan that helps a researcher obtain answers to the research questions and helps the researcher address challenges that may arise while conducting the research (Polit & Beck, 2008:66). This design was chosen to gain an in-depth understanding of the various factors that are related to low PHC supervision by PHC managers. The descriptive design provides an accurate portrayal or account of characteristics of an individual. It assisted the researcher to gain more information about the characteristics within the current field of study and to provide a picture of situations as they naturally appear (Burns & Grove, 2009:16).

3.3 RESEARCH SETTING

The setting refers to the area or location where the study is conducted (Burns & Grove, 2009: 362). The research study was conducted in a conference facility over a period of 3 days, immediately after the day's session as all the PHC managers and Operational managers had attended a workshop and were accommodated for three days.

According to Brink, van der Walt, and van der Rensburg (2009:143), the setting for data collection must be carefully determined. This study was conducted in South Africa in the Province of KwaZulu-Natal in Ugu District Municipality. KwaZulu-Natal has 11 districts.

Ugu District has a population of 741 541 people and is situated on the KwaZulu-Natal South Coast extending inland. The 5 866 km² district is bordered by the Eastern Cape to the south, eThekwini Metropolitan to the north, the Indian Ocean to the east, Harry Gwala District to the west and UMgungundlovu to the north west of the District. Ugu District Municipality comprises of four (4) local municipalities namely Umdoni, Umzumbe, Ray Nkonyeni and Umuziwabantu. The district has one regional hospital, three district hospitals, one specialized TB hospital, two community health centres, and 51 PHC clinics. The fifty-one operational managers and seven PHC managers are responsible for management of clinics under this district (Ugu District profile, 2016:3).

3.4 POPULATION

The total population is the entire group of people or objects that is of interest to the researcher (Brink, van der Walt and van der Rensburg 2014:131). In this study, two

population groups were interviewed. They were operational managers who are each responsible for the management of a clinic and PHC managers who have the responsibility of supervising a cluster of clinics.

3.5 SAMPLE AND SAMPLING PROCEDURE

The researcher employed a non-probability purposive technique. Seven PHC managers, who are responsible for a cluster of clinics and 51 operational managers, who are each responsible for the management of one clinic were selected to be part of the sample.

De Vos, Strydom, Fouche and Delport (2013:223) define a sample as the simultaneous existence of a population or universe of which the sample is a smaller section, or a set of individuals selected from a population. According to Polit and Beck (2012:275) sampling is the process of selecting cases to represent an entire population so that inferences about the population can be made. Burns & Grove (2009:708) state that sampling is selecting groups of people, events, behaviours or other elements with which to conduct the study.

3.5.1 Inclusion criteria

Inclusion sampling criteria are those characteristics that a subject or element must possess to be part of the targeted population (Burns & Grove, 2005: 343). The PHC managers and operational managers working in Ugu District were selected based on the following criteria:

- In possession of a 4-year Diploma or Degree in Nursing Science
- Trained in 1 year Post Basic Diploma in Primary Healthcare
- Minimum of 3 years managerial experience in PHC

3.5.2 Exclusion criteria

Participants were excluded in the study based on the following criteria:

PHC managers and operational managers of PHC clinics who are linked to other districts in line with the new Municipality Demarcation arrangements.

3.6 RESEARCH INTERVIEW GUIDE

A self-designed, unstructured interview guide was used to collect data from the participants. The interview guide had open-ended questions (Brink, *et al.,* 2009:152). The interview guide covered and explored the following variables from the two categories of managers.

3.6.1 Interview guide used for operational managers

Section A.1 of the interview guide that the researcher used to collect data from operational managers, looked at Demographic Data in relation to name of sub district, level of education, gender, age, years of working experience in PHC and current position while Section A.2 focused on Workload per Supervisor; Frequency

of Supervisory Visits; Reasons for PHC Manager's Failure to visit PHC Clinics on a monthly basis as a main question, and Benefits of PHC Supervision and Strategies to Improve PHC Supervision.

3.6.2 Interview guide used for PHC managers

Section B.1 of the interview guide that the researcher used to collect data from PHC managers, looked at Demographic Data in relation to name of the sub-district, level of education, gender, age, years of working experience in PHC and current position while Section B.2 focused on Workload per PHC Manager; Frequency of Supervisory Visits; Reasons for failure to visit PHC clinics on monthly basis as a main question, and Impact of PHC Supervision and Strategies to Improve PHC Supervision.

3.7 DATA COLLECTION METHOD

Participants from both groups of managers (operational managers and PHC managers) were given a letter explaining the process and purpose of the study. A written informed consent to conduct the interview was obtained from each participant. The venue at the conference facility was prepared ahead of time to help each participant feel comfortable and welcomed.

Data was collected through unstructured interviews using a self-designed interview guide. The guide covered issues in much greater detail to explore the participants' views and ideas about PHC Supervision. The questions were asked in English. The open ended main question for PHC managers was "*What could be the reason for you not visiting clinics monthly?*" The main open-ended question for operational managers was *"Can you provide me with any reason(s) why you are not being supervised on monthly basis?"*

Probe-type questions to both groups of participants were based on what the participants said and consisted mostly of clarification and elaboration probes. Two research assistants were trained to conduct the interviews and record the participant's responses. Notes were taken in order not to miss non-verbal cues. A written record (transcript) of what the participant said was obtained for data analysis. Each interview lasted between 15 to 20 minutes. Saturation was reached after 21 participants (5 PHC managers and 16 operational managers) had been interviewed. Data saturation occurred when there was repetition of themes from participants (Brink, *et al.* 2014:173). At the end of the study, the researcher sent a written acknowledgement to the people involved in assisting the researcher (Brink, *et al.,* 2009:151-152).

3.8 DATA ANALYSIS

Data analysis entails categorising, ordering, manipulating, summarising data and describing them in meaningful terms (Brink, *et al.,* 2009:170). According to Maree (2016:109), qualitative data analysis is aimed at examining meaningful and symbolic content of qualitative data. It seeks to establish specific phenomenon by analysing

participants' knowledge, experiences and feelings. Data analysis started as early as at the initial stage of data collection. Data analysis and interpretation from interviews of both operational managers and PHC managers commenced immediately after data collection, to avoid unnecessary delays that could result in the loss of data. All documents such as letters of permission to conduct the study, consent forms, and responses from the interview were kept in a locked safe in the researcher's office during the study. These will be stored in the registry for 5 years after completing the study. Unauthorised persons will not have access to the study documents.

In this study, data was analysed by thematic content analysis using Creswell's 6 steps content analysis method as indicated in the table 3.1 below.

Table: 3.1: *Creswell's steps in data analysis*

STEP	**DESCRIPTION**
1	Organise and prepare data for analysis. This involves transcribing and sorting data from the interview.
2	Read through all data. This is done to get sense of the information and its overall meaning.
3	Coding of the data. This step involves the process of organising data into information and writing a word that represents an identified category in the margin.
4	Description of themes for analysis. It involves detailed description of themes for analysis.
5	Present results of the analysis. Conveying the findings of the analysis through description of several themes or discussion of interrelated themes.
6	Interpretation of results. This step includes discussion of lessons learnt.

Source: Adapted from Creswell (2014: 196)

The first step in analysing data was to transcribe the interview data from both groups of participants (operational managers and PHC managers), where the researcher sorted and arranged information. The researcher analysed data from operational managers first. Data from the PHC managers was analysed last. In step 2 the researcher read through data with the aim of understanding the overall meaning of information. The researcher reread the transcriptions to further gain understanding of what was said. Steps 3 involved coding of data into chunks of information and the researcher identified words that represent the category. Themes, sub-themes and categories were formed and described in step 4. Step 5 involved a detailed narrative analysis of themes. In the final step, the researcher interpreted the results and come up with lessons learnt from the study (Creswell, 2014:196). The findings of the analysis including its interpretation were presented in the next chapter.

3.9 TRUSTWORTHINESS

The researcher utilised the strategies of credibility, transferability, dependability and confirmability as four criteria to measure trustworthiness of the study for both operational managers and PHC managers (Maree, 2016:123). These criteria are briefly described in Table 3.2 below.

Table 3.2: *Application of the 4 strategies of trustworthiness*

Strategy	**Criteria**	**Application in the study**
Credibility	Use of qualitative, descriptive design and purposive sampling	All participants had a good knowledge of the phenomenon being investigated. The research participants had more than 3 year's managerial experience in PHC.
	Researcher credibility	The researcher has worked within this district for more than 10 years and has done a basic research principles course.
	Peer debriefing	The researcher used a colleague who is a manager at district level and has a lot of experience in qualitative research to go through the work and methodology that has been used.
	Use of reflective notes and member checking	Transcripts and field notes were shared with participants and research assistants to check for accuracy.
Transferability	Comparison of sample to demographic data Participants are typical to the context being studied.	All participants have a minimum of 3 years' experience working in the PHC setting. The sample size of 58 participants included OMs and PHC Managers overseeing all clinics in Ugu district. Sufficient information had been given about the characteristics of a sample for judgements to be made about the extent to which findings could be expected to apply more widely.
	Thick descriptions	Detailed descriptions of the study setting, population, sampling procedure, the research design, and the results were provided to allow readers to make their own decision about transferability.

	Selection of sample	A purposive sampling design where in OM and PHC Managers in charge of these clinics were selected.
Dependability	A written record (transcript) of what the interviewee said was obtained for data analysis	A self-designed interview schedule with open-ended questions was used for all participants. Data was transcribed verbatim and thereafter coded into themes.
	Peer debriefing	The researcher used two research assistants who are managers at district level and have vast experience in qualitative research.
	Member checking	Transcripts and field notes were shared with participants and research assistants.
Confirmability	Member checking and involving others	Two (2) research assistants were used to collect data. Data was transcribed verbatim.
	Reflexivity	Use of written personal field notes and tape-recorded information. Use of direct quotes from participants.

Source: Adapted from Polit & Beck (2010:496)

3.9.1 Measures for trustworthiness

3.9.1.1 Credibility

Credibility concerns the compatibility of the research findings with what is really happening on the ground. It further looks at how the research design fits the research questions. It is enhanced through early familiarization of the researcher with the participants and their organizations but also through well-defined purposive sampling (Maree, 2016:123).

3.9.1.2 Transferability

Transferability refers to the extent to which the readers of research can link the elements of the study with their own experience. To maximise transferability, qualitative researchers should focus on how typical participants are to the context being studied and the context to which the findings apply. The researcher is responsible for portraying the full picture of the context, thus allowing the reader to determine if the research is transferable to their own setting (Maree, 2016:124). There should be evidence of the findings of the study, recommendations and conclusions are supported by data (Brink, *et al.,* 2014:128).

