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CHALLENGES HINDERING THE IMPLEMENTATION OF QUALITY SUPERVISION IN PRIMARY HEALTH CARE FACILITIES IN OLIVER REGINALD TAMBO DISTRICT, EASTERN CAPE PROVINCE

BY

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DECLARATION

I, the undersigned, declare that this thesis entitled "Challenges hindering the implementation of Quality Supervision in Primary Health Care facilities in Oliver Reginald Tambo District, Eastern Cape, South Africa, submitted to the University of Fort Hare for the Master's Degree in Public Health, in the Faculty of Health Sciences, and the work contained herein is my original work with exemption to the citations and that this work has not been submitted to any other University in partial or entirely for the award of any degree.

Name: Nontlantla Caroline Zamxaka

Signature: 

Date: 01 October 2018

DECLARATION ON PLAGIARISM

I, Nontlantla Caroline Zamxaka student number 201415835 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.

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CERTIFICATION

This thesis entitled "Challenges hindering the implementation of Quality Supervision in Primary Health Care facilities in Oliver Reginald Tambo District, Eastern Cape, South Africa" meets the regulation governing the award of the Masters' Degree of the University of Fort Hare and is approved for its contribution to scientific knowledge and literary presentation.

Supervisor

01 October 2018
Date

DEDICATION

I dedicate this mini-dissertation to my husband for his encouragement and support throughout my studies. Also, to my mother for laying the foundation for my success and achievements in education, and for the generally enlightened life which I am enjoying today.

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ABSTRACT

The study investigated the factors that prevent quality supervision in primary health care (PHC) facilities in Oliver Reginald Tambo (O.R. Tambo) district of the Eastern Cape Province of South Africa. The motivation for this study was a concern regarding consistently poor performance by PHC facilities in the province despite regular supervisory visits. The objectives of the study were to explore practices of PHC supervisors in implementing supervision, and to assess perceptions, opinions, and attitudes of PHC supervisors and PHC operational managers with regards to PHC supervisory visits.

On search methodology, qualitative approach was predominating whilst quantitative data was supplementing the study. A purposive sample of PHC supervisors and operational managers was drawn from PHC facilities which had a consistent, 100% rate of supervisory visits. The data was analysed thematically.

The results revealed systemic and structural challenges that affect the implementation of quality supervision, rendering supervisory visits inefficient. These were: a high workload resulting from inconsistency in the allocation of facilities, as well as the many other responsibilities which supervisors have; a lack of knowledge and experience in supervisors; a lack of health service resources including transport; a high turnover of nurses; lack of support from the district and sub-district leadership and management; lack of collaboration, coordination and integration of activities; and delayed procurement processes resulting in a recurring lack of equipment and medical supplies.

The findings of the study brought an understanding of the systemic and structural requirements that need to be made for a functioning quality supervisory system. Successful interventions require strengthening of leadership and governance, and the diligent application of the systems approach to solving problems at facility, district and provincial level. An improvement in leadership and governance should include innovative strategies to utilise the limited resources available without compromising the key objective of quality health care.

ACRONYMS

BANC	Basic Antenatal Care
DHB	District Health Barometer
DHIS	District Health Information System
DMT	District Management Team
FGD	Focus Group Discussion
IPO	Input, Process and Outcome
MDG	Millennium Development Goal
NDoH	National Department of Health
NHI	National Health Insurance
OHSC	Office of Health Standards Compliance
OM	Operational manager
PHC	Primary Health Care
PHCF	Primary Health Care Facility
PHCFS	Primary Health Care Facility Supervisor
SA	South Africa
SDGs	Sustainable Development Goals
WHO	World Health Organisation

CONTENTS

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 INTRODUCTION TO THE STUDY

This study focuses on the implementation of quality supervision in primary health care (PHC) facilities in the Oliver Reginald Tambo (O.R. Tambo) District of the Eastern Cape Province of South Africa. The aim of the study was to develop an understanding of the challenges that hinder the implementation of quality supervision in PHC facilities. The outcome of the study may form a basis for developing strategies to strengthen the quality of primary health care facility supervision, for better health outcomes.

The study is theoretically grounded in systems theory and related theories, such as human relations theory and behavioural theory that were applied to better understand the health system. The implications of these theories are discussed in chapter two of this study. One of the guiding principles of quality supervision should be the systems approach to problem solving, by both PHC facility supervisors and PHC facility personnel. The systems approach entails understanding the manner in which different components of the health system interact with each other to produce the desired outcomes (National Department of Health, 2009: 3.3).

Both qualitative and quantitative research methodologies were used in this study, with qualitative methodologies predominating and quantitative data supplementing these. Mixed methods research (MMR) is a form of research that systematically combines both qualitative and quantitative data collection, analysis and interpretation to rationally answer the research question (Nastasi & Hitchcock, 2016:19). The qualitative data approach was predominantly used to develop an in-depth understanding and interpretation of supervisors' experiences, practices, perceptions and attitudes while conducting the supervisory function within the district health system (DHS) (Joubert & Ehrlich, 2012: 318 - 319).

The World Health Organisation's (WHO) Alma Ata conference, 1978, in De Haan (2013) defined primary health care as "an essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to

individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-resilience and self-determination" (De Haan, 2013: 51). Based on this definition, the importance of community access to quality care cannot be over-emphasised.

South African health reform consists of robust strategies to strengthen the health system, focusing on a primary health care (PHC) approach to health service delivery. PHC supervision is the strategy put in place to improve the quality of health care provided through PHC facilities, in order to attain the intended health outcomes of the health reforms (National Department of Health, 2009). The researcher argues that, despite regular supervisory visits to fixed PHC facilities, even where a 100% supervisory visit rate was reported, health outcomes and quality of care remain poor in PHC facilities. There were no significant differences in performance by PHC facilities with consistent monthly supervisory visits and those without consistent supervisory visits, as reflected on the district health information system (DHIS).

The absence of such returns on investment from the supervision system in place called for research to answer the question, "What hinders the implementation of quality supervision in PHC facilities?" As Hsiao and Sparkes (2012) articulated, the design of functional health systems requires an investigative framework that identifies existing problems and the root causes for such problems (Hsiao & Sparkes, 2012).

The study was carried out within the South African health policy framework, which is reflected in the Department of Health's strategic plans and priorities. South African health policy priorities include the attainment of the Sustainable Development Goals (SDGs), National Health Insurance readiness, the Re-engineering of Primary Health Care initiative, the Ideal Clinic Realisation and Maintenance (IDEAL CLINIC) initiative and health facility readiness for accreditation by the Office of the Health Standards Compliance (OHSC). O.R. Tambo District was identified as one of the National Health Insurance (NHI) pilot site districts in the country (Department of Health, E.C., 2015).

According to the PHC Supervisory Manual of SA, 2009, which is a guide to PHC facility supervision, "Quality supervision entails embarking on a process of assessing the extent to which a health facility meets required standards for better health outcomes and engaging in activities that assist the facility to attain such standards. Therefore, the process of quality supervision results in a continuous quality improvement process" (National Department of Health, 2009: 3.2).

"The purpose of quality supervision is to maintain a service platform with all required enablers and the proper utilisation of resources to produce the intended output and eventually ensure a health outcome within set norms and standards" (National Department of Health, 2009: 3.3). The Revised National PHC Supervision Manual is a policy document that set guidelines for the systematic approach to PHC supervision for PHC facilities in South Africa. The guidelines provide for the elements of a supervisory visit, the five steps of the supervisory process and the requirements for a functioning supervisory system termed pillars of PHC supervision (National Department of Health, 2009).

Processes or activities are very important transactions that turn inputs (resources) into results (service delivery). It is critical that PHC facility supervisors understand and analyse patient health care processes in the PHC facility during their assessments, as ensuring correct processes forms the core of quality supervision. Key facilitation activities during a supervisory visit include, amongst other skills, mentoring, coaching and developing action plans. Supervisors require several skills in order to effectively facilitate the closure of identified gaps along the IPO chain. The skills mostly required are leadership skills, problem solving skills, collaboration, networking, interpersonal relationship skills and advocacy. A complete supervisory visit entails completion of the five steps of a supervisory process which includes the development of a quality improvement plan. (National Department of Health, 2009: 3.2-3.5).

1.2 STATEMENT OF THE PROBLEM

There is inconsistency in service delivery performances by primary health care facilities (PHC) despite a facility supervision rate of 100% in some PHC facilities in the Eastern Cape. This scenario leads one to question the quality of the PHC facility supervision system in place. The intention of implementing quality supervision in PHC facilities is to move towards the attainment of health service delivery standards that lead to improved health outcomes and client satisfaction with services received, according to the Revised PHC Facility Supervision Manual (National Department of Health, 2009: 3.2).

Although the intention of quality supervision was known from the literature reviewed, there was little knowledge available about the challenges that hinder implementation of quality supervision processes. This study was therefore undertaken to find out the challenges that hinder the implementation of quality supervision in PHC facilities in O.R. Tambo District. Knowledge and understanding of challenges that constrain the implementation of quality supervision would necessitate a review and development of policies and strategies that would improve health status, client satisfaction and financial risk protection (Roberts, Hsiao, Berman & Reich, 2008: 91).

1.3 PURPOSE OF THE STUDY

The purpose of the study was to investigate the contributing factors concerning the challenges that hinder implementation of quality supervision in PHC facilities.

1.4 OBJECTIVES OF THE STUDY

The objectives of the study were:

- to explore the practices of PHC supervisors in implementing quality supervision;
- to assess the perceptions, opinions and attitudes of PHC facility supervisors regarding quality supervision;
- to asses PHC operational managers' experiences of their supervisory visits.

1.5 RESEARCH QUESTIONS

The questions that the study sought to answer were the following:

- What were the practices affecting the quality of the PHC supervisory visit?
- What were the perceptions, opinions and attitudes of PHC supervisors in relation to quality supervision?
- What were the experiences of operational managers of supervisory visits?
- How did these experiences or challenges affect the quality of supervisory visits?

1.6 SIGNIFICANCE OF THE STUDY

The study may be used as a benchmark towards assisting the department to take informed, evidence-based and focused decisions in developing strategies to improve the quality of PHC facility supervision. The findings of this study may contribute to a strengthened health system in planning and policy changes.

A strengthened health system would result in an improvement of the immediate health outcomes which include, amongst others, access, efficiency and quality of PHC services. Consequent to the achievement of the immediate health outcomes, the ultimate outcomes of the health system would be achieved, which are a reduced burden of disease, client satisfaction and financial risk protection (Roberts, et al., 2008: 91). Understanding these consequences implies that quality supervision is a means to an end. It was therefore of importance to identify obstructions within and outside the health system that negatively affected the implementation of quality supervision.

1.7 DEFINITIONS OF TERMS

The following definitions are intended to impart an understanding of the concepts within the context of this study:

1.7.1 Primary Health Care

This is a set of prescribed health services, which are rendered by a Professional nurse, a trained counsellor, midwife and a medical practitioner as well as a community health worker, these are the services that are made to be accessible as first level of care to the community, families and individuals (National Department of Health, 2009: 5).

1.7.2 Primary Health Care Facility (PHCF)

The PHCF is a fixed health care facility that functions fully for eight hours a day, five days a week, offering integrated comprehensive primary health care services. (National Department of Health, 2009: 1.2).

1.7.3 Primary Health Care Supervisor

This is a manager responsible for a cluster of PHC facilities, providing a leadership and coordination function, supporting and guiding the performance of the facilities. This person performs an administrative and monitoring role. (National Department of Health, 2009: 2.2-2.6).

1.7.4. Quality supervision

Quality supervision is a process of assessing the challenges that hinder the attainment of expected results, norms and standards in a PHCF, and fast-tracking interventions to curb unwanted occurrences within the health system for better outcomes. (National Department of Health, 2009: 3.2).

1.7.5 National Core Standards

National core standards are the list of pre-determined standards and norms set by the Office of Health Standards Compliance (OHSC) for all health establishments in South Africa, in order to provide quality care. There are six priority areas for the National Core Standards, which are patient safety, infection control, cleanliness, the availability of medicines, positive staff attitudes and reduced waiting times (Moleko, 2012).

1.7.6 PHC Supervision System

The system of supervising the provision of health services in PHC facilities involves the availability of supervisors, transport, supervisory tools, knowledge of supervisory work,

communication, a conducive environment for supervisory visits to take place, multidisciplinary teams and forums within the district health service leadership and governance – and the interaction of all these components (National Department of Health, 2009).