3.9.1.3 Dependability

Dependability refers to the stability of data overtime. It also refers to the provision of evidence such that if it were to be repeated with the same or similar participants or context, its findings would be similar (Brink, *et al.,* 2014:172).

3.9.1.4 Confirmability

Confirmability is concerned about whether the data reflects the views or voices of the participants and not biased by the researcher's thinking, motivation and interest. The strategies to confirm confirmability are enquiry audit, reflexivity and triangulation. Reducing biasness of the findings can be achieved through member checking and involving others (Maree, 2016:125).

3.10 ETHICAL CONSIDERATIONS

According to Maree (2016:44), ethical consideration is an essential issue in protecting the participants' identity.

Ethical clearance was obtained from the University of Fort Hare Ethics Committee, since the study involved human subjects. Permission to conduct the study, at the identified clinics was also obtained from the Chief Director of District Health Services in KwaZulu-Natal Department of Health.

Ethics approval was obtained from KwaZulu-Natal Department of Health, Health Research & Knowledge Management unit/committee.

3.10.1 Informed consent

The ethical principles of voluntary participation and protecting the participants from harm are formalised in the concept of informed consent (Barbie & Mouton, 2001 in Brink, *et al.,* 2009:35).

Transparency was maintained in terms of informing all participants of the purpose of the project, procedures to be followed and their right in terms of their participation.

Participants were further informed of their right to withdraw from the study at any time.

Furthermore, consent was obtained from each participant; the researcher explained in simple terms (to each participant) what the research was about, its purpose and explaining the risks and benefits attached to it (Polit & Beck, 2010:127).

3.10.2 Maintaining confidentiality

Confidentiality was maintained by ensuring that data was not linked to individual participants by name (Maree, 2016:376). This factor was explained before they signed consent. According to Brink, *et al.,* (2009:35) the process of ensuring confidentiality refers to the researcher's responsibility to prevent all data gathered during the study from being divulged or made available to any other person. After the interviews, data in the form of responses to the interview schedule and transcription

thereof was kept in a safe. Interviews were conducted in a closed room with individual participant.

3.10.3 Anonymity

Anonymity requires that the respondent's identity is not linked to his or her responses (Polit & Beck, 2010:127). According to Brink *et al.,* (2009:34), anonymity means namelessness. The process of ensuring anonymity refers to the researcher not disclosing the participants' identities with regards to their participation in the study. In the study, this principle was respected through ensuring that responses collected from interviews were anonymous. Each participant was asked individually to come for the interview since they were accommodated in separate rooms in a conference facility.

3.11 CONCLUSION

In this chapter, the researcher described the research design and methodology, which included study population and sampling and data collection and analysis. The strategies of trustworthiness were discussed in detail. The ethical principles that govern the study participants' rights were further discussed**.**

CHAPTER 4: ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

In the previous chapter, the researcher discussed the research design, methodology, population and sampling process. Data collection was discussed including how trustworthiness was ensured. Creswell's 6 steps of thematic data analysis were used to evaluate data. In this chapter, findings are presented in the light of the available results.

The findings are presented according to two sections:

Section A represents the findings from the operational managers, wherein:

Section A.1 shows Demographic Analysis of Participants in terms of age, gender, level of education and experience in PHC.

Section A.2 represents the findings on reasons contributing to low supervision rate in PHC clinics under Ugu District.

Section B represents the findings from the PHC managers, wherein:

Section B.1 is showing Demographic Analysis of Participants in terms of age, gender, level of education and experience in PHC.

Section B. 2 represents the findings on reasons contributing to the low supervision rate in PHC clinics under Ugu District.

4.2 SECTION A.1: DEMOGRAPHIC ANALYSIS

A total of 16 operational managers were interviewed.

The majority of participants (9) were between the ages of 40-49.

In terms of gender, 4 were males and 12 were females. This is common in nursing profession because most nurses are predominantly females.

Regarding the level of education, 11 were in possession of a Diploma in Nursing Sciences, while 5 had a Degree. This is in line with the inclusion criteria which stated that all participants must have Diploma or Degree in Nursing Science as a qualification.

4.3 SECTION A.2: THEMES EMERGING FROM DATA

The reasons for a low supervision rate amongst operational managers resulted in two main themes which were reasons for inability to supervise PHC clinics and benefits of PHC Supervision. The study findings is presented in terms of themes, categories and sub categories with accompanying responses from participants followed by supporting literature.

Table 4.1: *Themes related to reasons for the inability to supervise clinics and benefits of PHC Supervision.*

Main-Theme	Category	Sub-Categories
4.1.1 Reasons for inability to supervise PHC clinics	4.1.1.1 High workload	Too many fixed PHC clinics and outreach services supervised by one PHC Manager/Supervisor
	4.1.1.2 Poor planning	Too many unscheduled meetings and workshops / trainings
	4.1.1.3 Low resource allocation	No dedicated transport Shortage of staff at PHC clinics
4.1.2 Benefits of PHC supervision	4.1.2.1 Monitoring and evaluation	Identification of gaps in performance to ensure service delivery improvement Development and monitoring of Quality Improvement plans
	4.1.2.2 Support and guidance	Giving directions relating to clinical practices Giving feedback and updates on new developments
	4.1.2.3 Improve staff relations	Assistance with disciplinary procedures Conflict resolution

4.3.1 Reasons for inability to supervise PHC clinics on monthly basis

The first theme about the reasons contributing to the inability to supervise PHC clinics emerged with three categories of high workload, poor planning and low resource allocation and four sub categories.

4.3.1.1 High Workload

The majority of operational managers mentioned high workload as an obstacle to undertaking supervision of clinics in Ugu District. This high workload was in relation to the number of clinics allocated to each PHC manager and a shortage of staff at PHC clinics. This accounted for 9 out of 16 responses. Failure to conduct these monthly onsite visits consistently compromises the quality of care rendered to patients and negatively impacts on health outcomes. Participants verbalised this in the following comments:

"…She used to say she is supervising too many clinics and she is overworked."

"…There should be 1 PHC Manager supervising 5 clinics. "

"…It is impossible to visit clinics monthly because they all also supervise school health teams, mobile clinics and Ward based outreach teams."

"…Even the quality of supervision is compromised because of many clinics to be visited by one person."

In agreement, Siu (2002:218) and Darwish (2000:6) nursing studies show a high correlation between workload, exhaustion and the job satisfaction of healthcare workers, while a strong association also exists between job satisfaction, work commitment and performance.

4.3.1.1.1 Too many PHC Clinics and outreach services supervised by one PHC manager

The majority of the participants indicated that there are too many PHC clinics supervised by one PHC manager. This compromises quality of supervision and impacts negatively on health outcomes. This is in line with the provisions of the KwaZulu-Natal PHC Supervision Policy, 2010, which recommended the norm of one (1) PHC Manager to five (5) clinics or units. This was supported by the direct quotes from participants such as:

"…The number of clinics supervised by one PHC manager is too many."

"… The department must employ more PHC managers".

"…She supervises many facilities and no matter what, you cannot expect the best results out of that."

"…You cannot expect the best output where the Manager supervises more than 7 clinics."

Nkosi *et al.* (2009:12) reports that supervisors reported that they were responsible for 6 clinics on average, however, this ranged between 2 and 20 clinics.16 out of 22 (72%) supervisors reported that they visit one clinic a day, and the mean time spent at a clinic was reported as 3 hours per visit. While 64% of clinics reported having monthly supervisory visits, only 38% recorded being visited in the past month. Most supervisors said they missed visits due to other commitments, such as attending meetings.

4.3.1.2 Poor Planning

In addition to workload, participants also identified poor planning as one of the reasons for failure of PHC managers to conduct supervisory visits on monthly basis. Poor planning was because there are too many unplanned meetings and workshops which the PHC managers must attend.

4.3.1.2.1 Too many unscheduled meetings and workshops

All respondents in the study identified unscheduled meetings and workshops as a major contributor to their inability to visit clinics on monthly basis. This practice interfered with the planned PHC Supervision schedule. This was verbalised in the following quotes from participants:

> *"…There are too many unplanned/unscheduled meetings and workshops. I recall an incident where a PHC Manager was called to attend a meeting at District Office, when she was already on her way to supervise my clinic as per itinerary".*

> *"…And there are so many meetings and workshops that will always cause her not to comply according to the planned schedule"*

A study by Nkosi *et al.* (2009:13) confirmed that most clinics, as well as most supervisors, reported that visits were not scheduled in advance. Supervisors said they were not scheduling the visits because often they had to cancel due to other commitments. Most supervisors felt clearer guidelines regarding supervisory visits were needed, and senior management needed to be more supportive and enable them to perform their supervisory functions.

4.3.1.3 Low resource allocation

In addition to workload and poor planning, low resource allocation was also identified as the reason for failure to supervise clinics on monthly basis. Participants verbalized that shortage of transport and staff at PHC clinics remains a challenge. The sub-category below was identified as a contributing factor.

4.3.1.3.1 Shortage of transport

Most participants mentioned shortage of transport as one of the reasons for failure of PHC managers to supervise PHC clinics on monthly basis. The implementation of effective and comprehensive PHC programs or District Health Services (DHS) is dependent on the availability of adequate transport, especially in rural areas. It is therefore important that districts and sub-districts use their limited transport resources effectively and efficiently. There is a common cry from programme managers and PHC managers that there is shortage of transport for them to carry out their duties effectively. The thoughts from the majority of the participants were as follows:

> *"… Transport is a problem; they do not have vehicles to visit our clinics as they rely on the pool vehicles from the supporting institution".*

> *"…There are no vehicles allocated to PHC Managers for them to visit clinics "*

In support of this sub-category, Nkosi *et al.* (2009:12) study concurs that transport was reported to be one of the reasons why supervisory visits were sometimes

missed, with 32% of the supervisors reporting having missed more than one visit in the past month for this very reason. Only 32% of the supervisors said they had dedicated transport to conduct supervisory visits. The majority said they used carpools or travelled with other colleagues with the general feeling expressed by most supervisors that they need dedicated vehicles so they can visit their clinics anytime they need to. Furthermore, the fact that supervisors are not able to visit their clinics regularly undermines the concept of clinical supervision, which requires face-to-face interaction.

4.3.1.3.2 Shortage of staff at PHC Clinics

Shortage of staff at clinics was mentioned by most of the participants as a hindrance in supervision. If the clinic is short staffed, it does not allow for quality face to face support supervision.

In October 2015, the National Minister of Health, Dr Aaron Motsoaledi, gazetted the Human Resource for Health Normative Guide and Standards in line with the requirements of the National Health Act, (Act No. 61 of 2003). This aim of this guide is to monitor the provision, distribution, management and utilisation of human resources within the National Health System. These standards are informed by the Workload Indicator of Staffing Needs (WISN) for service delivery. Once finalised, this analysis will be used to determine the staffing needs per PHC clinic by indicating whether there in under or oversupply of staff (Health, 2015:1).

> "*…There is shortage of staff at clinics because vacant posts are not filled"*
>
> *"…Clinics are experiencing staff shortage"*
>
> *"…They must fill posts at clinics because the staff shortage is huge"*

As supported by Kitenge and Govender (2013:4) the majority of the PHC professional nurses (more than 50%) expressed the opinion that the challenges faced in monitoring the Road to Health Card (RTHC) were staff shortages, lack of equipment, a work overload and unequal distribution of professional nurses on duty per shift, with the degree of understaffing ranging from moderate to severe.

4.3.2 Benefits of PHC supervision

The second theme of benefits of PHC supervision emerged with three categories of monitoring and evaluation, support and guidance and improvement of staff relations and seven sub-categories.

4.3.2.1 Monitoring and evaluation

Most of the participants mentioned monitoring and evaluation as a major benefit of constant supervision. It allows for early identification of gaps in performance to be able to develop quality improvement plans.

Monitoring aims to provide managers, decision makers and other stakeholders with regular feedback on progress in the implementation, results and early indicators of

problems that need to be corrected. It usually reports on actual performance against what was planned or expected.

This is what participants had to say:

> *"…Ongoing monitoring and evaluation remains key in ensuring quality improvement initiatives are implemented in a clinic."*
>
> *"…Monitoring of implementation of programs is very important"*
>
> *"…Managers must ensure that monitoring and evaluation is done at clinics"*

Clinical supervision entails assessment of skills, where the supervisor observes patient care, identifies gaps in knowledge and/or skills, and acts to improve skills and performance of healthcare providers. Directly observed practice is beneficial to the healthcare providers as instant feedback is received (Smith, 1996:36).

4.3.2.1.1 Identification of gaps in performance to ensure service delivery improvement

Supportive supervision should be prioritised at all levels of the health system, be adequately resourced, and accompanied by training and mentoring of the managers as confirmed by the following participants' statements:

> *"…Gaps will be identified timeously and remedial actions be put in place."*
>
> *"…They assist with identification of gaps and support with planning, especially on infrastructure and human resource."*

In support of the above sub-category, the modern approach to supervision puts emphasis on quality improvement where clinical supervision is regarded as one of most important support systems for effective, high quality healthcare services (Tavrow, Kim, & Malianga, 2002:57). Clinical supervision entails assessment of skills, where the supervisor observes patient care, identifies gaps in knowledge and/or skills, and acts to improve skills and performance of healthcare providers. Directly observed practice is beneficial to the healthcare providers as instant feedback is received (Smith, 1996:16). Most clinic-based managers often lack the skills and authority to manage and address service delivery challenges hence, the importance of regular supervisory visits by sub-district based managers, or external clinic supervisors (Marquez & Kean, 2002:1).

On the contrary, a study by Bosch-Capblanch, Liaqat and Garner (2011) showed that while supervision involved regular visits and played a role in performance and motivation, joint problem solving and feedback were minimal. Such models of supervision can have negative consequences for staff retention, job satisfaction, motivation, and job performance (McAuliffe, *et al.,* 2013:5).

4.3.2.2 Development and monitoring of quality improvement plans

The majority of the participants appreciated that supervision will enhance monitoring of quality improvement plans. A PHC supervisory visit allows one to identify poorly performing PHC facilities, the reasons for the poor performance, and possible solutions, and to assist the facility manager and staff to understand their own performance better. On the other hand, lessons could be learnt from PHC facilities doing very well in certain areas, which could be used to improve service provision in other PHC facilities (PHC Supervision Manual, 2009:24). The participants commented as follows:

> "…*To bridge gaps and develop action plans to improve allocation of resources."*
>
> *"…It encourages staff to do their work because they know that the supervisor is coming on regular basis."*
>
> *"…Monitoring and Evaluation to promote quality in work set up."*

Supportive supervision can promote quality improvement by strengthening relationships within the system, identifying and solving problems, and maximizing resource allocation (Chambers & Long, 1995: 311). A study by Manzi *et al.* (2014) concurs, suggesting that mentoring skills of active listening and relationship building improves morale, confidence, and self-esteem of both the mentor and healthcare workers.

4.3.2.3 Support and guidance

Participants mentioned support and guidance as an important factor in enhancing performance. Supervisory visits give the PHC manager the opportunity to acknowledge, appreciate and recognize good performance, thus motivating staff efficiency and productivity.

Supportive supervision has been seen to improve health worker's satisfaction, motivation, performance and retention, thus enhancing competence and patient outcomes. It allows PHC managers to create a more supportive environment for operational managers and staff and further enhances practice and knowledge. It allows the PHC Manager to share organizational policies and guidelines and updating the staff on any pertinent information. It allows for collaborative decision making and problem solving as opposed to all decisions being made by the Supervisor. This was reflected in:

> *"…Identify areas where staff are lacking, needing in-service training."*
>
> *"…Update staff on new developments.'*
>
> *"…They provide necessary support and guidance to operational managers."*

As stated in the PHC Supervision Manual (2009:33), most feedback involves a combination of supportive and corrective feedback. Giving feedback is probably the most important quality improvement skill for a supervisor to achieve.

4.3.2.3.1 Giving directions relating to clinical practices

Most of the participants indicated that regular PHC supervisory visits would enhance their clinical practice. This is reflected in the following participant's responses:

> *"...To identify areas in which staff is lacking, needing in-service training."*
>
> *"...They remind us of the correct procedures to be followed in clinical practice."*
>
> *"…On the job support is very important".*

It has been recognised that clinic supervisors need to be trained for them to play a meaningful role. Strasser (1998:2) has suggested that supervisors undergo periodic training and updates to keep abreast with changes. Reid (2002:1) further alludes to the importance of training of supervisors.

To support training of supervisors in South Africa, like in other developing countries, primary healthcare services are provided by professional nurses or clinic nurses. Though clinic nurses are usually provided with management protocols, they are often left on their own with poor or little support and supervision (Reid, 2002:1). To provide quality services, clinic nurses need to have regular skills assessment and development. It has been suggested that clinic supervisors can help improve quality of care in clinics by providing both administrative and technical support to service providers (MSH, 2006:1). Furthermore, some authors see the primary aim of supervision as that of providing advisory support and training to health professionals, while administrative control is viewed as of secondary importance (Görgen, Kirsch-Wolk & Schmidt-Ehry, 2004:72).

4.3.2.3.2 Giving feedback and updates on new developments

Most of the participants mentioned giving feedback and updates on new developments as critical benefit of PHC Supervision:

> *"...Operational managers get support from PHC managers through sharing and dissemination of information."*
>
> *"...They can also use supervisory visit to update staff on new development."*
>
> *"...They provide first-hand information."*
>
> *"...She guides you, bring new guidelines and enhance knowledge."*
>
> *"...It is useful for orientation and induction of new employees."*

Fatti *et al.* (2013:2) describe that supervision can increase motivation by showing nurses the results of their work and thus, act as a positive affirmation of work well done. Communication between supervisor and supervisee was described as a crucial factor for the quality of supervision. Bradley and Igras (2005) found two-way communication to be a critical factor in staff motivation, and an important mechanism to create team spirit by ensuring staff could express their opinions and make suggestions.

4.3.2.3.3 Improved staff relations

Most of the participants mentioned improved staff relations as a benefit of PHC supervision. Staff relations can be maintained by instilling culture of discipline. Employee relations management is a process that organizations use to effectively manage all interactions with employees, ultimately to achieve the goals of the organization. The participants below supported these ideas in the extracts below:

> *"… They help staff with disciplinary procedures."*
>
> *"…They implement disciplinary action where needed and give appraisal where it is due."*
>
> *"…If staff members know that the supervisor come on regular basis, they always maintain discipline."*
>
> *"…keeps nurses on their toes to doing their correct procedures to shine during supervisory visit."*

4.3.2.3.4 Assistance with disciplinary procedures

Discipline can be maintained through proactive and reactive ways. Proactively, a high level of discipline can be cultivated by communicating visually and the do's and don'ts by word of mouth. It can be implemented in relation to prompt service, and the late submission of work and in contravention of Batho-Pele principles (Ijeoma, *et al.* 2013:170). The extract below from a participant confirms that regular supervisory visits capacitate operational managers to deal with issues of discipline:

> *"…We need our supervisors to assist us especially when discipline staff in our clinics."*
>
> *"…The PHC Manager is expected to manage staff and attend to Labour issues."*

4.3.2.3.5 Conflict resolution

The majority of participants mentioned conflict resolution as one of the benefits of PHC supervision. Conflict is inevitable and can either be good or bad. Good conflict effectively exposes problems and generates creativity while bad conflict can be destructive. It is therefore, critical to prevent conflict or manage it before they destroy the other party (Marcus, 2011:11).

This is what most of the participants had to say:

> *"… Operational managers need support when it comes to conflict resolution in a clinic."*
>
> *"...They assist the operational managers to manage difficult conflict and problems."*

As stated by Brown, Lewis, Ellis, Stewart, Freeman and Kasperski (2011) lack of motivation to resolve conflict could take several forms. Some team members ignored conflict. Differing personalities within the team was also attributed to the lack of motivation to address conflict. Some team members were conflict avoidant. Another major barrier to conflict resolution was some people did not want to cause other team members' emotional distress by offending them or hurting their feelings.

Brown *et al.* (2011) agree that sources of team conflict were described as role boundary issues, scope of practice, and accountability. Barriers to conflict resolution included lack of time and workload issues, people in less powerful positions, lack of recognition or motivation to address conflict, and avoiding confrontation for fear of causing other team members' emotional discomfort. Participants in busy practices with heavy workloads described a lack of time to deal with conflict which was connected to minimal opportunities to resolve conflicts and limited time for communication as stated by Brown *et al.* (2011).

Brown *et al.* (2011) concurs that another barrier to conflict resolution was team members who were in less powerful positions. These participants described feeling intimidated, resentful, and often silenced. These feelings became a barrier to communication and impeded conflict resolution. Issues of power, leadership and authority not only fuelled conflict, but hindered resolution. When this occurred, those in leadership positions failed to hear and respond to the conflict as identified by Brown *et al.* (2011).

According to Brown *et al.* (2011) conflict could ensue when there was a lack of understanding of the scope of practice of other professions. Therefore, conflict related to scope of practice was amplified when new professions were added to teams, particularly when the professional roles and responsibilities of new members potentially 'threatened' established scopes of practice. Brown *et al.* (2011) concurs that issues of accountability could also be a source of conflict on Primary Healthcare Teams (PHCTs). For example, family physicians described themselves as being ultimately accountable for patient care.

4.4 DEMOGRAPHIC ANALYSIS OF DATA FROM PHC MANAGERS

A total of 5 PHC managers were interviewed. The age of most participants ranged from 40-49 years. The distribution by gender was three (3) females and two (2) males which are common in the nursing profession since it is dominated by females.