1.7.7 Quality care

This is health care that meets the health standards and norms, resulting in the realisation of the best health outcomes within reasonable costs (Moleko, 2012).

1.7.8 Quality improvement

This is an ongoing undertaking aiming at increasing quality to meet the expected levels as determined by the set norms and standards (Moleko, 2012). It comprises interventions that address deviations from quality, namely, the accessibility, efficiency and effectiveness of service delivery. In this way, quality improvement influences the achievement of better health outcomes as an ongoing and continuous process (Joubert & Ehrlich, 2012: 308-309). In quality supervision, quality improvement is undertaken to facilitate closure of identified gaps during supervisory visits (National Department of Health, 2009: 3.6).

1.7.9 Systems approach

This is the ability to view the health system in a holistic way, appreciating all forces, elements, structures and processes that, when working together as interdepended elements, produce the best results (National Department of Health, 2009: 3.3).

1.8 RESEARCH DESIGN AND METHODOLOGY

A mixed-methods research design was conducted. Although qualitative and quantitative data collection methods were used, the study was predominantly qualitative. A qualitative approach was chosen to develop an in-depth understanding and interpretation of PHC supervisors' experiences, perceptions, practices, opinions and attitudes while conducting

PHC facility supervisory visits, and the operational managers' experiences of such supervision (Jourbert & Ehrlich, 2012: 310). According to Jourbert and Ehrlich, qualitative research is also useful in determining causes and practices that influence inefficiencies and inequities within health systems (Joubert & Ehrlich, 2012: 310).

Quantitative data was used to strengthen the findings from the qualitative data by enabling statistical inferences and triangulation to increase validity. Data produced from the focus group discussions and the individual interviews comprised open ended, in-depth responses to questions which were designed to collect qualitative data, while quantitative data was collected using individual interviews and closed questions in the Likert scale. Another research method that could have been employed was active participative, which would have entailed observing supervisors' practices, experiences and behaviour. Due to time constraints, this was found to be unfeasible (Silverman, 2004, in Joubert & Ehrlich, 2012).

1.8.1 Research setting

The study was conducted at O.R. Tambo District Municipality, in the Eastern Cape province of South Africa. O.R. Tambo District has four sub-districts containing 145 fixed PHC facilities (135 clinics and 10 community health centres) in total. The district is mostly rural with an uninsured population of 1 308 551, according to the 2015 DHIS midyear population estimate.

1.8.2 The study population

The target population comprised PHC facility supervisors and PHC facility operational managers from the four sub-districts of O.R. Tambo district, which are the King Sabatha Dalindyebo, Mhlontlo, Nyandeni and Qaukeni sub-districts.

1.8.3 Sampling procedure

Purposive sampling was used for the PHC facility supervisors and operational managers from the 48 PHC facilities that were supervised regularly; that is, those which achieved a 100% supervisory visit rate over a period of twelve months, from January to December 2015. Since the study design was mostly qualitative, a purposive sampling method was adopted in order for the researcher to select the respondents that would best represent the target population and the study setting (Joubert & Ehrlich, 2012: 323).

A list of 48 PHC facilities that met the criteria was drawn from the DHIS. PHC supervisors were identified for each facility on the list and nine supervisors in total were selected. Nine supervisors with at least one facility under their supervision met the criteria. Twelve PHC operational managers who were selected worked at the same facilities from which the supervisors were drawn.

Thus, nine PHC supervisors participated in the focus group discussions (FGD), all of whom had fulfilled the 100% supervisory visit requirement over the period under study for at least one facility; some had a 100% visit rate for more than one facility. The operational managers managed facilities that had achieved 100% of their required supervisory visits.

Exclusion criteria applied where a PHC supervisor had not conducted regular supervisory visits in the last 12 months in at least one PHC facility, and where operational managers managed facilities that had not received supervisory visits regularly during the last 12 months.

1.8.4 Research instruments

Instruments used were structured interviews, using standardised questionnaires. Self-administered questions were also delivered to the participants, and hand-delivered back to the researcher in sealed envelopes. Focus group discussions and structured interviews were used to collect data. The questions were standardised closed and open-ended questions (Henning, Van Rensburg & Smit, 2004). A tape recorder was used to capture the discussions, allowing the researcher to fill in non-verbal cues as respondents spoke. The recording was used to strengthen data verification.

1.8.5 Trustworthy and credibility

Trustworthiness involves establishing credibility, transferability, dependability and confirmation of the research study. Credibility deals with the question of the congruency of the findings with reality (Shenton, 2004). Data credibility and trustworthiness were strengthened through triangulation data collection methods, focus group discussions and the in-depth individual interviews. The researcher was able to take notes of her personal thoughts and feelings during the data collection process as a self-monitoring mechanism to avoid bias. A scribe took notes verbatim during discussions to complement the recordings. Facts and meanings were summarised at the end of each question during discussions in order to allow for verification of meaning by participants (Shenton, 2004).

Transferability was ensured through a thick description of findings contextually, and therefore the research findings will apply in settings similar to the O.R. Tambo district; they cannot be generalised throughout the province, due to the contextual nature of the information (Brantlinger, Jiminez, Klingner, Pugach & Richardson in Nastasi & Hitchcock, 2016: 120-121).

1.8.6 Data collection procedures

Data were generated using individual interviews and focus group discussions. Respondents were allowed to speak in both Xhosa and English in order to prevent any language barriers. An individual, self-administered questionnaire was distributed to all participants and received back by the researcher in sealed envelopes. An in-depth interview approach was used in focus group discussion in order to elicit in-depth responses regarding each issue. Focus group discussions were transcribed from the tape recorder verbatim and non-verbal cues were noted and written down by the researcher. A scribe wrote everything down that was said during discussions.

1.9 DATA ANALYSIS

The analysis process was started during the data collection phase, allowing the researcher to constantly confirm new information and to re-direct questions to obtain more

understanding for further analysis. From this data, the researcher started to analyse its content, noting recurrent themes related to the supervision framework and quality improvement cycle.

The collection of data from the interviews and focus group discussions was transcribed verbatim by listening to the tape recorder and standardised by translation into English. Responses that were not clear were confirmed with the interviewee before they were transcribed, thereby ensuring accuracy of the data.

The content of the data was coded in order to bring meaning to the responses of the respondents; responses were then sorted into categories. Categories were formulated according to the study objectives.

Clusters of categories were formulated and thereafter a thematic analysis was conducted (Gale, Heath, Cameron, Rashid and Redwood, 2013). Two analysts were used throughout the process of data collection and analysis, in order to prevent researcher bias and to improve the consistency and reliability of data analysis.

1.10 ETHICAL CONSIDERATIONS

Researchers are required to consider that the rights of individuals and institutions are safeguarded (Polit & Beck, 2004)

The research proposal was evaluated by the Higher Degrees and Research Ethical Committee of the University of Fort Hare in South Africa. The researcher also received a clearance certificate to conduct research from the Eastern Cape Department of Health. The researcher received written permission to undertake the study from the District Manager of the Department of Health. The participants were told about the purpose of the study and voluntarily signed the consent for the provision of information. Privacy, confidentiality and anonymity were maintained. The research procedures adhered to professional, legal and social obligations to study participants (Polit & Beck, 2004).

1.11 CONCLUSION

This research study is presented in five chapters. Chapter one presents a summary of the study by introducing the phenomenon investigated. The background and setting of the study are illustrated so that the reader may understand the context within which the study was conducted. The impact of quality supervision on the provision of quality primary health care is briefly discussed to highlight the significance of the study for the broader sphere of the health system. Thus, the chapter provides the rationale for the study, the statement of the problem, the research questions and objectives as well as the methodology used. Lastly, the chapter introduces the content of the succeeding chapters.

Chapter two gives detailed information on the related literature reviewed. Chapter three provides an explanation of the research methodology, the rationale for its choice and the data collection methods. It also describes the study population and the sampling procedure and outlines some further ethical considerations. Chapter four presents the results of the data collected, the analysis conducted and the findings. Lastly, chapter five discusses the results and reflects on the findings from the literature reviewed, making relevant recommendations.

CHAPTER 2: REVIEW OF RELATED LITERATURE

2.1 INTRODUCTION

This chapter provides information on the literature and several studies that were reviewed. This includes studies carried out internationally, in Africa and in South Africa in the field of primary health care supervision. The literature was reviewed in order to broaden knowledge and insights regarding the supervision of PHC service provision in relation to what is known and what is unknown about the phenomenon (LoBiondo-Wood & Haber, 2006). The literature was searched electronically through Google Scholar (scholarly articles), Sabinet, and academic sites of the University of Fort Hare library, East London Health Resource Centre and the Department of Health's routine review reports. The key words used were supervision, management, quality, poor performance and primary health care.

Several studies in the literature provided in this chapter revealed that PHC supervision does influence health programme performance and quality. Supportive and enhanced supervision was confirmed by other studies to be effective. There was little information in the studies reviewed on factors that hinder the implementation of quality supervision.

This study was contextual to O.R. Tambo district which is one of the NHI pilot health districts for the country. Findings can be applied only to similar settings and contexts. The District Health Barometer (DHB) 2014/15 Report states that there are many health system strengthening activities and supports provided to NHI districts in the country, but there are still NHI districts that are not performing well in health indicators and some are deteriorating. In view of this, recommendations are made in this study to conduct investigations regarding poor performance (Massyn, Peer, Padarath, Barron, Day, 2015).

2.2 CONTEXT OF THE STUDY

According to the district health plan (DHP) 2014/15, O.R. Tambo district has a population of 1,366,244, and is mostly rural. The district has 145 PHC facilities (135 clinics and 10 community health centres (CHCs)). A fixed PHC facility is supposed to be visited at least

once a month by a supervisor from the district office to conduct supervision. PHC facility supervision is monitored by determining a supervision rate. The norm is one visit per month. (Department of Health, 2014: 21& 31). The table below shows the status of supervision in O.R. Tambo during the year 2015.

Table 2.1.1: Status of PHC facility visits in O.R. Tambo district during a 12-month period, 2015, as per the routine DHIS report.

Supervisory visit rate	Number of facilities				
	KSD	***Mhlontlo***	***Nyandeni***	***Qaukeni***	***District total n (%)***
Total number of PHC facilities	***49***	***27***	***49***	***20***	***145 (100)***
Total number visited every month (100%)	17	9	15	7	48 (33)
Total number not visited every month (<100%)	***32***	***18***	***34***	***13***	***97 (67)***
- Missed one month (91.7%)	14	8	11	2	35 (36)
- Missed two months (83.3%)	10	2	4	3	19 (20)
- Missed three months (75%)	3	1	4	0	8 (8)
- Missed more than three months (66.7%)	5	7	15	8	35 (36)

Out of 145 facilities, 48 were supervised regularly every month for the 12-month period during the year 2015 – a 100% supervision rate. Out of 97 facilities not visited regularly, 35 facilities (36% of the total) had a lower than 75% supervision rate. These missed more than three visits during the period under study. In the same period, 19 facilities (20% of the total) missed at least two visits, meaning that they had an 83.3% supervision rate.

The table shows that most PHC facilities were visited regularly, as 102 (70% of the total) had a more than 80% supervision rate (DHIS report 2015). There were no noticeable differences in the performances of facilities with regular supervisory visits and those which

did not get regular monthly supervisory visits, measured in health outcomes as per the analysis of the performance indicators (DHIS 2015).

2.3 PHC SUPERVISION PERFORMANCE

A workshop held with district staff to discuss district health barometer findings came up with several challenges to supervision activities. The recommendations made during the workshop were to assess the way supervisory visits were conducted in PHC facilities, so that support could be provided to improve quality of service (Massyn, et al., 2015: 25).

An immunisation audit that was released in the Eastern Cape Province in 2012 reported inconsistency in information management, reflected in unavailability of registers, inconsistent verification processes, insufficient training and communication issues (Massyn, et al., 2015:138). These findings are associated with poor quality of supervision, which is the system in place to identify PHC facilities' service delivery gaps and facilitate improvements. These findings formed the motivation for the quest to uncover factors that hamper the quality of supervision (Jamin, Kaposhi, Schopflocher and Mqoqi, 2014).

Health care facilities depend on supervision to improve the quality of care provided. The challenge was that health facility supervision was not occurring as planned and intended, due to a lack of required resources (Criel & De Brouwere, 2012). The researcher concurs with commentary by Criel and De Brouwere (2012) that high costs are incurred in conducting supervisory visits to health facilities, and therefore assessment of such is essential in order to discover reasons for their apparent ineffectiveness.

2.4 THE LEGAL FRAMEWORK OF PRIMARY HEALTH CARE SUPERVISION AND QUALITY HEALTH CARE

2.4.1 The South African Constitution of 1996

Primary health care services operate within the legal framework of the Republic of South Africa and the World Health Organisation decisions. The Constitution of the Republic of South Africa, 1996, chapter 2, section 27(1) states: "Everyone has the right to access

health care services, including reproductive health care" (South African Parliament, 1996).

2.4.2 The National Health Act (Act no 61 of 2003)

The National Health Act of the Republic of South Africa (Act no 61 of 2003 as amended) prescribes the national health system that underpins the provision of health services in South Africa (Republic of South Africa, 2004). The white paper on the transformation of health services in South Africa of 1995 made provision for the establishment of the District Health System (DHS) as a key health sector reform strategy that will ensure access to health services by the communities, using the primary health care (PHC) approach.

The White Paper further prescribed the functions of the Department of Health to include the provision of leadership in quality assurance, including the formulation of norms and standards (South African Government, 1995). The PHC supervision manual, which is a guide to PHC facility supervision, endorses the importance of maintaining PHC norms and standards through supervision, and states that the supervisor of a PHC facility is the driver for the DHS through primary health care (National Department of Health, 2009: 2).

2.4.3 The Office of Health Standards Compliance

In view of the above, the National Health Act (Act no 61 of 2003) was amended by the National Health Amendment Act (Act no. 12 of 2013), which in chapter 10 prescribes the establishment of the Office of Health Standards Compliance (OHSC). One of the objects of the National Health Amendment Act was the protection and promotion of the health and safety of users of public health services, through assessing and ensuring compliance by health establishments with norms and standards of the national health system (Republic of South Africa, 2013).

The national core standards focus area identified by the Minister of Health, Dr. Motsoaledi, were cleanliness, the safety and security of staff and patients, staff attitudes towards patients, infection control, reduction of waiting times and the availability of medicines.

Attainment of these national core standards by health facilities would facilitate the attainment of the Sustainable Development Goals. The six priority core standards were identified to assist managers and supervisors to focus on the critical areas, which would affect overall quality of care (National Department of Health, 2011).

2.4.4 The National Health Insurance

The NHI White Paper prescribes an implementation process of three phases over a period of fourteen years. The first phase, 2012/13 – 2016/17, focused on strengthening the public health sector and implementing key enablers such as the OHSC (Minister of Health, 2015). The researcher believes strengthening the supervision of health facilities would increase the chances for health establishments to meet the requirements of the OHSC.

2.4.5 Sustainable Development goals (SDGs) 2030

The Sustainable Development Goals, 2030, adopted by world leaders at the United Nations Sustainable Development Summit on the 25th September 2015, consists of 17 goals. Goal three is "to ensure healthy lives and promote well-being for all at all ages" and consists of 13 health sector targets. Target seven is "achieving universal coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (World Health Organisation, 2015). The above statement supports the intentions of the current study. The researcher supports the sustainable development target that through quality supervision, access to safe, effective and quality services will improve and financial waste will be prevented.

2.4.6 The National Development Plan

The National Development Plan 2030 set out nine long-term goals for South Africa that relate to improvements in health and well-being for the people of South Africa. All relate to the strengthening of health systems, under which quality supervision of primary health care is located (Department of Health, E.C., 2015).

The Eastern Cape Department of Health envisages a quality health service for the people of the Eastern Cape Province, promoting a better life for all. The efforts of the department focus on providing and ensuring accessible, comprehensive, integrated services in the Eastern Cape, emphasising the primary health care approach, that optimally utilises all resources to enable the present and future generation to enjoy health and quality of life, as reflected in the vision and mission statement of the Department of Health in this province (Department of Health, E.C., 2015). The emphasis on quality of care and a primary health care focus were the key concepts that formed the framework of this study and its relevance to the vision and mission of the Department of Health.

2.4.7 Revised Primary Health Care Facility Supervision Manual 2009

The National Department of Health (NDoH) of South Africa, in its efforts to improve the quality of health care in PHC facilities, developed a revised PHC Facility Supervision Manual in 2009, to be used as a guide to the implementation of supervision in the country (National Department of Health, 2009). The manual defines and describes how quality supervision is conducted and provides checklists to be used during facility visits. It is stated in the manual that supervision of PHC facilities, when implemented efficiently, will improve the quality of care received by clients (National Department of Health, 2009). This was confirmed by the Minister of Health, Dr. Aron Motsoaledi in the preamble to the PHC Supervision Manual, dated October 2009, which states: "The revised version of PHC Facility Supervision Manual comes at a time when a renewed focus is being placed on strengthening service delivery and improving the primary health care service, the cornerstone of the national health care system." (National Department of Health, 2009: 2).

2.4.8 District Health Barometer (DHB)

A DHB is a national annual publication that presents health resource financial allocations, health outcomes and efficiencies at all levels – districts, provinces and national. It is a valuable tool for the Department of Health, making information available for service monitoring and strategic planning, as selected performance indicators are reflected

(Massyn, Maomi, Nazia, Padarath, Ashnie, Barron, Peter, Day & Candy, 2015: ii). The publication is a valuable source of information for health performance evaluation.

An important component of the role of a supervisor is to monitor the performance of primary health care facilities in their provision of accessible, comprehensive and integrated quality health services. One way of doing this was by direct visits to the facility to conduct quality supervision. Quality supervision is that which identifies in a measurable way the gaps in health care quality and facilitates the closing of those gaps. This means that quality supervision is composed of an assessment component and an enabling component along the chain of input, process and outcome (IPO) in a health care facility (National Department of Health, 2009). According to the supervision manual, supervisors should conduct a systematic assessment of the elements of the health care facility. Elements of supervision include "the in-depth programme review; problem solving; information system review; referral review; PHC facility administration review; community involvement review and staff support" (National Department of Health, 2009: 2.2-2.3).

The persistent low quality of care and poor health outcomes in PHC facilities, despite regular supervisory visits, is of great concern in O.R. Tambo district, as an NHI pilot site for the province. The district health barometer (DHB) 2014/15 reported O.R. Tambo as poorly performing in achieving the Millennium Development Goals (MDGs). Immunisation coverage was 74.9% against national targets of 95% (Massyn, et al., 2015: 131).

The researcher views the above picture as of great concern, as low immunisation coverage indicates an ineffective immunisation programme and is also a proxy indication of a dysfunctional health system. The routine health reports have shown recurring poor performances in PHC facilities, as reflected also in national core standards assessments, regardless of a supervisory visit rate of 100% in 60% of PHC facilities, according to the District Health Information publication, year 2014/15.

2.5 THEORETICAL FRAMEWORK

There are various models and theories that constitute the framework within which quality supervision operates. These theories include, among others, systems theory, human relations theory, behavioral theories, motivation theories, leadership and management

theories, theories X, Y, and Z and quality improvement theories. Due to the complex nature of the role of a supervisor, all these theories apply to the supervision system framework. Effective and successful supervisors realise the effectiveness of using various models of supervision as well as the relevance of recognised leadership styles in their daily work with employees (Bradley, 2013). This study contains a review of only those theories which are considered relevant to the research question.

2.5.1 Systems Theory

A system comprises interrelated, independent components and elements, processes and procedures, with various specific functions and interrelated responsibilities, organised for a common purpose for the whole (Hayajneh, 2007). Hayajneh (2007), in his paper "Management of Health Care Professionals", views the universe as a system comprising multiple subsystems, such as the health care system, which can be described by the functioning of its components through processes that unify them.

The significance of systems theory to health care management is that it can be used to understand health care structures and processes and specifically the relationship amongst the components (Hayajneh, 2007). Drawing from the insights of Hayajneh (2007), the researcher sees systems theory as foundational to quality supervision. Primary health care exists as a sub-component of the district health system, through which district health services are delivered. Primary health care facilities form vital components in the system, where transactions for health care take place with clients or patients. The effectiveness of the individual health care transaction depends on the functioning of the whole district health system, which in turn depends on the national health care system. Although the components of the health system are independent structurally, they are interrelated and integrated in achieving the purpose of the health system (National Department of Health, 2009).

It is critical for PHC supervisors and health personnel working at PHC facilities to understand clearly how the different components of the health care system function together. This understanding would help facilitate the implementation of quality services, as it involves a synergy between inputs (resources), processes (activities) and outcomes

(effects) – the IPO. A deep understanding of this aspect of the system allows the PHC team (supervisors, programme managers and PHC personnel) to identify health service delivery challenges along the IPO route and to effect changes and improvements at specific points that would benefit the whole health system (National Department of Health, 2009).

The task performed by the individual PHC facility is health care provision, but each one operates within a totality; a national, provincial and district health care system. Improvements in health care take place at all levels of the overall system – the facility level, the district level, the provincial level and the national level. At provincial and district level, problem-solving meetings are held with supervisors and district health service teams. The researcher argues that the problems that arise at PHC facility level should be identified using the input, process and outcome (IPO) model, with much input from PHC supervisors and the health personnel. Their experiences and familiarity with the daily challenges in PHC facilities, when coupled with an understanding of the model, could go a long way to resolving some of the challenges besetting PHC facilities

2.5.2 Behavioural Theory

Behavioural theory states that leaders are made rather than born. This implies that leadership skills can be taught and developed. There are two models of leadership within behavioural theory that apply well to PHC supervisors; task-oriented leadership and people-oriented leadership (Cumming & Worley, 2008).

Task-oriented leaders focus on tasks to be carried out according to set standards, operation procedures and polices within the structure. The task-oriented leader may be effective in making a team aware of the correct activities to carry out according to the rules, but there is likelihood that such an approach, if too heavily emphasised, may discourage innovation and creativity in a team. The PHC supervisor that adopts the task-oriented leadership style would be successful in providing policy guidelines, in organising and initiating quality improvement plans, in assessing and facilitating patient care processes and in making staff aware of proper norms and standards. However, drawing from experiences of working in the PHC-environment, this researcher contends that the

success of this approach depends on the power the task-oriented supervisor has to access much-needed resources to carry out the expected tasks. Most of the support needed to access these resources depends on collaboration, coordination, human relations, networking, and innovation and creativity applied within the entire health system. In short, people-oriented leadership skills are needed (Cumming & Worley, 2008).

The people-oriented leader motivates exemplary staff behaviour through encouraging, listening, observing, coaching and mentoring PHC facility personnel. The people-oriented leader is successful in workforce retention as well as personnel development. These successes are due to the behaviour modelled by the leader, which is indirectly task-oriented. The learning environment thus created leads to more motivated staff.

Drawing from the insights of behavioural theory, the researcher is of the view that PHC supervisors need to integrate elements of both the task-oriented and the people-oriented leadership styles. The supervisory function introduced by the Department of Health implies a focus on correctly-carried out tasks; in this respect, supervisors need to know the requirements of the system and be able to convey them with accuracy. However, they also need all-important skill of motivating managers and staff to co-operate, to work as a team, to use resources efficiently and to affect their own behaviour change where required.

The PHC supervisor with a knowledge of behavioural theory and a measure of the task-oriented approach could develop skills that will enable her to feed useful information back into higher levels of the system. Applying the people-oriented approach, the versatile supervisor would also be able to guide teams to solve problems, using critical thinking skills and the resources available to them (Cumming & Worley, 2008).

2.5.3 Human Relations Theory

The human relations theory proposes the application of approaches and procedures that encourage dealing with workers as socio-psychological beings (Swinton, 2004). To promote work performances with better outcomes, human relations theorists propose the

application of "the psychological and moral qualities – such as goals, motivation, and values" (Swinton, 2004). The human relations approach to management is the contribution of Elton Mayo, who was an Australian interested in workers' motivation and commitment and the management–worker relationship, as stated by Lyndsay Swinton (2004).

Human relations theory applies to the implementation of quality supervision of PHC facility personnel as stated in the PHC Facility Supervision Manual (2009): "Supervision is a relationship that extends over time. The process of supervision occurs within a relationship that is established between the supervisor and the supervisee". The relationship grows and develops because supervision is ongoing. Clearly in any workplace it is important for the supervisor to apply skills that promote good human relations and instil a good "human relationships culture" in all personnel supervised. The insights brought by human relations theorists raise the question of whether the poor quality of supervision is affected by the lack of these human relations skills. The bulk of the literature reviewed in this study did not touch on this possible area of lack, but Swinton does make recommendations regarding supervisor-supervisee relationships (Swinton, 2004).