Four out of five participants were in possession of a degree while one participant had a diploma as a highest qualification. This is in line with the inclusion criteria.

The years of experience in the PHC range from 4-35 years and most of the participants had an experience in PHC of between 15-25 years and this is in line with the inclusion criteria.

4.5 THEMES EMERGING FROM DATA - SECTION B.2

The findings on reasons contributing to the low supervision rate amongst PHC managers resulted in two main themes: the inability to supervise PHC clinics and the failure to conduct PHC supervision on service delivery and performance. The study findings will be presented in terms of themes, categories and sub-categories with accompanying responses from participants followed by supporting literature.

Table 4.2: Themes relating to reasons for inability to supervise clinics and impact of failure to conduct PHC supervision

Main Theme	Category	Sub-Category
4.2.1 Reasons for inability to supervise PHC clinics	4.2.1.1 High workload	Too many PHC Clinics supervised by one PHC Manager/Supervisor
	4.2.1.2 Scope of work	Too many clinical programs to be managed
	4.2.1.3 Poor planning	Too many unscheduled meetings and workshops
	4.2.1.4 Low resource allocation	No dedicated transport Shortage of staff at PHC clinics
4.2.2 Failure to conduct PHC supervision on service delivery and performance	4.2.2.1 Lack of monitoring and evaluation	Poor performance management systems resulting in no service delivery improvement.
	4.2.2.2 Unresolved conflicts	Low staff morale

4.5.1 Reasons for the inability to supervise PHC clinics monthly

The first theme on the reasons for the inability to supervise PHC clinics emerged with four categories: of high workload, scope of work, poor planning and low resource allocation and four sub-categories. The second theme related to the impact of failure to conduct PHC supervision on service delivery and performance, emerged with two categories: lack of monitoring & evaluation and unresolved conflicts and two sub categories.

4.5.1.1 High workload

The majority of PHC managers concurred with operational managers that high workload is an obstacle to undertaking supervision of clinics in Ugu District. This high workload was in relation to the number of clinics allocated to each PHC manager and a shortage of staff at PHC clinics. This accounted for 5 out of 5 responses.

Failure to conduct these monthly onsite visits consistently compromises the quality of care rendered to patients and negatively influences health outcomes.

The participants verbalised the following thoughts:

> *"…The very first one is unscheduled workshops and visitors coming to our sub-district, thus disturbing the itinerary for the month."*
>
> *"… The department must employ more PHC managers".*

4.5.1.1.1 Too many PHC Clinics supervised by one PHC Manager

The KZN Draft PHC Model, states that each PHC manager must be allocated 5-7 units to manage or supervise effectively. A unit includes a fixed PHC clinic, a mobile clinic team, school health services and a ward-based outreach team. This was supported by the following participant extracts:

> *"…The number of clinics supervised by one PHC manager is too many."*
>
> *"… The department must employ more PHC Managers".*
>
> *"…She supervises many facilities and no matter what, you cannot expect the best results out of that."*
>
> *"….you cannot expect the best output where the manager supervises more than 7 clinics."*

In support, Siu (2002:218) and Darwish's (2000:6) nursing studies show a high correlation between workload, exhaustion, absenteeism, staff conflict and the job satisfaction of healthcare workers, while a strong association also exists between job satisfaction, work commitment and performance.

4.5.1.2 Scope of work

The majority of the participants indicated that the scope of work has increased due to an increasing number of clinical programs. With the change in disease profile, the National Department of Health has introduced additional interventions or programs to respond to service delivery demands. These include, but not limited to HIV and AIDS, Sexually Transmitted Infections and Tuberculosis (HAST); Centralised Chronic Medication Dispensing and Distribution (CCMDD); ward-based outreach teams and school health services.

4.5.1.2.1 Too many clinical programs to be managed

Most of the participants felt there were too many clinical programs to be managed and it is reflected in the following extract:

> *"…There are too many clinical programs to be managed in a PHC clinic…"*
>
> *"…The clinical programs priorities increase every year."*

As supported in this study, it is clear that clinic supervisors have a responsibility to do clinical supervision to ensure excellent quality healthcare services. This should

form part of the day-to-day activities, whenever the supervisor interacts with supervisees. In addition to other challenges that lead to the supervisor not being able to effectively fulfil her role, the fact that guidelines and training on supervision do not clearly spell out the clinical supervision role, has led to supervisors overlooking the importance of role (Nkosi *et al.*, 2009).

4.5.1.3 Poor planning

Planning is the cornerstone of good management and is grounded in the vision, mission, philosophy, goals and objectives of the organization. It spells out methods and an approach for carrying out specific activities and functions towards accomplishing a particular goal. Therefore, a fair amount of time should be spent on planning (Ijeoma, *et al.,* 2013:46).

4.5.1.3.1 Too many unscheduled meetings and workshops

Many participants had the following to say related to too many workshops and unscheduled meetings:

> *"…Many unscheduled meetings, workshops and trainings are the main cause of failure to supervise clinics."*
>
> *"…There is generally poor coordination of meetings."*
>
> *"…Supervision not included in the year planner."*

A study undertaken by Moosa and Gibbs (2014:3) showed that there was harsh criticism of managers as many participants thought that there was poor planning, systems were inadequate with poor allocation of staff at the clinics. While managers regarded primary care as a port of entry into the continuum of care, nurses and doctors reported that referral was severely hampered by fragmentation and poor systems between provincial and local government clinics and the hospitals. The study further highlighted that there was a shortage of staff, a poor work ethic and poor attitude among nurses and doctors. Nurses conflicted with managers, who wanted them to go beyond their scope of duty. Trained nurses were unable to implement their new skills. Their widening scope of work resulted in them feeling ill-treated (Moosa & Gibbs, 2014:3).

4.5.1.4 Low resource allocation

Shortage of resources was also mentioned by the majority of participants as a hindrance in complying with monthly supervisory visits to clinics. The following sub-categories emerged from low resource allocation as a theme.

4.5.1.4.1 No dedicated transport

All PHC managers responded to the issue of transport as follows:

> *"…There are no vehicles allocated to PHC Managers for them to visit clinics as planned. "*
>
> "… *The department must provide PHC Managers with a reliable transport."*
>
> *"… The unavailability of transport remains a challenge."*
>
> *"…The problem is that there is no transport for clinic supervision.* "

According to Crigler, Gergen and Perry (2013:5) the cost and logistics associated with traveling to visit Community Health Workers (CHWs) is perhaps the greatest challenge. Most supervision systems require that supervisors travel from a peripheral health facility to the village where the CHW works. The distance requires the use of motorized transportation (motorbike or vehicle), and one of the following conditions is often present: (a) there is no vehicle or motorbike assigned to the facility, (b) the source of transport is not in working order, (c) there is no money to buy fuel, (d) the vehicle is being used for some other purpose. Per diems (a fee paid when employees such as supervisors carry out some special activity, such as travelling out into the field for some purpose) often become the real motive for supervisory visits rather than to provide the necessary support to CHWs. Although visits should happen with relative frequency; at least once every 3 months, they rarely occur.

A further issue is that there is too many facilities to visit, especially in remote areas. The lack of transport for supervision when transport is available is old and unreliable. No specific budget allocated or sufficient resources to perform PHC supervision tasks. Despite several submissions made to the district, infrastructure and equipment are still not maintained, and there is insufficient working space in some facilities as supported by Jacobs, Dikgale, Maartens and Mkhonto (2014:14) that poor resource allocation will result in the inability to supervise PHC in clinics.

4.5.1.4.2 Shortage of staff at PHC clinics

The majority of participants reported a shortage of staff at clinics as a challenge. In October 2015, the National Minister of Health, Dr Aaron Motsoaledi, gazetted the Human Resource for Health Normative Guide and Standards in line with the requirements of the National Health Act, (Act No. 61 of 2003). The aim of this guide is to monitor the provision, distribution, management and utilisation of human resources within the National Health System. These standards are informed by the Workload Indicator of Staffing Needs (WISN) for service delivery. Once finalised, this analysis will be used to determine the staffing needs per PHC clinic by indicating whether there in an under or oversupply of staff (Health, 2015:1). Below are the responses from some of the participants mentioned:

"…Absence of critical people in the clinic you have planned to visit."

"…The quality of care is affected if the clinic is functioning with less staff."

"…Staff shortage is a real problem."

As supported by Kitenge and Govender (2013:4) the majority of the PHC professional nurses (more than 50%) expressed the opinion that the challenges faced in monitoring the RTHC were staff shortages, lack of equipment, a work overload and unequal distribution of professional nurses on duty per shift, with the degree of understaffing ranging from moderate to severe.

4.5.2 Failure to visit clinics on a service delivery and performance

This second theme emerged with two categories and one sub category.

4.5.2.1 Lack of monitoring and evaluation

Monitoring and evaluation involves collecting, analysing and reporting on inputs, activities, outputs, outcomes and impacts as well as external factors, in a way that supports effective management. Monitoring aims to provide managers, decision makers and other stakeholders with regular feedback on the progress of implementation, and results and early indicators of problems that need to be corrected. It usually reports on actual performance against what was planned or expected. A set of organisational structures, management processes, standards, strategies, plans, indicators, information systems, reporting lines and accountability relationships which enables national and provincial departments, municipalities and other institutions to discharge their monitoring and evaluation functions effectively.

This was confirmed by the following quote from the participants:

"…There will be lack of performance due to poor M&E.

"…Lack of supervision compromises quality of care."

"… There will be no constant supervision and support."

4.5.2.1.1 Poor performance management systems resulting in no service delivery improvement

The performance management system refers to the mechanisms and processes used towards identifying those behaviours and activities that produce actual results and solutions to address them. The main aim is to identify and remedy the gaps between the actual results versus the desired outcome (Ijeoma, *et al.* 2013: 170).

An important component of the supervisor's role is to monitor the performance of PHC facilities. One way of doing this is by direct visits at the PHC facility. Another important way is to compare the performance of the PHC facilities that one PHC supervisor is responsible for supervising. This should be undertaken using the

quality supervision tools described such as graphs or run charts to highlight key aspects of PHC facility's performance. This method allows one to identify poorly performing PHC facilities; reasons for the poor performance and possible solutions; as well as to assist the facility manager and staff to understand their own performance better. On the other hand, lessons could be learnt from PHC facilities doing very well in certain areas, which could be used to improve service provision in other PHC facilities (PHC Supervision Manual, 2010:24). The following quotes from the participants confirm this statement:

> *"…Lack of constant supervision can compromise quality of service and that can have negative impact on service delivery and staff performance."*
>
> *"…Clinics not visited as often as they should because the PHC manager is pulled to all angles."*
>
> *"… it won't be possible to meet the desired performance targets because there is no constant feedback."*
>
> *"…In my opinion, there will be an increase in the number of complaints from the community."*

As stated by Crigler, Gergen and Perry (2013:8) in many cases, the supervisor is the only consistent link that the CHW has with the formal health system and is expected make sure that the CHW understands his/her tasks and can perform them to an acceptable standard. When new tasks are assigned, the supervisor should train or reinforce (if refresher training is offered), the CHW in these tasks.