The researcher is of the view that supervisors who utilise the systems theory approach in their work also inevitably apply human relations theory when they motivate health workers to see their contributions as part of health system performance. Communications scholars used to emphasise the linearity of human relations between workers and managers, but human relations theory has brought about a far greater understanding of the two-way nature of real communication. The success of supervision processes depends to a large extent on the dialogue, discussions, explanations and feedback as well as the problem-solving processes that lead to improved action (Swinton, 2004). In view of these necessary engagements, the human relations approach offers valuable insights and is a determinant for a successful supervisory visit.

2.6 LITERATURE REVIEW ON QUALITY OF CARE AND SUPERVISION

Quality supervision is supervision that assesses work processes and detects deficiencies in quality against the expected standards; and then engages in a process of improving personnel practices in a measurable way. This means that quality supervision is composed of an assessment component and a facilitation component along the chain of input, process and outcome (IPO) in a health care facility (National Department of Health, 2009). According to the supervision manual, supervisors are supposed to conduct a systematic assessment using the elements of supervision.

A study was conducted in two hospitals in the Eastern Cape, assessing the effects of WHO guidelines on case fatalities in the integrated management of childhood illnesses (IMCI) and the influence of operational factors. Findings showed that quality of care was compromised due to weaknesses within the health system, especially when adequate doctor and nurse training, supervision and support were lacking. Quality improvement processes were affected by poor infrastructure, lack of leadership, lack of supportive supervision and inappropriate undergraduate training (Ashworth, Chopra, McCoy, Saunders, Jackson, Karaolis and Sogaula, 2012). Supervision was one of the operational factors that influenced adherence to IMCI; the lack of supervision resulted in nonadherence to set standards and child mortality.

Another similar study was carried out in Cape Town on the effect of an IMCI intervention on quality of care across four districts in Cape Town, South Africa. The findings were that improved supervisory support, utilising the supervisory guidelines for IMCI, could improve implementation (Chopra, Patel, Cloete, Sounders & Peterson: 2004).

A study conducted in eThekwini district, KwaZulu-Natal utilised a descriptive quantitative design to examine factors that influence the implementation of basic antenatal care (BANC) in PHC facilities. PHC supervisors' knowledge of BANC and supervision of midwives influenced successful implementation. From this study, one can deduce that lack of programme knowledge in supervisors' results in poor programme outcomes (Ngxongo & Sibiya, 2013). Limitations in this study were that it investigated only the factors that influence successful implementation of BANC; it did not investigate factors that hinder correct implementation

2.7 EFFECTIVE SUPERVISION

Systems theory that applies to quality supervision includes supportive supervision. Supportive supervision is supervision that enhances the quality of care by promoting interpersonal cooperation within the health system, by timeous identification of problems and a solution-oriented approach. This approach in supervision enhances worker performance (Bella, Hassan, Afolaranmi, Tagurum, Chirdan, Zoakah, 2013).

A study in Jos, Nigeria on "supportive supervision as an effective intervention in achieving high quality malaria case management at PHC level", showed that supportive supervision is a feasible and practical tool to improve malaria case management amongst PHC workers. It was shown that supportive supervision can impact on the knowledge and skills of health workers in malaria case management (Bella, et al., 2013).

In another study conducted in Malawi, Tanzania and Mozambique, there was a strong indication that strengthened leadership and a strong supervisory framework were effective in improving health care services. The survey investigated the main supervision approach used in primary health care facilities in these countries and evaluated staff job satisfaction and staff turnover in the presence of strong supervision. The results showed that staff retention, good performance and better health outcomes were the result of strong formal supervision. There was a high level of intention to leave the job in settings where supervision was unstructured or absent (McAuliffe, Daly, Kamwendo, Masanja, Sidat, de Pinoh, Helen, 2013:5).

Weakened systems, like delays in replacing workers who have left, weaken results even when supervision is strengthened. A study was carried out to determine whether enhanced supervision in an eye-care unit would increase performance. The findings were that regular supervision based on skills transfer did elicit improvements, although not significantly as only a quarter of the facilities followed supervisory interventions appropriately. Notable was a high turnover of trained staff during the study period without a consistent replacement programme (Kalua, Gichangi, Barassa, Eliah, Lewallen, Courtright, 2014).

The literature review in a study in effective supervision in clinical settings concluded that quality of supervision had not been looked at by previous studies and that more structured research methods should be used to characterise supervision in the workplace (Kilminster & Jolly, 2000). The current study used predominantly qualitative methods to explore factors that hinder the implementation of quality supervision.

2.8 CONCLUSION

The literature reviewed in this chapter was searched electronically through Google scholar (scholarly articles), Sabinet, academic sites University of Fort Hare library, East London Health Resource Centre and the Department of Health routine review reports. Key words used were supervision, quality, quality improvement, systems view, supervision, Primary Health Care.

The chapter has reviewed the existing body of knowledge on the phenomenon under study; it has also reflected on the theoretical framework of supervision, the legal basis of primary health care and the need to seek more knowledge to improve quality supervision.

Several studies have highlighted that correctly-applied supervision of PHC facilities results in improvements in the quality of programme implementation and service delivery in these facilities. Supervision has many components that, when incorrectly applied, has little effect; the key is a broad and deep grasp of various elements in the total health care system, and knowledge on human behaviour as well as content knowledge.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

The previous chapter reviewed the existing literature on quality supervision as well as the legal and theoretical framework of quality supervision. This chapter explains the research method used to collect the data, the study population, the sampling procedure and the measuring instruments and their trustworthiness. The qualitative research methodology was deemed best, in keeping with the approach of previous researchers on supervision in primary health care facilities, to get an in-depth understanding of the phenomenon.

3.2 RESEARCH DESIGN

The research question to be answered by the study was, "What are the factors that hinder the implementation of quality PHC supervision?" Research design is defined as a planned path to be followed to find a solution to the research question (Jourbert & Ehrlich, 2012: 77). A mixed-method research approach was used. Johnson et al., (2007: 129), in Nastasi & Hitchcock (2016), describe mixed-methods research as the use of both qualitative and quantitative inquiry methods that are pooled together in an organised manner (Nastasi & Hitchcock, 2016: 19).

The study is predominantly qualitative although both quantitative and qualitative methods were employed. A contextual study design was conducted focusing on O.R. Tambo district PHC supervision. A predominantly qualitative approach on data collection and analysis was chosen to develop an in-depth understanding and interpretation of PHC supervisors' experiences, perceptions, practices, opinions and attitudes while conducting PHC supervisory visits. Operational managers' experiences of supervision were also assessed to confirm the findings derived from the supervisors' responses (Joubert & Ehrlich, 2012: 310). According to Joubert and Ehrlich, qualitative research is also useful in determining causes that influence inefficiencies and inequities within health systems (Joubert & Ehrlich, 2012: 310).

Quantitative data was used to strengthen the findings from the qualitative data by drawing statistical inferences and to enable triangulation to increase the validity and trustworthiness of the findings. The mixed methods used are a recognised feature of qualitative research (Joubert & Ehrlich, 2012, p. 319). Another research method that could have been used is the active participative research method, but time constraints precluded this option (Jourbet & Ehrlich, 2012; 321).

3.3 RESEARCH SETTING

The study was conducted in four sub-districts of the O.R. Tambo district. The fixed PHC facilities within the four sub-districts – King Sabata Dalindyebo, Mhlontlo, Nyandeni and Qaukeni sub-districts – were 134 clinics and 10 Community Health Centers. The district of O.R. Tambo carries a population of 1,308, 551 uninsured people, according to the DHIS midyear population estimate of 2015.

3.4 TARGET POPULATION

The target population was all PHC facility supervisors and PHC facility operational managers from the four sub-districts of O.R. Tambo district.

3.5 SAMPLING PROCEDURE

Purposive sample of PHC facility supervisors and operational managers was done. This sampling technique was chosen in order to locate participants with experience in the phenomenon under study (Brink, Van Der Walt and Van Rensburg, 2012). The criterion for selection was a PHC facility supervisor who had conducted the required supervisory visits on a monthly basis over the last 12 months, as shown in the district health information system (DHIS), in at least one facility. Nine PHC facility supervisors were selected. The exclusion criterion was not having conducted the required number of supervisory visits in the last 12 months. The sample also included 12 operational managers from 12 regularly supervised facilities. The operational managers were selected from the same facilities as the selected supervisors.

3.6 RESEARCH INSTRUMENTS

Instruments used were structured interviews utilising standardised questionnaires. Self-administered questions were delivered to the participants by hand and sent back to the researcher by hand in sealed envelopes. Questions for supervisors were structured as A: Demographic data; A1: Practices of the facility supervisor and A2: Perceptions, opinions and attitudes. Operational managers' questionnaires were on experiences with supervisory practices. The questions were standardised, and were both closed and open-ended (Henning, et al., 2004). Focus group discussions were conducted using structured questionnaires to collect data. A tape recorder was used to record the discussions verbatim, allowing the researcher to write down non-verbal cues. The recording was used to strengthen data verification.

3.7 TRUSTWORTHY AND CREDIBILITY

Trustworthiness involves establishing credibility, transferability, dependability and confirmability of the research study. Credibility deals with the question of the congruency of the findings with reality (Shenton, 2004). Triangulation data collection methods were used in that focus group discussions and the individual interviews strengthened the written data's credibility and trustworthiness. The researcher was able to take notes of her personal thoughts and feelings during the data collection process as a self-monitoring mechanism to avoid bias. The scribe took notes verbatim during discussions to complement the recorded discussion. There was a summarising of facts and a checking for meaning at the end of each response to confirm that what was understood was exactly what was intended by the speaker (Shenton, 2004).

3.8 DATA COLLECTION PROCEDURES

Data was generated using the focus group discussions (FGD) and the individual interviews. Respondents were allowed to use both Xhosa and English in order to prevent any language barriers. An individual self-administered questionnaire was distributed to each participant and received back to the researcher in a sealed envelope. An in-depth

interview approach was used in focus group discussions in order to explore and get in-depth input for each issue. Focus group discussions were transcribed from the tape recorder verbatim and non-verbal cues were noted and written down by the researcher. A scribe wrote down questions and responses during the discussions.

3.9 DATA ANALYSIS

The analysis process was started during the data-collection phase, allowing the researcher to confirm new information and re-direct questions to elicit greater understanding for further analysis. From this data, the researcher started to analyse its content, noting recurrent themes related to the topic under discussion.

The collection of data from the interviews and focus group discussions were transcribed verbatim by listening to the audio tape and standardised by translation into English. Responses that were not clear were confirmed with the interviewee before they were transcribed, thereby ensuring accuracy of the data.

The content of the data was coded and categorised in order to bring meaning to the responses. Categories were formulated according to the study objectives.

Clusters of categories were formulated and thereafter a thematic analysis was conducted (Gale, et al., 2013). Two analysts were used throughout the process of data collection and analysis, in order to prevent researcher bias and to improve the consistency and reliability of data analysis.

3.10 ETHICAL CONSIDERATIONS

Researchers are required to ensure that the rights of individuals and institutions are safeguarded (Polit & Beck, 2004). The research proposal was evaluated by the Higher Degrees and Research Ethical Committee of the University of Fort Hare. The researcher received the clearance certificate to conduct research from the Eastern Cape Department of Health, with permission obtained to conduct the study from the district manager. The participants were told about the purpose of the study and asked to voluntarily sign the

consent form for the provision of information. Privacy, confidentiality and anonymity were maintained. The research procedures thus adhered to all professional, legal and social obligations in studying the participants (Polit & Beck, 2004).

3.11 CONCLUSION

This chapter explained how the study was conducted, outlining the research design and methodology used as well as describing in some detail the data measuring instruments used. The researcher also gave explanations on ethical considerations and described how the trustworthiness and credibility of the data were ensured

CHAPTER 4: DATA PRESENTATION, ANALYSIS AND DISCUSSION

4.1 INTRODUCTION

The previous chapter described the methodology used for collecting data. The mixed methods approach was used, comprising both quantitative and qualitative data collection, analysis and interpretation (Johnson et al., 2007: 129 in Nastasi & Hitchcock, 2016:19). The study was predominantly qualitative in order to explore the contributing factors concerning the challenges that hinder quality supervision. This chapter presents and analyses the data and discusses the finding in relation to the available literature on the phenomenon under investigation.

To this end, the sample population is described through biographical information and distribution, and themes, categories and sub-categories that arose in the study are presented for easy analysis (Gale, et al., 2013). The data is presented in tables, diagrams and figures, with brief descriptions. Respondents are frequently quoted verbatim. Numbers and percentages are assigned to qualitative data to measure the frequency and magnitude of responses and to determine recurring concepts.