The supervisor further needs to communicate, gather, and share information with the CHW. The supervisor gathers data from the CHW to learn where she has gone, how many clients she has seen, what services she has provided, and other statistics on the overall health and well-being other catchment area. Sometimes, if the CHW is not very literate, the supervisor can help with forms and show her how to draw or select pictures to communicate what is happening within a community. The supervisor also provides the CHW with updates on new guidelines and other information regarding the health status of a community, a planned event such as a vaccination campaign, and other key information from the Ministry of Health (Crigler, Gergen & Perry 2013:8).

Crigler, Gergen and Perry (2013:8) also agrees that a third area of consequence, is providing support to the CHW. The supervisor coaches and helps the CHW solve problems s/he might encounter. Furthermore, as the CHW is often isolated and asked to provide support and counsel to patients with difficult conditions, she/he sometimes needs counselling and support herself. A supervisor often can help the CHW develop or maintain a respectful relationship with his/her community. This can be achieved by positioning himself/herself as an important and valued member of the health team and by clarifying and reaffirming to the community, the details of the specific expectations the CHW is trained and expected to fulfil.

4.5.2.2 Unresolved conflicts

Participants indicated that failure to visit clinics on monthly basis negatively influences a timeous resolution at clinic level. Conflict itself is inevitable in a work place. It can be viewed as a vehicle to assist an individual to better perceive her/himself, the people they work with and what they want to achieve together. If they truly understand it and choose how to work with it, it can uncover opportunities for institutional as well as personal improvement (Marcus,Dorn & McNulty 2011:11).

A quote from participants below supported the finding of unresolved conflicts:

> *"…Operational managers need support when it comes to conflict resolution in a clinic."*
>
> *"…Conflicts must be resolved on time."*

Sources of conflict on PHCTs can transpire at the micro, meso, and macro levels. At the micro level, conflict can ensue when for example, there are differing personalities, physical space concerns or issues regarding scope of practice. A combination of issues at the meso and macro levels such as patient volume, patient expectations, financial remuneration, and new clinical practice guidelines can also be a source of conflict on PHCTs. Brown *et al.*, (2011:4) differentiates two sources of conflict within teams: substantive issues and emotional issues. Substantive issues include scope of practice and differing philosophical perspectives regarding patient care, whereas emotional issues reflect personality differences and power differentials (Brown, *et al.* 2011:5).

4.5.2.2.1 Low staff morale

Low staff morale impacts negatively on productivity.

Most of the participants indicated that unresolved conflict might lead to low staff morale

> "…*Poor service delivery."*
>
> *"…The will not be motivated to work."*
>
> *"…There will be no productivity if staff are not motivated to work."*

In the study on The Effect of Low Morale and Motivation on Employees' Productivity & Competitiveness in Jordanian Industrial Companies, the results showed that the relationship between the three variables is statistically significant. Based on their path coefficient scores, it would appear that the influence of Low Morale and Low Motivation on Productivity and Competitiveness is significant (Osama, Ziad & Atalla, 2013:6).

4.6 CONCLUSION

Although the organisational forms of primary healthcare providers may vary considerably across countries, every healthcare system aims to achieve equitable, efficient and effective delivery of healthcare services. In doing so, each system

seeks to maximize its positive effect on health-related quality of life of people in different communities. It is unrealistic to expect clinic nurses to provide quality healthcare services without support and supervision to ensure clinical skills are developed and maintained. The relationship between supervisor and supervisee is an important factor in the effectiveness of supervision; supervisors selected for the task need to be able to create a non-judgmental and supportive environment. Supervisors must also be equipped with good communication skills, as well as clinical knowledge.

Considering the multiplicity of stakeholders in the healthcare sector, it is essential to ensure that the ultimate results of performance measurement are demanded and of interest to certain stakeholders. As the demand for healthcare services is increasing, most healthcare organisations find themselves overwhelmed with the large volumes of patients. With such a robust market, many providers cannot justify the cost of trying to improve the system.

CHAPTER 5: DISCUSSION AND RECOMMENDATIONS

5.1 INTRODUCTION

In the previous chapter, the researcher presented the findings of the study in the light of the available literature.

In this chapter, the researcher draws conclusions from the findings of the study, discusses the application of theory into the study findings, the study's limitations and finally, makes recommendations. The researcher will further discuss the role, contribution and impact of supervision by PHC managers on service delivery and performance using the systems approach by Donabedian.

5.2 IDENTIFIED BARRIERS TO PHC SUPERVISION

Table 5.1: *Common recurring themes and variations from both groups of participants*

	Operational Managers	**PHC Managers**
Common/Joint responses	High Workload Poor Planning Lack of resources/low resource allocation	Workload Poor Planning Lack of resources/low resource allocation
Variations	Scope of work – Too many outreach teams managed by one PHC Manager	Scope of work – Too many clinical programmes to be managed

The barriers to PHC Supervision are further described below in line with the study findings:

5.2.1 High Workload

During data analysis, both operational managers and Primary Healthcare managers identified High workload as an obstacle to undertaking supervision of clinics in Ugu District. This high workload was in relation to the number of clinics allocated to each PHC manager and the shortage of staff at PHC clinics.

Siu (2002:218) and Darwish (2000:6) nursing studies show a high correlation between workload, exhaustion, absenteeism, staff conflict and the job satisfaction of healthcare workers while a strong association also exists between job satisfaction, work commitment and performance. These findings support the finding of high workload.

As supported by Kitenge and Govender (2013:3) the majority of PHC professional nurses (more than 50%) expressed the opinion that the challenges faced in monitoring the RTHC were staff shortages, lack of equipment, a work overload and

unequal distribution of professional nurses on duty per shift, with the degree of understaffing ranging from moderate to severe.

The second contributory factor to high workload was many clinical programmes that are implemented in each clinic as a response to ever changing disease profile (quadruple burden of disease).

As identified in this study, it is clear that clinic supervisors have a responsibility to undertake clinical supervision to ensure the quality of healthcare services. This should form part of day-to-day activities when the supervisor interacts with supervisees. In addition to other challenges that lead to the supervisor's inability to effectively fulfil his/her role, the fact that guidelines and training on supervision do not clearly spell out the expected role requirements of clinical supervision, has led to supervisors overlooking the importance of this role (Nkosi et al, 2009)

In October 2015, the National Minister of Health, Dr Aaron Motsoaledi, gazetted the Human Resources for Health Normative Guide and Standards in line with the requirements of the National Health Act (Act No. 61 of 2003). This aim of this guide is to monitor the provision, distribution, management and utilisation of human resources within the National Health System. These standards are informed by the Workload Indicator of Staffing Needs (WISN) for service delivery. Once finalised, this analysis will be used to determine the staffing needs per PHC clinic by indicating whether there is an under or oversupply of staff (Health Workforce Normative Guide).

If the workload is not aligned to the WISN guideline, the staff will not be able to undertake supervision, and this will compromise service delivery and performance at the clinic level. Failure to conduct these monthly onsite visits consistently compromises the quality of care rendered to patients and negatively impacts on health outcomes.

5.2.2 Poor planning

In this study, both operational managers and PHC managers identified poor planning as an impediment to ensuring that PHC supervision is conducted on a monthly basis. This, according to the research findings, was due to many unscheduled meetings and workshops.

This finding correlates with the study by Nkosi *et al.* (2009: 13) that highlighted most clinics, as well as most supervisors, reported that visits were not scheduled in advance. Supervisors said they did not schedule visits because they often had to cancel due to other commitments. Most supervisors felt clearer guidelines regarding supervisory visits were needed, and senior management needed to be more supportive and enable them to perform their supervisory functions.

Planning forms an integral part of any organisation or healthcare system. Planning is the cornerstone of good management and is grounded in the vision, mission, philosophy, and goals and objectives of the organisation. It outlines an approach for

carrying out specific activities and functions towards accomplishing a particular goal. Therefore, a fair amount of time should be spent on planning (Ijeoma, *et al.,* 2013:46).

Another important part of planning is monitoring and evaluation. Monitoring aims to provide managers, decision makers and other stakeholders with regular feedback on the progress in the implementation and results and early indicators of problems that need to be corrected. It usually reports on actual performance against what was planned or expected.

The impact of poor planning will result in a lack of monitoring and evaluation, thus leading to the failure to identify gaps in performance to ensure the improvement of service delivery. Monitoring and evaluation involves collecting, analysing and reporting on inputs, activities, outputs, outcomes and impacts as well as external factors, in a way that supports effective management.

5.2.3 Low resource allocation

In this study, low resource allocation was identified by both groups of participants as the biggest contributor to a low PHC supervision rate in Ugu District.

The lack of dedicated transport and shortage of human resources were the main gaps identified. In support of this finding, a study by Nkosi *et al.* (2009:12) concurs that transport was reported to be one of the reasons why supervisory visits were sometimes missed, with 32% of the supervisors reporting having missed more than one visit in the past month due to a lack of transport. Only 32% of the supervisors said they had dedicated transport to conduct supervisory visits. The majority said they used carpools or travelled with other colleagues and there was a general opinion expressed by most supervisors, was that they need dedicated vehicles to be able to visit their clinics when necessary. Furthermore, the fact that supervisors are not able to visit their clinics regularly undermines the concept of clinical supervision, which requires face-to-face interaction.

As supported by Kitenge and Govender (2013:4) the majority of the PHC professional nurses (more than 50%) were of the opinion that the challenges faced in monitoring the RTHC were staff shortages, lack of equipment, a work overload and unequal distribution of professional nurses on duty per shift, with the degree of understaffing ranging from moderate to severe.

5.3 THE ROLE, CONTRIBUTION AND IMPACT OF SUPERVISION

PHC supervision is fundamental in providing excellent quality healthcare services which facilitates a safe and conducive working environment required by legislation for staff members, enables personnel motivation, ensures cost effective and appropriate use of resources, undertakes monitoring and evaluation of interventions, and planning of healthcare services to respond to community needs (KZN PHC Supervision Policy, 2010:1). The following criteria for primary healthcare supervision

to meet the PHC supervisory visit entered on the District Health Information System (DHIS) database are:

1. The visits must be a planned visit to the facility;
2. The Red Flag Checklist (as adapted by the Province and District) must be used at each visit;
3. An in-depth programme checklist must be used at each visit;
4. An action plan of the innovative and correctional activities must be left at the facility and a copy must be available at the PHC supervisor's level and;
5. All personnel at the visited facility must have annual work plans and the reports must be updated.

Strengthening PHC services is critically dependent on improved management at facility (clinics and community health centres) and district levels. In addition to strengthening management capacity (e.g. through improving managers' skills and upgrading information systems), there will be a need to delegate greater management responsibilities to the district level in the earlier phases so that the necessary decisions related to service delivery can be made and managers held accountable for their performance.

Given that PHC services will be provided through a range of providers (including Ward Based Outreach Teams WBOTs, school health teams, fixed and mobile public-sector facilities and contracted private providers), the PHC re-engineering vision of integrated comprehensive services would best be promoted through coordination and management of these services at the district level (NHI White Paper Policy, 2015:42).

5.4 APPLICATION OF SYSTEMS APPROACH MODEL BY DONABEDIAN

5.4.1 Inputs

According to the systems approach model by Donabedian, inputs measure resources: human and financial resources; physical facilities; and equipment and supplies that enable implementation of a program. These inputs are measured in terms of availability and accessibility. For example, health facilities require the availability of equipment and drugs; infrastructure; equipment, materials and drugs. An organisation requires staff in a specified number and the distribution/allocation of job competencies.

This study revealed that there was shortage of PHC managers, professional staff and no dedicated vehicles for PHC Supervision.

5.4.2 Process

The process reflects whether a program is being carried out as planned and how well program activities are being carried out.

Measure activities:

- Quality – how well the tasks are performed
- Efficiency – optimal use of resources
- Supervision
- Clinical governance
- Referral systems

The study findings showed that PHC supervision was not followed according to the norm of a monthly visit. This affected the quality of performance at clinic level. Clinical governance was compromised because of a limited time to attend to clinical supervision due to many clinical programmes. This was due to many unplanned meetings and workshops that the PHC Manager had to attend.

5.4.3 Outputs

Outputs report on the results of programme efforts at programme level. This refers to a measured proportion of the target group that has received a particular service; the effects of health interventions on service users or the programmes' level of improving service; accessibility, acceptability of service, and the perceived quality and client satisfaction.

This study finding revealed that failure to conduct monthly supervision led to a lack of monitoring and evaluation which resulted in poor performance management systems and no improvement on service delivery. This further resulted in unresolved conflicts (NDOH Primary Healthcare Supervision Manual, 2009:29)

5.5 LIMITATIONS OF THE STUDY

The study only focused on factors contributing to low supervision rate. The limitation was that quality of PHC supervisory visits and its impact on health outcomes was not explored.

5.6 RECOMMENDATIONS

The recommendations were outlined according to the categories that were highlighted as contributing factors to the low rate of PHC supervision. These categories are high workload; poor planning and low resource allocation.

5.6.1 Recommendations to reduce workload

- The Management at both Provincial and District levels of KwaZulu-Natal's Department of Health must implement the guidelines of the Health Workforce Normative Guides and Standards for Fixed Primary Healthcare Facilities as per the Government Gazette, dated 02 October 2016.

- Finalise and ensure implementation of the proposed Sub District Model for PHC Management, and ensure the organizational post structure is funded. This will ensure appropriate leadership at all levels of healthcare delivery.
- Fast track rollout and implementation of Chapter 6 of the NHI White Paper Policy, as per Government Gazette, dated 10 December 2015, to non-pilot districts.
- Implement the Clinical Service Management System as suggested by the Ideal Clinic Realization and Maintenance Approach to ensure optimal utilisation of all programme managers.

5.6.2 Recommendations for planning

- Improve management and governance at PHC level.
- Coordination of the development and implementation of the annual calendar for meetings at district level, including inputs from all sub districts.
- The annual Workplace Skills Development Plan must be developed in line with service delivery demands and must be communicated to all levels.
- Adopt an on the job training and mentoring programme to avoid taking staff members out of their work stations.
- The Provincial and Regional Training Programme needs to be largely informed by the district's training needs.

5.6.3 Recommendations to ensure equitable resource allocation

- Conduct situational analysis on the status/condition and number of fleet or vehicles at sub district level.
- Allocate dedicated vehicles to all PHC managers to ensure transport to monthly supervision.
- Review the policy on the use of private vehicles for official purposes to accommodate employees irrespective of whether they are on the Middle Management Service (MMS) or Senior Management Service (SMS) package. It must be based on what the job functions entail. This will ensure that PHC managers are eligible to apply for this authority.

5.6.4 Recommendations for further research

Conduct further research that will consider the quality of PHC supervisory visits and its impact on health outcomes.

5.7 CONCLUSION

The investigation of factors contributing to the low Primary Healthcare supervision rate in Ugu District revealed that supervision is not conducted on a monthly basis by all PHC managers. The themes that emerged from data analysis revealed that a high

workload, poor planning, low resource allocation and scope of work remains a challenge in achieving monthly supervision.

For the best provision of excellent quality primary healthcare in facilities, there should be a supervisor who facilitates effective teamwork and promotes healthy working relationships among all the structures of the primary healthcare system. She/he should regularly monitor and maintain good performance in the form of the information system, communication strategies, regular targeted trainings and comparison of the PHC facility's performance with the prescribed health standards as stipulated in The Primary Healthcare Package for South Africa – A Set of Norms and Standards, and employees' Performance Management and Development System (PMDS) (Primary Healthcare Supervision Manual, 2009:4). Implementation of the recommendations made above will enhance supervision, thus improving health outcomes within the district health system.

REFERENCES

Abiddin, N.Z. (2006). Mentoring and coaching: the roles and practices. *The Journal of Human Resource and Adult Learning*, 1:107-116.

Bernard, J.M., & Goodyear, R.G. (1998). *Fundamentals of clinical supervision 2nd ed..* Needham Heights, MA: Allyn & Bacon.

Bosch-Capblanch, X. & Garner, P. (2008). Primary healthcare supervision in developing countries. *Tropical Medicine and International Health,* 12(3): 369-383.

Bosch-Capblanch, X., Liaqat, S. & Garner P. (2011). Managerial supervision to improve primary healthcare in low- and middle-income countries. *Cochrane Database of Systematic Reviews 2011, Issue 9.* Art. No.: CD006413. DOI: 10.1002/14651858.CD006413.pub2

Bowles, N. & Young, C. (1999). An evaluative study of clinical supervision based on Proctor's three function interactive model. *Journal of Advanced Nursing*. 30(4): 958-964.

Bradley, J. & Igras, S. (2005). Improving the quality of child health services: Participatory action by providers. *International Journal for Quality in Healthcare.* 17(5):391–399.

Brink, H., van der Walt, C. & van der Rensburg, G. (2014). *Fundamentals of research methodology for healthcare professionals*. *3rd edition*. Cape Town: Juta.

Brink, H., van der Walt, C. & van Rensburg, G., (2009). *Fundamentals of research methodology for healthcare professionals*. *2nd edition*. Cape Town: Juta &Co. (Pty) Ltd.

Brown, J., Lewis, L., Ellis, K., Stewart, M., Freeman, T.R. & Kasperski, M.J. (2011). Conflict on interprofessional primary healthcare teams – can it be resolved? *Journal of Interprofessional Care,* 25: 4–10

Burns, N. & Grove, S.K. (2005). *The practice of nursing research: conduct, critique and utilization.* Philadelphia: WB Saunders.

Burns, N. & Grove, S.K. (2008). *The practice of nursing research, appraisal, synthesis and generation of evidence*. *6th edition*. St Louis: Elsevier/Saunders.

Burns, N & Grove, SK. (2009). *The practice of nursing research: conduct, critique and utilization*. *6th edition*. St Louis, Missouri: Elsevier Saunders.

Butterworth, T. & Faugier, J. (1992). *Clinical supervision and mentoring in nursing*. London: Chapman and Hall.

Butterworth, T., Bishop, V. & Carson, J. (1996). First steps towards evaluating clinical supervision in nursing and health visiting: Theory, policy and practice development. *Journal of Clinical Nursing,* 5:127-132.

Butterworth, T., Carson, J. & White, E. (1997). *Clinical supervision and mentorship - it is good to talk: an evaluation study in England and Scotland*. Manchester: School of Nursing, Midwifery and Health Visiting, University of Manchester.

Chambers M. & Long A. (1995). Supportive clinical supervision: a crucible for personal and professional change. *Journal of Psychiatric Mental Health Nursing 2*:311–316.

Creswell, J.W. (2014). *Research design qualitative, quantitative & mixed methods approaches. 4th edition*. London: Sage.

Crigler, L., Gergen, L. & Perry, H. (2013). *Supervision of community health workers*. Available: http://www.mchip.net/sites/default/files/mchipfiles/09_CHW_Supervision.pdf; [Accessed 10 June 2017].

Darwish, A.Y. (2000).Organizational commitment: a mediator of the relationships of leadership behavior with job satisfaction and performance in a non-western country. *Journal of Managerial Psychology. 2000*; 15:6–24. doi:10.1108/02683940010305270.

De Vos, A.S., Strydom, H., Fouché, C.B. & Deport, C.S.L. (2013). *Research at grass roots: for the social and human service professions*. *4th edition*. Pretoria. Van Schaik.

District Health Profile. (2015/2016). Ugu Health District, KwaZulu-Natal

Donabedian A. (1980). *The Definition of Quality and Approaches to its Assessment*. Ann Arbor, MI: Health Administration Press.

Fatti, G., Rundare, A., Pududu, B & Mothibi, E. (2013). An innovative approach to improve the quality of prevention of mother-to-child transmission of HIV programs through nurse clinical mentoring in South Africa. *JAIDS Journal of Acquired Immune Deficiency Syndromes:* June 1st, 2013 - Volume 63 - Issue 2 – p76-78.

Fisher, B. (1994). *Mentoring*. London: Library Association Publishing.

Görgen, H., Kirsch-Wolk, T. & Schmidt-Ehry, B. (2004).*The District Health System: Experiences and prospects in Africa. Manual for public health practitioners. 2nd ed.* Wiesbaden: Deutsche Gesellschaft für.

Gray, D.E. & Jackson, P. (2012). Coaching supervision in the historical context of psychotherapeutic and counselling models: a meta-model. In: T. Bachkirova, P. Jackson, and Clutterbuck D. *Coaching and mentoring supervision*, Maidenhead: OUP: McGraw-Hill Education.

Gray, D.E. (2007). Towards a systemic model of coaching supervision – some lessons from psychotherapeutic and counselling models. *Australian Psychologist. 42(4*):300-309.

Ijeoma, E., Nzewi, O &. Sibanda, M. (2013). *Public administration for community service. 1st edition*. Pretoria: Verity .