4.2 SAMPLE REALISATION

The study sample was composed of nine primary health care facility supervisors (PHCFS) and twelve operational managers (OMs), drawn from the 48 fixed PHC facilities that had a supervisory visit regularly, that is, every month during the 12 months of January to December 2015. It also shows the number of focus group discussions (FGD) held. Only one OM questionnaire was spoilt, but the absence of data from this questionnaire did not affect the sample size. The table below shows the sample realisation.

***Table 4.1**: Study sample realisation.*

Participants	Number	Questionnaires issued	Questionnaires received back = n (%)
PHCF	9	9	9 (100%)
OM	12	12	11 (92%
FGD	9	-	9 (100%)

4.2.1 Participants' demographic data

Demographic data were collected from the participants on sex, age and years of experience on the current job. The biographic distribution of participants is shown in the table below.

***Table 4.2**: Biographical distribution of PHC facility supervisors (n = 9).*

Characteristics		Frequency	Percentage
Gender :	Female	8	89%
	Male	1	11%
Age in years:			
	< 40	0	0
	41 - 55	5	56%
	≥56	4	44%
Supervisory experience:			
	< 2years	1	11%
	2 - 5 years	3	33%
	> 5 years	5	56%

The table above shows that participants were predominantly females (89%) between 41 and 55 years old (56%). Gender distribution of one male did not have an effect on the sample.

4.2.2 Participants' experience

The findings were that the majority of PHCFS – five (56%) – had five or more years' experience in supervisory work. This fact strengthens the dependability of the data collected as participants with such long experience in the field of study were likely to bring valuable answers, drawing from long and varied experiences regarding the research questions.

Table 4.3: *Biographic distribution of PHC operational managers.*

Characteristics	Frequency	Percentage
Gender:		
Female	10	90%
Male	1	10%
Age in years:		
< 40	1	10%
41 - 50	6	55%
>50	4	36%
Supervisory experience: <1 - 2years	6	55%
3 - 5 years	1	10%
> 5 years	4	36%

The results revealed that the majority of operational managers – five (55%) – had only one to two years' experience in their positions. This finding confirmed one of the challenges reported by supervisors; that there was a high turnover rate of nurses at PHC facilities.

Table 4.4*: Focus group discussion (FDG): PHCFS distribution per sub-district representation.*

No	Sub-district	100% Supervised PHC facilities (Year 2015)		Number of PHC supervisors	
1.	KSD	17	35%	3	33.33%
2.	Mhlontlo	9	19%	2	22.22%
3.	Nyandeni	15	31%	3	33.3%
4.	Qaukeni	7	15%	1	11.1%
	Total	**48**	**100%**	**9**	**100%**

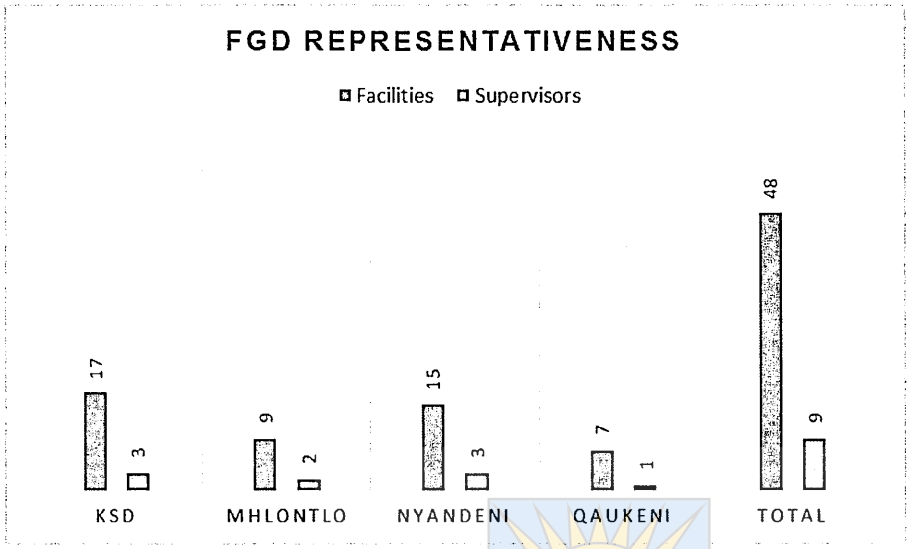

Figure 4. 1. *Representation of facilities per supervisor*

4.3 DATA ANALYSIS AND RESULTS

The study investigated the factors that hinder the implementation of quality supervision in PHC facilities. Three themes developed from the study questions and participants' responses: the practices of PHC facility supervisors (PHCFS); the perceptions, opinions and attitudes of PHCFS; and the experiences of PHC facility operational managers (OMs) of supervisory visits. The related views and ideas from the participants were grouped into categories and sub-categories that emerged from the themes (Gale, et al., 2013). Similar responses were also quantified to strengthen the findings. The table below shows the major themes, categories and sub-categories that emerged:

***Table 4.5**: Themes, categories and sub categories.*

Major Themes	Category	Sub-category
Theme 1 Supervisory practices on implementation of quality supervision	1.1 High work load	□ Inappropriate allocation of PHC facilities □ Long travelling distances and time □ Other activities outside supervisory work
	1.2 Knowledge and experience	□ Training on supervision □ Use of supervisory tools by PHCFS
	1.3 Resources	□ Shortage of workforce □ Lack of equipment and medical supplies □ Lack of transport
Theme 2 Perceptions, opinions and attitudes of supervisors towards implementation of quality supervision	2.1 Lack of sub-district and district management team support	□ Lack of collaboration and teamwork □ Lack of integrated approach in implementing health programmes □ Delayed procurement processes
	2.2 Supervisory work and manual	□ Perceptions, opinions and attitudes on use of supervisory tools □ Relationship between quality supervision and the performance of the facility □ Stress management
	2.3 Operational management	□ Follow-up on action plans by operational managers □ On-the-job training of operational managers by supervisors
Theme 3. Experiences of operational managers of supervisory visits	3.1 Use of supervisory assessment tools 2.2 Implementation of PHC-facility action plan 3.3 Causes, effects and solutions for poor performance of facilities, despite supervision	Lack of resources □ Inadequate infrastructure □ Unclear guidelines □ Lack of transport □ □

4.3.1 Theme 1: Supervisory practices

The results revealed that the quality of supervisory practice was affected by various factors. High workloads, lack of knowledge, inadequate experience and lack of resources emerged as factors that influence the ineffectiveness of PHC facility supervisory visits.

4.3.1.1 High workload

The manner in which PHC facilities are allocated to supervisors and the amount of other delegated activities unrelated to supervisory work emerged as contributing to the high workload of PHCFS. Findings are that the PHC facilities allocated to supervisors did not take into consideration the number of facilities already allocated per PHCF or the distance and time required to travel from the supervisor's office to the PHC facility. Other delegated activities included attending workshops and meetings, which were viewed by supervisors as consuming an inordinate amount of time.

4.3.1.1.1 Allocation of PHC facilities to supervisors

Emerging as a contributory factor to the high workload was the high number of facilities allocated per supervisor. The table below illustrates the distribution:

***Table 4.6**: PHC facility distribution per supervisor. (P = Participant).*

	Distribution									Total
Supervisor	P1	P2	P3	P4	P5	P6	P7	P8	P9	9
No. of facilities	9	8	9	7	6	9	9	10	9	76

The table above shows that there was inconsistency in the allocation of PHCFs to supervisors. The measures of the central tendency were: mean 8; median 9; mode 9; and range 4. These results showed an excess of 11 PHCFs when compared against the norm of five to seven facilities per PHCFS, according to the Eastern Cape Clinic Supervision Policy of 2004. The results also show inconsistency in the allocation of PHC facilities to PHCFS; only two (22%) met the norm of seven PHC facilities and 78% exceeded the norm by one to three facilities. The findings were that although some PHC facilities were regularly visited for supervision by the supervisors, the high number of PHC facilities allocated to each supervisor contributed to the poor quality of supervision performed.

4.3.1.1.2 Travelling distances and time required for supervisory visits

The findings revealed that some facilities took over two hours to reach by car. During focus group discussions, supervisors pointed out that the longer the time spent on the road, the less time spent in the facility being visited. The implication of this findings is that the allocation of facilities to supervisors should take into consideration many factors, including travelling distances. The condition of the roads was also mentioned as prolonging travel time. This is even more the case after rains, when gravel roads become muddy and partially washed away. The longest distances mentioned were 167km and 144km for two facilities, while the majority of facilities were between 60km and 120km away for supervisors. Interestingly, the two facilities situated the furthest away were not those with the longest travelling times; an indication that poor-quality roads play a part in prolonging travel time. Only 15 facilities (20% of the total) took longer than two hours to reach for a supervisory visit.

***Table 4.7**: Distance in kilometres and travelling times to facilities.*

No	Question	P1	P2	P3	P4	P5	P6	P7	P8	P9	Total
-	*Total number of PHC facilities*	*9*	*8*	*9*	*7*	*6*	*9*	*9*	*10*	*9*	*76*
A1.2	Kilometres travelled to get to the furthest facility	-	-	64	60	167	72	120	144	-	627
A1.3	Number of facilities that takes two or more hours to reach	2	1	3	2	-	-	5	0	2	15

Three participants (P1, P2 and P9) did not give responses to the question "kilometres travelled to get to the furthest facility" and two participants (P5 and P6) did not respond to the number of facilities that took a supervisor two or more hours to reach. It was not clear whether the two participants who did not respond did so because they did not know the answer or because they had no facilities that took them two or more hours to reach.

The results show 61 facilities (80%) could be reached in less than two hours. It appears that the 20% of facilities which took longer than two hours to reach were affected the most by poor quality supervision, as visits to these facilities were short, and fatigue was mentioned as a factor. When asked what the result was of long travelling distances, one respondent said, "Exhaustion and lack of interest to do On-site trainings and follow-ups on previous action plans".

Another respondent stated, "The supervisor is affected physically, being exhausted, arriving late at the facility, getting to the facility while the nurses are tired from the peak hour of the day or arriving at the peak hour of the day."

The shortage of professional nurses sometimes resulted in supervisors having to consult with patients instead of doing their supervisory work.

The greatest contributory factors to time spent away from the facilities were, "attending meetings and workshops, bad roads and bad weather". Based on the reported information, the researcher concludes that PHCFs have to drive slowly on bad roads and on rainy days they take even longer. In addition, they sometimes have to wait for weather to clear before they drive, and if the weather deteriorates while they are in a facility they may have to spend less time there in order to drive back while the bad road is not yet muddy and dangerous.

The table below shows quantified responses by participants on the effects of time spent on the road on a supervisory visit:

***Table 4.8**: Effect of time spent on the road on a supervisory visit.*

No	Responses	Number
1.	Little time available for adequate supervision	2
2.	Exhaustion, lack of interest to do on-site trainings and other follow-up	4
3.	Getting to the facility at peak hour because of late arrival	1
4.	Attending unscheduled meetings with late notice	1
5.	Arrived late, when nurses are overworked and exhausted, especially where there is a shortage of staff	1

Only one of the nine supervisors did not respond to the question exploring the amount of time spent on supervisory work. Of those who responded, the findings were that four (50%) spent 70% of their worktime on supervisory work. Those who spent less that 70% of their work time on supervision gave several reasons: lack of transport, attending an

excessive numbers meetings and workshops, many of them unscheduled meetings with late notification, and having to attend to other responsibilities in addition to supervision.

One responded said, "Most of the time we are called to meetings that are unscheduled and some are communicated very late."

Another responded stated, "Since 2009 I am working as both clinic supervisor and the community-based service manager."

4.3.1.1.3 Delegated activities apart from supervisory work

It emerged that work other than supervisory activities had an effect on the quality of supervisory visits conducted by the PHCFS. This emerged from the following participants' responses, quoted verbatim;

"Due to shortage of nurses, supervisors assist with clinical work to reduce long queues before conducting supervision work."

"Orientation of new facility managers and staff now and again, due to high staff turnover before conducting supervisory work in a facility."

"Sharing of transport with other managers who are attending other meetings, workshops or outreach services before going to the PHC facility for supervision."

"Working both as a clinic supervisor and a community-based service manager."

4.3.1.2 Knowledge and experience

Adequate training on supervisory work and the specific training of PHC managers contributes to knowledge and experience which affects supervisory visits.

4.3.1.2.1 Training

Participants who reported having undergone training on supervision and who were familiar with the supervision manual said that such training made a great difference to their PHC facility supervision. One responded stated, "Training was an eye-opener in

understanding strategic priorities and performance indicators and also serves as a platform for sharing solutions for supervisory problems."