Jacobs, D., Dikgale, F., Maartens, T. & Mkhonto, S. (2014). Evaluation of primary healthcare supervision services in Mpumalanga Province. Technical Report. Published by the USAID ASSIST Project. Bethesda, MD: University Research Co., LLC (URC).

Kim, Y.M.P., Tavrow, L., Malianga, L., Simba, S., Phiri, A & Gumbo, P. (2000). The quality of supervision-provider interactions in Zimbabwe. *Operations Research Results*, *1(5*):1-16.

Kitenge, G. & Govender I. (2013). Nurses' monitoring of the road to health chart at primary healthcare level in Makhado, Limpopo province. *South African Family Practice Journal. 2013 275 Vol 55* No 3.

Department of Health KwaZulu-Natal, 2010. *Policy on primary healthcare supervision.* Pietermaritzburg.

Lehman, U. (2001). Investigating the roles and functions of clinic supervisors in three districts in the Eastern Cape Province. Durban: Health Systems Trust.

Lyth, G.M. (2000). Clinical supervision: a concept analysis. *Journal of Advanced Nursing,* 31(3): 722-729.

Mackenzie, B. (2004).*The complete guide to successful coaching*. Available: http://www.sports-coach.net/prewp/prelaunch-htw21-7950.html; [Accessed March 10, 2015].

Malin, N.A. (2000). Evaluating clinical supervision in community homes and teams serving adults with learning disabilities. *Journal of Advanced Nursing*, *31(3*): 548-557.

Manzi, A., Magge, H., Hedt-Gauthier, B.L., Michaelis, A.P., Cyamatare, F.R., Nyirazinyoye, L., Hirschhorn L.R. & Ntaganira, J. (2014). Clinical mentorship to improve pediatric quality of care at the health centers in rural Rwanda: a qualitative study of perceptions and acceptability of health care workers. BMC Health Services Research 2014 14:275. https://doi.org/10.1186/1472-6963-14-275.

Marcus, L.J., Dorn, B &. McNulty, E. (2011). *Renegotiating healthcare: resolving conflict to build collaboration. 2nd edition*. United States of America: Jossey-Bass.

Maree, K. (2016). *First steps in research. 2nd edition*. Pretoria: Van Schaik.

Marquez, L. & Kean, L. (2002). Making supervision supportive and sustainable: new approaches to old problems. MAQ Papers.

McAuliffe, E., Daly, M., Kamwendo, F., Masanja, H., Sidat, M. & de Pinho, H. (2013). *The critical role of supervision in retaining staff in obstetric services: a three country study.* Available: htttp://journals.plos.org/plosone/article?id=10.1371/journal.pone.0058415; [Accessed 16 October 2016].

Moosa, S. & Gibbs, A. (2013). A focus group study of primary healthcare in Johannesburg Health District, South Africa: 'we are just pushing numbers'. *South African Family Practice Journal*. *56 (2):*147–52

Naledi, T., Barron, P. & Schneider, H. (2011). In: *South African health review.* Padarath A, English R, editor. Durban: Health Systems Trust; Primary Healthcare in SA since 1994 and Implications of the New Vision for PHC Re-engineering.

National Department of Health (2014). District health barometer. Pretoria, South Africa: Government Printers.

National Department of Health (2009). *Primary healthcare supervision manual: a guide to primary healthcare facility supervision.* Pretoria: NDoH: Quality Assurance.

National Department of Health (2010). *Negotiated service delivery agreement for outcome 2: a long and healthy life for all South Africans*. Pretoria: Government Printer.

National Department of Health (2015). *Implementation guideline of health workforce normative guides and standards for fixed primary healthcare facilities.* [Online] [Accessed 02 October 2015].

National Department of Health (2015). *White paper on national health insurance.government notice No. 1230. Government Gazette No. 39506, 11December 2015,* Tswane: Government Printers.

Nkosi, P.H., Horwood, C., Vermaak, K., Cosser, C. & Haskins, L. (2009). The role of clinic supervisors in clinical supervision in primary healthcare services in KwaZulu-Natal. *South African Family Practice Journal*. *2009*;51(5):408-412

Osama, S.S., Ziad, N.A. & Atalla A. (2013).The effect of low morale and motivation on employees' productivity & competitiveness in Jordanian industrial companies *International Business Research 10(7):1* · June 2017, doi:10.5539/ibr.v10n7p1.

Polit, D.F. & Beck, C.T. (2008). *Nursing research: generating and assessing evidence for nursing practice. 8th edition*. Philadelphia: Lippincott Williams & Wilkins.

Polit, D.F. & Beck, C.T. (2012). *Nursing research: generating and assessing evidence for nursing practice. 9th edition*. Philadelphia: JB Lippincott.

Polit, D.F. & Beck, C.T. (2010). *Essentials of nursing research: appraising evidence for nursing practice*. *7th edition*. Lippincott Williams & Wilkins

Reid, S. (2002). *A training programme for rural primary care nurse practitioners in South Africa. World Rural Health Conference, 1-3 May 2002 Melbourne. ABC Rural.* Available: http://www.abc.net.au/rural/worldhealth/papers/50.htm [Accessed 17 October 2016].

Republic of South Africa, (2004). *National health act no 61 of 2003*. Pretoria: Government Printers.

Republic of South Africa, (1998). *The constitution and local government municipal structures act no 117 of 1998*. Pretoria: Government Printers

Ronnestad, M.H. & Skovholt, T.M. (1993). Supervision of beginning and advanced graduate students of counseling and psychotherapy. *Journal of Counseling & Development*, 71:396-405

Rowe, A.K., de Savigny, D., Lanata, C.F. & Victora, C.G. (2005). How can we achieve and maintain high-quality performance of health workers in low-resource settings? *Lancet,366*: 1026-35.

Siu, O. (2002). Predictors of job satisfaction and absenteeism in two samples of Hong Kong nurses. *Journal of Advanced Nursing, 40:*218–229. doi: 10.1046/j.1365-2648.2002.02364.

Smith, M.K. (1996). The function of supervision. The encyclopaedia of informal education. Available: http://www.infed.org/biblio/functions_of_supervision.htm; [Accessed: 17 October 2016].

Strasser, S. (1998). Supporting staff through effective supervision: how to assess, plan and implement more effective clinic supervision. Kwik-Skwiz 15. Durban: Health Systems Trust.

Tavrow, P., Kim, Y.M. & Malianga, L. (2002). Measuring the quality of supervision or provider interactions in healthcare in Zimbabwe. *International Journal for Quality of Healthcare*, 14(1): 57-66.

Uys, L.R., Minnaar A., Reid, S. & Naidoo, J.R. (2004).The perceptions of nurses in a district health system in KwaZulu-Natal of their supervision, self-esteem and job satisfaction. *Curationis. 2:*50–56.

White, E., Butterworth, T., Bishop, V., Carson, J., Jeacock, J. & Clements, A. (1998). Clinical supervision, insider reports of a private world. *Journal of Advanced Nursing,* 28(1):185-192.

APPENDIX A: ETHICAL CLEARANCE CERTIFICATE

University of Fort Hare
Together in Excellence

ETHICAL CLEARANCE CERTIFICATE
REC-270710-028-RA Level 01

Certificate Reference Number:	JIN051SMKH01
Project title:	**Factors contributing to low Primary Health Care (PHC) supervision rate in Ugu District PHC Clinics.**
Nature of Project:	Masters
Principal Researcher:	Ntokozo Clarice Mkhize
Supervisor:	Prof N Jinabhai
Co-supervisor:	N/A

On behalf of the University of Fort Hare's Research Ethics Committee (UREC) I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instrument(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate, using the reference number indicated above.

Please note that the UREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the document
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research

The Principal Researcher must report to the UREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

Special conditions: Research that includes children as per the official regulations of the act must take the following into account:

Note: The UREC is aware of the provisions of s71 of the National Health Act 61 of 2003 and that matters pertaining to obtaining the Minister's consent are under discussion and remain unresolved. Nonetheless, as was decided at a meeting between the National Health Research Ethics Committee and stakeholders on 6 June 2013, university ethics committees may continue to grant ethical clearance for research involving children without the Minister's consent, provided that the prescripts of the previous rules have been met. This certificate is granted in terms of this agreement.

The UREC retains the right to

- Withdraw or amend this Ethical Clearance Certificate if
  - Any unethical principal or practices are revealed or suspected
  - Relevant information has been withheld or misrepresented
  - Regulatory changes of whatsoever nature so require
  - The conditions contained in the Certificate have not been adhered to
- Request access to any information or data at any time during the course or after completion of the project.
- In addition to the need to comply with the highest level of ethical conduct principle investigators must report back annually as an evaluation and monitoring mechanism on the progress being made by the research. Such a report must be sent to the Dean of Research's office

The Ethics Committee wished you well in your research.

Yours sincerely

Professor Gideon de Wet
Dean of Research

21 June 2016

APPENDIX B: APPROVAL TO CONDUCT RESEARCH

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

330 Langalibalele street,
Private Bag X9051 PMB, 3200
Tel: 033 395 2805/3189/3123 Fax: 033 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:
Health Research & Knowledge Management (HKRM)

Reference: HRKM259/16
KZ_2016RP7_681

23 August 2016

Dear Ms N C Mkhize
(University of Fort Hare)

Subject: Approval of a Research Proposal

1. The research proposal titled 'FACTORS CONTRIBUTING TO LOW PRIMARY HEALTH CARE (PHC) SUPERVISION RATE IN UGU DISTRICT PHC CLINICS' was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

   The proposal is hereby **approved** for research to be undertaken at Ugu Primary Health Care Clinics.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
Date: 26/8/16

Fighting Disease, Fighting Poverty, Giving Hope

APPENDIX C: APPROVAL LETTER FROM DISTRICT HEALTH SERVICES

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:
District Health Services

Physical Address: 121 Chief Albert Luthuli, Pietermaritzburg, 3201.
Postal Address: Private Bag X9040, Pietermaritzburg, 3201
Tel: 033 - 8467217 **Fax:** 033 846 7121 **Email:** [redacted]
www.kznhealth.gov.za

13 July 2016

Mrs N.C. Mkhize
District Director – Ugu Health District
Kwazulu – Natal

RE: REQUEST FOR APPROVAL TO CONDUCT A RESEARCH STUDY IN UGU DISTRICT

Your request dated 22 June 2016 is acknowledged.

Permission to conduct the study is hereby granted under the following condition.

- You need to obtain an approval from the Department of Health prior to the study
- Need to have an approval from Ethics Committee

Wish you good luck with your study.