Lack of knowledge and experience of PHC facility managers appeared to be affecting supervisory practices, as respondents mentioned that they spend most of their supervisory time orientating and mentoring new facility managers due to high staff turnover.

The table below show participants' responses regarding the status of training for supervision:

Table 4.9: *Status of training for supervision.*

Participant	Trained on Supervision	Last training	Was training of assistance?	If yes: How training assisted. If no: Why not trained.
P1	Yes	>3yrs	Yes	Use of supervisory tools
P2	No	-	-	Nobody ever organised training.
P3	No	-	-	-
P4	Yes	2yrs	Yes	Eye-opener, orientated on new vision, strategic priorities and performance indicators, platform for sharing problems
P5	Yes	>3yrs	Yes	Use of tools and supervision manual
P6	Yes	>3	Yes	Ability to implement supervisory manual
P7	No	-	-	-
P8	Yes	>3	Yes	Using supervisory tools, knowing roles and responsibilities, able to assist facilities to achieve targets
P9	No	-	-	Only got orientation on supervision

The majority of participants – five (56%) – reported being trained on supervision. All those who reported being trained felt that training assisted them in carrying out their supervisory roles and their ability to use supervisory manual tools. Four supervisors had never been trained; of these, one had received general orientation on supervisory work but no formal training. The researcher is of the opinion that although supervisors may have fulfilled the 100% visit-rate for 48 PHC facilities during the period under study, the quality of

supervisory visits was chiefly compromised by a lack of knowledge and skill on the part of the supervisors.

4.3.1.2.2 Use of supervisory tools and supervision guide

The table below shows the practices of supervisors when facilitating closure of identified gaps.

***Table 4.10**: Supervisory practices related to facilitation (closing identified gaps).*

No	Question	Always	Sometimes	Never
A1.8	Do you use the supervisory assessment tools (red flag and/or regular review) in the PHC facility supervision manual when conducting supervisory visits?	5 (56%)	4 (44%)	
A1.9	Do you develop an action plan after each visit based on the findings?	8 (89%)	1 (11%)	
A1.10	Are you able to follow up on the action plans' progress between visits?	2 (22%)	5 (56%)	2(22%)
A1.11	Are there other activities that prevent follow-up on action plans between visits?	2 (22%)	7 (78%)	
A1.12	Do you review the previous action plan's progress on each supervisory visit?	7 (78%)	2 (22%)	
A1.13	Are you able to facilitate support of your facilities by other stakeholders in order to close the service gaps identified?	3 (33%)	6 (67%)	
	Total	27 – 2 (50%)	25 (46%)	2(4%)

The table above shows responses of participants in relation to the practice of supervisory visits on facilitating the closure of identified gaps. The findings were that the majority of supervisors – five (56%) – used the supervisory tools presented in the supervisory manual when conducting supervisory work in a facility and eight (89%) developed the action plan, while seven (78%) reviewed the previous action plan during supervisory visits. The weak point revealed was follow-up on action plans in between visits, done by only two respondents (22%). Another two (22%) were never able to follow up on action plans in

between visits and the remaining six (56%) had never followed up on an action plan. Another finding was that collaboration with other stakeholders in facilitating the closure of identified gaps was weak amongst the supervisors, as only three (33%) were able to facilitate support from other stakeholders.

4.3.1.3 Resources for a supervisory visit

Causes, effects and solutions to the challenges experienced by respondents when conducting supervisory visits were explored. The finding was that a lack of health service resources was the factor contributing most to difficulties with quality supervisory visits. The resources most mentioned by both supervisors and operational managers were a shortage of PHC workforce, a shortage of dedicated transport for supervisory visits, and delayed procurement processes that prevent easy access to required equipment and supplies. Lack of access to resources was strongly mentioned during the focus group discussion.

4.3.1.3.1. Shortage of PHC workforce

The findings of the study were that a shortage of staff in PHC facilities led to a situation where supervisors were accompanied by less professional staff when conducting supervisory rounds at facilities, as the operational manager would inevitably be busy with clinical work. Sometimes the PHCF had to conduct clinical work instead of supervisory work due to the shortage of staff and long patient queues.

Most of PHC facilities operate without an operational manager and respondents' experiences are that those facilities perform poorly on priority indicators and fail to meet set targets. The appointment of operational managers in PHC facilities was mentioned as the solution to underperformance.

Lack of resources, both human and material, as well as a lack of dedication by the workforce were associated with systems failures by the participants in the focus group discussion and also in self-administered questionnaires. One of the respondents perceived decisions taken by the department to cut off employment and the non-filling of vacant posts timeously as contributing to systems failure.

4.3.1.3.2 Lack of PHCF supervisory transport

Lack of dedicated supervisory transport was viewed by most participants as affecting the pre-determined schedule for PHC supervisory visits. Constant disruption of the schedule was also perceived as leading to workforce demotivation and loss of interest as this delayed improvement plans and intervention processes. One responded wrote, "Schedule of visits are not followed, staff members lose interest and complain that I do not keep to the schedule." The provision of subsidised vehicles or a dedicated pool vehicle for supervisory visits were mentioned as the solution.

4.3.1.3 Delayed procurement processes

It emerged that delayed procurement processes contributed to the poor quality of services despite regular supervision. Respondents mentioned that even though gaps were identified and followed up for timeous closure, delayed procurement processes were a constant hindrance preventing resources reaching the point of need timeously. This scenario, according to the respondents, would render a supervisory visit inadequate. From the focus group discussion, a suggestion arose to fast-track procurement processes by decentralising signature requirements for supply chain processes.

One respondent stated, "Facilities without basic cleaning material and medical equipment cannot meet the core standards. It is required that procurement processes be improved." There had been attempts to understand the reasons for procurement delays – in the FGD it emerged that one of the sub-districts had called a meeting with procurement staff and had been apprised of long process required to procure materials and equipment, involving an approval chain right up to the provincial office.

4.3.2 Theme 2: Perceptions, opinions and attitudes

PHCFS perceptions, opinions and attitudes towards the implementation of quality supervision were explored in the interviews and focus group discussion (FGD). Three categories of responses to this question emerged: the lack of sub-district management

team support; supervisory work and PHC facility operations management. The responses are reflected in tables.

4.3.2.1 Lack of district and sub-district management support

The results revealed that 58% of PHCFS perceived the support of PHC supervision by the district and sub-district team as inadequate, of which 33% constituted "uncertain" support. Health systems failure manifested in a lack of collaboration and teamwork, disintegration and delayed procurement processes, and eventually in poor health outcomes. The table below shows responses by participant pertaining to the support from sub-district and district:

***Table 4.11**: Responses regarding PHCF supervisory support by district and sub-district management teams. 1=strongly disagree; 2 = disagree; 3= neither agree nor disagree; 4= agree; 5= strongly agree*

No	Question	1	2	3	4	5
A2.4	Threats emanating from the assessment that are above the competence of the PHC facility are easily solved at sub-district level.	1 (11%)	4 (44%)	3 (33%)	1 (11%)	
A2.5	Supervisors have opportunity to present their findings and action plans to the sub-district manager and team.	2 (22%)	4 (44%)	2 (22%)	1 (11%)	
A2.6	The sub-district management work as a team to install appropriate interventions to address findings from the supervisory visits within the subdistricts in order to improve health service delivery and health outcomes.	1(11%)	2 (22%)	5(55%)	1(11%)	
A2.15	Sub-district managers and district managers respond to PHC facility supervisors' reports by mobilising support.	2 (22%)	4 (44%)	2 (22%)	1 (11%)	
A2.16	Health programme managers are always willing to listen to the supervisor's report.	3 (33%)	3 (33%)	3 (33%)		
	45	**20%**	**38%**	**33%**	**9%**	

There was a clear perception that a lack of teamwork and collaboration exacerbated problems in PHCFs. This was confirmed by the number of "disagrees" regarding support provided by the district management team. The same scenario was very evident from the FGD, where it was mentioned that there was very poor implementation of recommendations. There tended to be a vertical approach, with key players "working in silos", rather than as members of a team, resulting in quality improvement plans not being implemented. Health systems failure was seen as the root cause for the poor implementation of quality supervision. One responded stated, "Systems that are not in place are the root cause."

4.3.2.2 Supervisory work and use of manual

Overall attitudes of supervisors towards supervisory work were positive at 60%, with "agree" responses at 27% and "strongly agree" at 33%, while 18% reveal negative attitudes and the remaining 22% reflected moderate attitudes towards supervision, having a "neither agree nor disagree" response.

Results show that most supervisors (89%) believe that there is a relationship between the performance of PHC facilities and the quality of supervision, while the remaining 11% are uncertain. Regarding stress levels, 67% of supervisors believed that supervision work was stressful, 11% disagreed with this and 22% were uncertain. Inability to handle stress was considered by 78% of respondents as affecting their quality of work; only 11% disagreed with this and 11% neither agreed nor disagreed.

Based on these results, supervisors perceive supervisory work as contributing to the performance of PHC facilities. Supervisors consider their work stressful and recognise that their inability to manage stress is affecting the quality of their supervision. It appeared that respondents strongly disagreed with the perception that they spent 70% of their time on supervisory work; most spend far less than this on supervisory work due to the reasons given above under Theme 1.

***2**: Responses on attitudes, opinions and perceptions to supervisory work.*

1 = strongly disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree; 5 = strongly disagree

No	Question	1	2	3	4	5
A2.1	There is a relationship between the performance of the facility and quality of supervision.			1 (11%)	3 (33%)	5 (55%)
A2.11	The PHC supervisory work is stressful		1 (11%)	2 (22%)	3 (33%)	3 (33%)
A2.12	Inability to manage stress may affect the quality of supervision.		1 (11%)	1 (11%)	3 (33%)	4 (44%)
A2.17	Supervisors spend 70% of their work time doing supervisory work in the facilities.		5 (55%)	2 (22%)	1 (11%)	1 (11%)
	45		**18%**	**22%**	**27%**	**33%**

Results revealed that 44% of supervisors perceived that the correct use of the supervisory checklist in the PHC facility supervision manual helped with critical issues that threaten quality of care, while 11% disagree and 44% showed uncertainty on this matter. Thus the finding can be stated as *supervisors valued the correct use of the supervisory checklist, although the amount of uncertainty on the issue is cause for concern.*

Most of the respondents (55%) strongly disagreed with the perception that supervisors do not like to read and apply the supervision manual, 33% disagreed, and 11% neither agreed nor disagreed with the statement. Based on the results, *the majority of supervisors (89%) showed positive attitudes towards the use of the supervisory manual.*

Only 11% of supervisors did not agree with the statement that applying knowledge from the PHC facility supervision manual improves skills on supervision; 44% were uncertain regarding this statement and 44% strongly agreed that applying knowledge from the PHC supervision manual improves their skills. Thus, *there is a relatively positive attitude (44% strongly agree) towards the supervision manual in terms of improving skills of supervisors, but there is reason for concern that 44% of supervisors feel ambivalent or uncertain on this issue.*

3: *Attitudes, opinions and perceptions regarding the use of the supervisory manual.*

1 = strongly disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree; 5 = strongly agree

No	Question	1	2	3	4	5
A2.2	Assessment checklist from the supervision manual, when used correctly during a supervisory visit, raises critical issues that threaten quality of health care service delivered in a facility.		1(11%)	4 (44%)	2 (22%)	2 (22%)
A2.13	Supervisors do not like to read and apply the supervision manual guideline when conducting supervision.	5 (55%)	3 (33%)	1 (11%)		
A2.14	Applying knowledge from the PHC facility supervision manual improves supervision skills.		1(11%)	4 (44%)		4 (44%)

4.3.2.3 Operational management

Overall responses showed that 52% of supervisors had good attitudes, perceptions and opinions of operational managers; 30.5% agree and 22% strongly agree; the remaining 30.5% were uncertain and 17% disagree.

4.3.2.3.1 Follow-up on action plans by operational managers

Supervisors that viewed operational managers as able to address most of the threats identified by the supervisor during visits were 67%, whilst 56% agree that operational managers follow up on actions developed during supervisory visits, 44% of supervisors agreed that it is easy to communicate with facilities in between supervisory visits, 33% disagreed with this statement and 22% showed uncertainty.

4.3.2.3.2 On-the-job training of operational managers by supervisors

Supervisors found it easy to conduct on-the-job training (44%), while 33% disagreed and 22% were uncertain.

***4**: Responses to operational management.*

1 = strongly disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree; 5 = strongly agree

No	Question	1	2	3	4	5
A2.3	Most of the threats revealed during assessments can be addressed at facility level by the operational manager or person in charge of the facility.		1 (11%)	2 (22%)	4 (44%)	2 (22%)
A2.8	Operational managers follow up on action plans developed during a supervisory visit.			4 (44%)	3 (33)	2 (22%)
A2.9	It is easy for a supervisor to conduct on-the-job training for the PHC facility staff and operational manager.		2 (22%)	3 (33%)	2 (22%)	2 (22%)
A2.10	It is easy to communicate with the PHC facility between visits.		3 (33%)	2 (22%)	2 (22%)	2 (22%)

4.3.3 Theme 3: Operational managers' experiences

This question and related questions examined how operational managers perceived the quality of supervision and the abilities of supervisors to help close identified gaps in service delivery. Only positive questions were asked, ranging in scale from 1 to 3, 1 being "always", 2 being "not always" and 3 being "never". "Always" would be the expected practice and "not always" shows insufficiency and inconsistency. "Never" may be regarded as abnormal and unacceptable practice. Results were analysed based on quantification of responses and the strength was determined by the number of responses on the scale.

4.3.3.1 Use of supervisory assessment tools (the red flag and regular review)

The findings of the study revealed that PHC facility operational managers had positive attitudes towards the use of assessment tools during supervisory visits with 64% reporting. that the tools were always used while only three (27%) reported "not always". The table below shows responses to the question that sought to determine OMs' experiences of the approved tools used during supervisors' assessments:

***Table 4.15**: OMs' experiences of the use of supervisory assessment tools: n (%).*

No	Question	Always	Sometimes	Never
B1.1	Do you use the supervisory assessment tools (red flag and/or regular review) during PHC facility supervision visits?	7(64)	3 (27)	
B1. 9	Do you use the operational manager's monthly checklist in the supervisory manual to address the gaps in operational management issues?	6(54.5)	5 (45.5)	
B1.10	Do you review the performance of the facility on PHC indicators from the previous month's DHIS during the facility visit?	8(73)	3 (27)	

4.3.3.2 OMs' experiences in facilitation of action plans

It also emerged that although 54% of the OMs developed action plans, only 45% followed up on action plans between visits. The same response emerged from the supervisors; 89% of them developed action plans on each visit but only 22% were able to follow up on these plans between visits. These results show that the facilitation component of supervision is quite inadequate.

Quality supervision entails assessment that identifies gaps in the expected standards of care followed by a process that facilitates closure of those gaps (National Department of Health, 2009). The findings are that it was difficult for either the OMs (27%) or the PHCFs (33%) to mobilise support from stakeholders in order to close identified health service gaps. The table below shows responses by participants on the closure of identified gaps during assessment:

Table 4.16: *OMs' experiences on closure of identified gaps.*

No	Response	Always	Sometimes	Never
B1.2	Do you develop an action plan after each visit based on the findings?	6 (54.5)	1 (9)	
B1.3	Are you able to follow up on the action plan progress between visits?	5 (45)	6 (54.5)	
B1.4	Are you able to communicate with your supervisor between visits when doing follow-up on action plans?	7(64)	4 (36)	
B1.5	Do you review the previous action plan progress during each supervisory visit?	6 (54.5)	5 (45.4)	
B1.6	Do you get feedback on actions that were to be facilitated by the supervisor?	9 (82)	2 (18)	
B1.7	Are you able to feedback to your clinic staff the supervisory findings and plans?	7 (64)	4 (36)	
B1. 8	Are you able to facilitate support of your facilities by other stakeholders in order to close the service gaps identified?	3 (27)	8 (73)	

4.3.3.3 Causes, effects and solutions for poor performance

The findings were that a weak health service delivery platform contributes to poor performance by PHC facilities, despite 100% supervisory visits. Most of the participants said that services were not performed according to the desired standard or outcomes and that this lead to poor quality health services.

Service platform challenges mentioned were the shortage of staff, poor infrastructure, lack of health programme guidelines, poor information management, lack of transport, lack of support by the programme managers and delays in procurement processes. All of these can be taken as evidence of a failing health system. The following were the specific responses from participants:

4.3.3.3.1 Shortage of staff 73% (n=8)

Most of the respondents – 73% (n=8) – shared the view that a shortage of staff, clinical and non-clinical, was manifested when the PHCFs were unable to conduct quality supervisory visits, due to there being only one professional nurse on duty and the facility being full of patients. One participant said that a shortage of staff was also related to an increased workload and having to work under pressure, resulting in inadequate care provided. The results clearly indicate that inadequate staffing contributes to poor quality of services rendered in PHC facilities despite supervisory visits. Employment of adequate staff, according to the Workload Indicator of Staffing Needs (WISN) guideline, was viewed by all participants as the obvious solution. WISN is a human resource management guideline that provides scientifically-calculated information for the staffing numbers and skill requirements of facilities according to their workload (Republic of South Africa, 2015). Related to staff shortages was the high staff turnover, indicating work conditions that failed to attract or retain staff, and a consistent lack of skill, due to many staff at any given time being new to their jobs.

The regular intrusion of unplanned meetings and workshops upon working time also contributed to shortages of operating staff. One participant said, "Meetings and workshops are taking staff away from the facilities, thus causing poor implementation of the programme. On-site training must be considered to prevent taking skeleton staff away from facilities."

4.3.3.3.2 Lack of equipment and medical supplies 64% (n=7)

Participants said that the lack of material resources such as medical equipment and supplies resulted in long waiting times for patients, since nurses were forced to share equipment.

One participant pointed out the result of this shortage: "Poor diagnosis that results in poor patient management, for example, lack of diagnosis equipment like haemoglobinometer."

The findings were that delayed procurement processes were the main cause for the lack of equipment and other supplies. At least 45% (n=5) of the respondents viewed

fast-tracking of procurement procedures and equipment maintenance as the solution to the problem.

4.3.3.3.3 Lack of transport

It emerged that lack of dedicated transport disrupted adherence to the supervisory schedule, resulting in poorly organised visits to the facilities. One participant said, "It is difficult for a supervisor to conduct regular supervisory visits without dedicated transport."

4.3.3.3.4 Lack of support from programme managers 27% (n=3)

Findings were that support in the form of facility visits by health programme managers was viewed as important and capacitating to the operational managers. OMs viewed the provision of guidelines as the responsibility of both supervisors and programme managers. The use of outdated programme guidelines and the delayed issuing of current guidelines results in inappropriate health care provided in PHC facilities and underperformance on set targets. One participant recommended, "Guidelines to be distributed to PHC facilities on time by programme managers and supervisors through team work, motivation of staff and the facility managers on use of the guidelines."

The results revealed that unplanned meetings and workshops were deeply disruptive to the work of supervisors and others. Such meetings fell within the general ambit of programme managers and could be prevented if properly scheduled. Meetings and workshops take staff away from the facilities, causing poor implementation of the action plans. As one participant said, "On-site training must be considered to prevent taking skeleton staff away from facilities and team work to integrate health programme demands."

4.3.3.3. Poor recording of health data 18% (n=2)

It emerged that information management is affected by poor recording, especially on health programme data. This was the opinion of 18% (n=2) of participants. The concern for poor health information management in facilities was also shared during the FGD by the PHCFs, who argued that despite the presence of data capturers, information capturing was frequently incorrect due to a lack of supervision of the data capturers by the operational managers.

4.4 DISCUSSION

The root causes of deficiencies and imbalances in a health system are best defined through qualitative research (Joubert & Ehrlich, 2012: 310). The study revealed the existence of factors that render the supervisory system inefficient; chief among these are a too-high workload for supervisors, exacerbated by inconsistent facility allocation and by regular interruptions to the working day by unscheduled departmental meetings and workshops; a lack of knowledge and experience on the part of supervisors; insufficient resources such as transport; a high turnover of nurses at the PHC facilities; an inefficient and unwieldy procurement process that delays the acquisition of essential medical supplies; a lack of support by health department managers, and a lack of teamwork and co-operation between various role players in the health care system.

The discussion seeks to reflect on the extent to which the findings met the objectives of the study, which was to answer the study questions (Brink, et al., 2012: 201), namely:

- What were the practices affecting the quality of the PHC supervisory visit?
- What were the perceptions, opinions and attitudes of PHC supervisors in relation to quality supervision?
- What were the experiences of operational managers of supervisory visits?
- How did these experiences or challenges affect the quality of supervisory visits?

The results of the study are discussed in relation to the existing literature on the subject. The practices reported by PHC facility supervisors, their perceptions,

opinions and attitudes and the experiences of operational managers all point to a poorly-run supervision system.

4.4.1 Practices affecting quality supervisory visits

The study revealed that the quality of supervisory visits was negatively affected by supervisors' high workloads, their inadequate knowledge and experience, and a lack of health service resources. The high workload for supervisors emanated from inappropriate allocation of PHC facilities, long travelling distances and times as well as supervisors' many other responsibilities apart from supervisory work.

Training in supervision and the appropriate use of supervisory tools were found to be, as expected, very important in determining knowledge and skill for the supervisory task. Although training is important for supervisors in order to boost performance, the findings were that uncoordinated, erratic training workshops and meetings had poor consequences. They served to interfere with, rather than enhance performance. On-the job training for both the scarce workforce and supervisors was preferred. The recommendation is that a well-coordinated training schedule from provincial and district level should be planned and communicated at the outset of each year, enabling supervisors to plan their activities and coordinate their various tasks for greater effectiveness.

The shortage of PHC facility staff and the inability of supervisors to influence the procurement of medical equipment and supplies, disrupted schedule to facilities, affecting follow-up on action plans and leading to demotivation amongst staff are all detrimental to quality health care and calls for effective leadership. It also leads to mistrust; if supervisors are unable to be where they have said they will be, relationships suffer, as pointed out in human relations theory as the basic requirement for teamwork and better performance of an organisation.

The high turnover of staff means that supervisors are forced to engage in frequent orientation sessions for new personnel. In a study conducted in Malawi, Tanzania

and Mozambique entitled, "The critical role of supervision in retaining staff in obstetric services," McAuliffe et al. (2013) found that a lack of supervision lead to job dissatisfaction by staff. Their finding was that an absence of a functioning supervision system impacts on staff retention (McAuliffe, et al., 2013). In the current study it did not appear that poor supervision was a direct cause of staff shortages; rather it seemed that the delay in filling of vacant posts contributed to poor supervision, in that supervisors were frequently forced to help out at facilities as nurses, rather than, or in addition to, supervising. Similarly, operational managers could devote little time to managing facilities, as they were forced by staff shortages to engage in full-time operational work. As a result, guidance and suggestions brought forward by supervisors were often not followed up on.

A lack of knowledge and experience emerged in the study as associated with the high staff turnover in PHCFs. Each time new staff were trained, and improvement plans set in motion, staff would leave, necessitating a renewed effort to train and implement improvement plans. Based on supervisors' views, the study finding was that PHCFS valued knowledge and experience on supervisory work. All supervisors who underwent training on supervision recognised that it had a positive effect on how they used the supervisory manual.

There was clearly a huge challenge in the area of transfer of skills to operational managers due to high staff turnover. A study in Kenya, Malawi and Tanzania entitled, "A randomised controlled trial to investigate effects of enhanced supervision on primary eye care services at health centres in Kenya, Malawi and Tanzania", found that delaying the replacement of workers who had left, weakened the supervision programme and the health care system (Kalua, Gichangi, Barassa, Eliah, Lewallen & Courtright, 2014).

Applying systems theory, the researcher concludes that insufficient time to conduct quality supervisory visits contributed to poor implementation of quality supervision. Provision of a conducive environment for PHC supervision is one of the requirements for a functioning supervisory system within the O.R. Tambo district.

Completion of a supervisory visit requires sufficient time and involves quality assessment using checklists provided in the supervisory manual. It also involves a facilitation component, which currently seems to be extremely weak. Facilitation implies problem-solving and the development of quality improvement plans involving other health system stakeholders, all of which need close follow-up to ensure that every improvement planned is implemented.

A study carried out in Benin on "the rise and fall of supervision in a project designed to strengthen supervision" found that time is a resource that is undermined by poor coordination. The recommendation of the study was that coordination should be maintained through effective communication and prioritisation as well as taking into consideration local pre-arranged supervisory activities (Rowe, Alexander, Onikpo, Faustin, Lama, Marcel, Deming, Micheal, 2009). Similary, in this study prioritisation and coordination of supervision would take into consideration equity in the allocation of health facilities and the consideration of bad roads, to ensure that supervisors have sufficient time to conduct quality visits.