Regards

Mr VE Khoza.
Chief Director: DHS
KZN – Department of Health

Fighting Disease, Fighting Poverty, Giving Hope

APPENDIX D: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

P.O. Box 671
Hibberdene
4220
22 June 2016

Mr V. Khoza
Chief Director: District Health Services
Kwazulu - Natal Department of Health
Pietermaritzburg
3200

RE:REQUEST FOR APPROVAL TO CONDUCT A RESEARCH STUDY IN UGU DISTRICT

I am a final Master's in Public Health Degree (MPH) student at the University of Fort Hare, East London Campus. Research is an integral part of this programme and is done in partial fulfilment of this qualification. The research study I have proposed is: "*Factors contributing to low Primary Health Care Supervision in Ugu District PHC clinics."* The study participants will be Operational Managers and PHC Managers of PHC clinics in Ugu District.
The main aim of the study is to investigate the factors contributing to low PHC Supervision rate in Ugu District PHC Clinics.

The objectives of the study are:
To identify factors contributing to low Supervision rate in Ugu District PHC Clinics
To describe the influence of low Supervision rate on service delivery and performance in Ugu District PHC clinics

The findings of the study will assist the health managers in developing strategies that will enhance the quality of care in PHC facilities through facilitative support supervision as a requirement for compliance with National Core Standards and PHC Reengineering.
The principles of ethics will be observed and the consent will be obtained from participants.
On completion of the study, a report will be compiled and your office will be furnished with a summary of the research findings and recommendations.

Yours faithfully

Mrs N.C. Mkhize
District Director- Ugu Health District
Contact Details:
Tel: 039 688 3000
Cell: 083 7097387
E-mail : ntokozo.mkhize@kznhealth.gov.za

Supervisor
Prof N. Jinabhai
University of Fort Hare
Cell: 082 7740836
Email:njinabhai@gmail.com

ANNEXURE E: CONSENT FORM

NAME OF APPLICANT Ethics Human 2015

<< >>

OFFICE USE ONLY	
Ref	Date

University of Fort Hare
Together in Excellence

Ethics Research Confidentiality and Informed Consent Form

Please note:

This form is to be completed by the researcher(s) as well as by the interviewee before the commencement of the research. Copies of the signed form must be filed and kept on record

Mrs Ntokozo Clarice Mkhize is asking Operational Managers and Supervisors from your Ugu District PHC clinics to answer some questions, which we hope will benefit your community and possibly other communities in the future.

Mrs Ntokozo Clarice Mkhize is conducting research regarding an investigation to the factors contributing to low PHC Supervision rate in Ugu District PHC Clinics.

The findings of the study will assist in enhancing quality of care in PHC facilities through facilitative support supervision as a requirement for compliance with National Care Standards and PHC Reengineering.

Please understand that you are not being forced to take part in this study and the choice whether to participate or not is yours alone. However, we would really appreciate it if you do share your thoughts with us. If you choose not take part in answering these questions, you will not be affected in any way. If you agree to participate, you may stop me at any time and tell me that you don't want to go on with the interview. If you do this there will also be no penalties and you will NOT be prejudiced in ANY way. Confidentiality will be observed professionally.

I will not be recording your name anywhere on the questionnaire or interview schedule and no one will be able to link you to the answers you give. Only the researchers will have access to the unlinked information. The information will remain confidential and there will be no "come-backs" from the answers you give.

The interview will last around 20-30 minutes (I will be asking you a questions and ask that you are as open and honest as possible in answering these questions. Some questions may be of a personal and/or sensitive nature.

If possible, our organization would like to come back to this area once we have completed our study to inform you and your community of what the results are and discuss our findings and proposals around the research and what this means for people in this area.

Document approved by UREC: 27 July 2015, V01

NAME OF APPLICANT

<< >>

OFFICE USE ONLY

Ref	Date

INFORMED CONSENT

I hereby agree to participate in research regarding an investigation to the factors contributing to low PHC Supervision rate in Ugu District PHC Clinics. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop this interview at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally.

I have received the telephone number of a person to contact should I need to speak about any issues which may arise in this interview.

I understand that this consent form will not be linked to the questionnaire, and that my answers will remain confidential.

I understand that if at all possible, feedback will be given to my community on the results of the completed research.

.....
Signature of participant

Date: 06/09/16

I hereby agree to the tape recording of my participation in the study

.....
Signature of participant

Date: 06/09/16

Document approved by UREC: 27 July 2015, V01

ANNEXURE F: INTERVIEW GUIDE FOR PHC MANAGERS

FACULITY OF HEALTH SCIENCES

My Name is Ntokozo Clarice Mkhize a student currently registered and studying towards a Masters in Public Health degree in the Department of Health Sciences at the University of Fort Hare. As part of the requirements of this programme, I am engaged in a research study, entitled "Factors Contributing to Low Primary Health Care (PHC) Supervision rate in Ugu District PHC Clinics"

I therefore kindly request your cooperation in responding to the interview questions. Your contribution to this academic endeavour will be greatly appreciated since it will provide a stepping- stone towards the realisation the objectives of this research by the researcher

Please be advised that the information and /or data which you will provide in this interview will only be used for academic purposes. Your ethical right to anonymity, privacy and confidently is much guaranteed since you not expected to reveal your names or any personal information which might identify you as respondent in this study.

Please answer all questions as honestly as you can.

SECTION A : Demographic Data

A.1 Name of sub- district	
A.2 Level of Education	
A.3 Gender	
A.4 Age	
A.5 Years of Working Experience in PHC	

A.6	**What is your current position in your organisation?**	**Operational Manager**
		PHC Supervisor
		PHC Manager
		Other – please specify

SECTION B

1. **Workload:**

   1.1 How many PHC Clinics do you supervise? ----------

   1.2 Do you visit the clinics monthly? ----------

2. **Reasons for failure to visit clinics**

2.1 What could be the likely reasons for you not visiting clinics monthly? (Main interview question)

---

3. **Impact Assessment**

3.1 In your opinion, what do you think is the impact of failure to visit PHC clinics on service delivery and performance?

---

4. Intervention

4.1 In your view, what do you think can be done (strategies) to support PHC clinics that are not visited regularly?

4.2 Do you have any views on how PHC Supervision could be improved? If so, what?

Thank you for your time.

ANNEXURE G: INTERVIEW GUIDE FOR OPERATIONAL MANAGERS

University of Fort Hare
Together in Excellence

My Name is Ntokozo Clarice Mkhize a student currently registered and studying towards a Masters in Public Health degree in the Department of Health Sciences at the University of Fort Hare. As part of the requirements of this programme, I am engaged in a research study, entitled "Factors Contributing to Low Primary Health Care (PHC) Supervision rate in Ugu District PHC Clinics"

I therefore kindly request your cooperation in responding to the interview questions. Your contribution to this academic endeavour will be greatly appreciated since it will provide a stepping- stone towards the realisation the objectives of this research by the researcher

Please be advised that the information and /or data which you will provide in this interview will only be used for academic purposes. Your ethical right to anonymity, privacy and confidently is much guaranteed since you not expected to reveal your names or any personal information which might identify you as respondent in this study.

Please answer all questions as honestly as you can.

SECTION A : Demographic Data

A.1 Name of sub- district	
A.2 Level of Education	
A.3 Gender	
A.4 Age	
A.5 Years of Working Experience in PHC	

A.6	**What is your current position in your organisation?**	**Operational Manager**
		PHC Supervisor
		PHC Manager
		Other – please specify

SECTION B

1. Are you being supervised by a PHC Supervisor / Manager? ----------

2. How often? ----------

3. Can you provide me with any reason(s) why you are not being supervised on monthly basis?
(Main interview question)

……
……
……

4. Could that be as a result of the workload of the PHC Supervisor?

……
……

5. As an Operational Manager in charge of a clinic, what do you think are the benefits of PHC supervision?

……
……

6. In your opinion, what do you think can be done to improve PHC supervision?

……
……

Thank you for your time

ANNEXURE H: INTERVIEW TRANSCRIPTS PHC MANAGERS

ANNEXURE H:

INTERVIEW TRANCRIPTS PHC MANAGERS

Researcher: How many clinics do you supervise and how often do you supervise them

Participant 3: Thank you for asking this question. I supervise 7 clinics plus 3 mobile teams. I am supposed to conduct supervisory visits to all clinics on monthly basis. The truth is, sometimes I don't manage to go to all clinics monthly

Researcher: What could be the likely reasons for you not visiting clinics on monthly basis?

Participant 3: You know, Supervision of clinics is not considered as an important program to be included in the year plan. There are too many meetings and workshops that I as a PHC Manager have to attend, sometimes unplanned meetings and workshops. We also experience shortage of transport to visit clinics. I must also state that there are too many outreach teams for one person. The clinics are poorly staffed and as a supervisor I do not get enough time to do the job. I monitor the performance of all programs in the facility (clinical and non -clinical)

Researcher: Thank you. In your opinion what do you think is the impact of failure to visit clinics on service delivery and performance?

Participant 3: It's really bad. There will be poor service delivery because there will be delays in identifying and resolving problems. Secondly communicating feedback on identified issues will also delay

Researcher: In your view what do you think can be done to support PHC Clinics that are not visited regularly?

Participant 3: They must include supervision program in the year planner; Increase the number of PHC Supervisors and also provide transport for supervision

INTERVIEW TRANSCRIPT FOR OPERATIONAL MANAGERS

Researcher: Are you being supervised by a PHC Manager? How often?

Participant15: Sometimes, I say this because sometimes we get supervised after 3 months

Researcher: Can you provide me with any reason(s) why are you not supervising monthly?

Participant15: She used to say she is supervising too many clinics and she is overworked. There should be 1 PHC Manager supervising 5 clinics. It is impossible to visit clinics monthly because they all also supervise school health teams, mobile clinics and Ward based outreach teams.

Even the quality of supervision is compromised because of many clinics to be visited by one person. The department must employ more PHC Managers .You cannot expect the best output where the Manager supervises more than 7 clinics. "...There are too many unplanned/ unscheduled meetings

and workshops. I recall an incident where a PHC Manager was called to attend a meeting at District Office, when she was already on her way to supervise my clinic as per itinerary.

Transport is a problem; they do not have vehicles to visit our clinics as they rely on the pool vehicles from the supporting institution

Researcher: What do you think are the benefits of PHC Supervision?

Participant15: Gaps will be identified timeously and remedial actions be put in place. They assist with identification of gaps and support with planning especially on infrastructure and human resource Identify areas where staff are lacking, needing In-service training. Update staff on new developments. They provide necessary support and guidance to Operational Managers.

They remind us of the correct procedures to be followed in clinical practice.

Operational Managers need support when it comes to conflict resolution in a clinic so the PHC Managers assist the Operational Managers to manage difficult conflict and problems.

Researcher: In your opinion, what do you think can be done to improve PHC Supervision?

Participant 15: I think the department must increase the number of PHC Supervisors; have 2 PHC Supervisors in case of sub districts with many clinics. Each PHC Supervisor to supervise 5 clinics. She must hold monthly meetings with all clinics discussing the poor performing performance indicators, come up with strategies on how to improve.