Although it is known that poor roads affect access to health facilities by communities, the study also revealed a profound effect on the quality of supervision, in terms of time taken travelling, exhaustion and inability to reach facilities on rainy days for scheduled visits. O.R. Tambo district is mostly rural, with the majority of health facilities accessed by gravel roads. This calls for a need to strengthen intersectoral collaboration strategies to improve road access.

Responsibilities allocated to supervisors could be limited, to allow for 70% supervisory time and 30% for other activities, including administration, meetings and training workshops. PHC facility supervisors are the critical link between the health facility at community level and the whole health system; therefore, coordination of supervisory activities and effective communication within the system cannot be over-emphasised.

4.4.2 Perceptions, opinions and attitudes of PHC facility supervisors and operational managers

Delayed centralised procurement processes that resulted in constant shortages of medical equipment and supplies in PHCFS was viewed by supervisors and operational managers as the key indicator of systems failure and a huge hindrance to the implementation of quality supervision. Based on the experiences of supervisors and OMs, it can be stated that the failing procurement process blocks the closure of identified gaps in quality health provision and renders supervisory visits a fruitless expenditure.

Quality improvement is clearly not facilitated. Moleko (2012) states, "an emphasis on systems is central to quality improvement – poorly designed systems generate inefficiency, waste, low-quality health care and negative health outcomes" (Moleko, 2012). Emerging from the current study was a great deal of frustration in both operational managers and supervisors on the material flow process, that is, the manner and pace at which ordered goods and services run through the system to reach facilities.

The results showed that lack of support by sub-district and district management teams for PHC facility supervisors was perceived as playing a major role in the poor quality of PHC facility supervision. This notion strongly emerged from both the operational managers and the PHC facility supervisors. Lack of collaboration and teamwork at subdistrict level in facilitating closure of identified gaps in PHC facilities, lack of integration in the efforts of various health programme managers, the invisibility of support for PHC facilities as mentioned by the operational managers, and the absence of opportunities for supervisors to give feedback to management regarding their supervisory visit reports all contributed to 58% of supervisors viewing support at district level as not available.

Participants related the perceived challenges to quality supervision as due to systems failure. Moleko (2012) stated that the five areas of quality improvement

which require a specific focus are the client, teamwork, data, systems and processes, and communication and feedback. The team approach improves quality by integrating the knowledge and experiences of all role players, enabling new insights regarding problems within various system components (Moleko, 2012).

The results of a study entitled, "Improving a mother-to-child HIV-transmission programme through health system redesign: quality improvement, protocol adjustment and resource addition" revealed that "identification of gaps in care and immediate feedback by the subdistrict office to the labour wards allowed for a timely response to any performance failure" (Youngleson, Nkurunziza, Jennings, Arendsa, Kedar & Barker, 2010). This finding confirmed the results in the current study that revealed lack of support by sub-district and district teams as a root cause for inefficient supervisory visits. Drawing insights from human relations theory, the success of supervision processes depends to a large extent on the dialogue, discussions, explanations and feedback as well as the problem-solving processes of an entire team, leading to improved action (Swinton, 2004).

4.4.3 Experiences of operational managers regarding supervisory visits

Results show that the operational managers (OMs) experienced supervisory visits as affected by a lack of resources and a lack of support by management. The findings were that operational managers' attitudes were positive towards the use of supervisory tools.

Each supervisory visit should end with an action plan, to be implemented between visits to allow a review of progress on the following visit. Operational managers revealed that although action plans were developed by 54% of the OMs, follow-up on the plans was seldom done. The findings were that OMs experienced challenges in facilitating closure of service gaps because of a lack of health service resources, inadequate infrastructure, lack of transport and unclear guidelines. The findings are that it was difficult for either the OMs (27%) or the PHCFs (33%) to mobilise support from stakeholders in order to close identified health service gaps. Development of

action plans during supervisory visits is an important step towards improving the service delivery gaps. Inability to implement the action plans renders the supervisory visit inefficient and indeed, fruitless.

Collaboration and networking is one of the management skills required for both operational management and supervision in order to facilitate improvements. The study revealed a deficiency of skills related to mobilising support from stakeholders, including health programme managers, in order to facilitate closure of gaps that were identified during supervisory visits.

4.4.4 Participants' proposed solutions to the challenges

Participants felt strongly that strengthening the supervision system and improving the health service platform was the solution required. This would include the allocation of dedicated transport for supervisory visits; an uninterrupted schedule for supervisory visits; improved support by the sub-district and district teams; stronger integration of health programme components; fast-tracking the filling of vacant posts; improving working conditions for PHC facility staff to improve retention, the timeous provision of updated guidelines, on-the-job training of limited staff; avoiding constant interruptions to work by being called out to meetings and ad-hoc workshops, and fast tracking the procurement process by decentralising signing and approval requirements. These systems solutions were envisaged as the cure to the persistent poor implementation of quality supervision.

4.5 CONCLUSION

This chapter presented the results emanating from the data collected from participants and from the available literature on the phenomenon under review. Factors that contributed to inefficiency in the implementation of quality supervision were brought to the fore, as stated by those who work daily in the system and know its weaknesses. Various possible solutions to the problems were also presented

and are further discussed in the next chapter, which gives conclusions and recommendations based on the above findings and discussions.

CHAPTER 5: SUMMARY, LIMITATIONS AND RECOMMENDATION

A presentation and discussion of the results was given in the previous chapter. In this chapter the researcher presents conclusions and recommendations drawn from the findings of the study in the light of the previous discussion. The limitations of the study are also given, and suggestions are made for further studies that might overcome the limitations of the current one.

5.1 SUMMARY

The study was conducted in the O.R. Tambo district of the Eastern Cape Province in South Africa. The province has long been challenged by poor service delivery in PHC facilities, with persistent failure to meet the required service standards and poor health outcomes for the general populace, despite a supervisory system that was put in place in all districts to strengthen the quality of health services rendered in these facilities.

Challenges concerning quality supervision were investigated, using predominantly qualitative methods of data collection and analysis, with quantitative methods supplementing these to increase vigour. The objectives of the study were to explore primary health care facility supervisors' practices; to assess perceptions, opinions and attitudes of PHC facility supervisors and to assess the experiences of operational managers. An additional objective was to propose solutions to the challenges faced. Participants were drawn from supervisors and operational managers from the 48 health facilities that had received regular monthly supervisory visits over a period of 12 months.

The findings of the study revealed that there are structural and systemic factors contributing to the poor implementation of quality PHC facility supervision in the study area. The following systemic contributory factors hindered the implementation of quality supervision in PHC facilities: High workload relating to inconsistency in the allocation of PHC facilities to supervisors, and also emanating from a shortage of PHC facility supervisors; long travelling times to reach PHC facilities; poor quality of roads, delaying visits; poor adherence to the PHC supervisory schedule due to lack of dedicated transport; the demands of numerous work responsibilities other than supervision;

erratically announced meetings and workshops, requiring attendance; a gross shortage of PHC facility workforce; a high turnover of professional nurses in general, coupled with delays in filling vacant posts; and a deeply flawed procurement process that results in the unavailability of crucial medical supplies at most facilities. These challenges reflect an environment that is not conducive to the implementation of quality supervision and reflect systems failure.

Systems failure is in particular manifested by procurement delays, which have direct impacts on community health. The insights afforded by behavioural theory, coupled with the findings of this study, highlight the absence of collaboration, teamwork and communication as contributing to procurement delays and other problems in the system. Guidelines to health facilities are not kept up to date, and there is an absence of feedback mechanisms from supervisory visits, resulting in an inability to facilitate closure of identified gaps in health service provision. Lack of collaboration and networking skills on the part of both supervisors and operational managers, means that solutions to problems are not sought from either external or internal stakeholders in the health system, so that problems remain. The researcher concludes that lack of sufficient time to conduct quality supervisory visits, lack of sufficient knowledge and experience and lack of leadership and governance were the focal points of the findings. The notion of "leadership and governance entail strategic direction, plans and policies, effective oversight, regulation, motivation and partnerships that integrate all health systems building blocks to achieve results" (Vriesendorp, 2010).

The researcher is of the view that an understanding of these factors explains the poor health outcomes and quality standards in PHC facilities, despite supervisory visit rates of 100%. The conclusions and recommendations are made in the next section.

5.2 LIMITATIONS

The study applied the concept of quality supervision as defined in the National Primary Health Care Supervisory Manual of South Africa (2009). The findings are contextual and a description of the context of the study area is provided to allow the application of findings

and recommendations to areas with similar conditions. The data collection method was a self-administered questionnaire; results depend on the honesty and level of detail given by participants, some of whom omitted to answer some questions. The results are drawn from the supervisor and supervisee perspective in the study area. The researcher is of the opinion that the inclusion of input from the district manager would have enriched the findings regarding quality supervision at district level.

5.3 RECOMMENDATIONS

As stated in the introduction to this study, the outcome of the study may form a basis for developing strategies to strengthen the quality of primary health care facility supervision, for better health outcomes. The recommendations apply to all levels of health service and comprise general management improvements using the minimum available resources.

5.3.1 Stronger collaboration

By implication the study revealed that implementing PHC quality supervision requires strategic planning and a supervision framework that involves district team collaboration and an integrated approach to PHC facility problems. For example, proper planning would determine the number of supervisors required per district, factors to be considered when allocating facilities, including distances and standards of roads, the availability of supervisees for the supervisory visit, and the manner of scheduling supervisory visits to accommodate available transport. Control measures also need to be put in place to avoid the interruption by ad hoc meetings and workshops. In addition, a mechanism for feeding back challenges and problems needs to be devised, so that they do not remain unsolved.

5.3.2 Strengthen facility operations management

It is recommended that operational managers be capacitated to take a stronger, more active leadership role in the supervision of PHC facilities. Time for on-the-job supervision should be created with facility personnel by the operations manager. It is also advisable that the

operational manager utilise the available facility management tools and guidelines from the PHC facility supervisory manual, the National Core Standards and the Ideal Clinic Realisation and Maintenance manual. These publications complement each other and assist the facility team to develop an integrated facility improvement plan. Continuous communication and feedback to the PHC facility supervisor should be encouraged. This intervention would improve the quality of PHC facility supervisory visits as operational managers would become more conversant with facility operations and improvement plans on the days that visits occurred. The application of a more people- oriented leadership may curb the high turnover of personnel.

5.3.3 PHC supervisor requirements

In order to improve the quality of supervisory visits, it is recommended that PHC facility supervisors prioritise PHC facility supervision over other activities within the district. This could be done by influencing decisions at district management meetings, continuous communication and feedback to facility operational managers, and strengthening collaboration with other team members to facilitate support and advocacy for facilities. Operational managers could be involved in developing a comprehensive supervisory visit plan for the year so that they have input on the schedule; so that they plan and discuss the challenges and expectations of supervisory visits and come up with solutions. For example, regarding the shortage of staff that limits supervisory visit times, an arrangement could be made to mobilise nurses from other facilities on the day of the supervisory visit so that the OM is available for the supervisory visit, or a relief system could be implemented.

5.3.4 Governance at district level

It is recommended that the district management team provides leadership and governance for the provision of quality supervision, by providing strategic management of PHC facility supervision, strengthening the coordination and integration of various programme activities, creating an environment for communication and feedback from the supervisory visits, aligning performance of the facility with supervision, and facilitating the

provision of required resources and accountability. At district level, in particular, managers need to have a strong grounding in systems theory and be able to view and troubleshoot the system in its entirety; to see the "whole forest" and not just the trees. The lack of a comprehensive sense of the entire system seems to be lacking in many role players. Lastly, it is recommended that the inefficiencies in the procurement process be re-examined with a view to simplifying and decentralizing the current system, which is frustrating to all concerned due to a detrimental effect to healthcare provision.

5.3.5 Governance and leadership at provincial level

A similar recommendation applies to leadership at provincial level, where policies need to be put in place for every aspect of supervision in order to address the many concerns raised in this study. Clear guidelines for accountability and controls need to be established. The integration of provincial programme activities with local level activities such as supervision needs to be more effective, to avoid the continuous round of ad hoc meetings and workshops which interfere with on-the-ground work. Currently, these meetings take already scarce staff away from their positions, placing strain on those remaining in facilities and contributing, in this way, to job frustration and high staff turnover.

Further studies are recommended to investigate the perceptions of district health management teams and the many challenges brought to light by this study. This study has been an eye-opener to the researcher regarding the very complex nature of PHC facility supervision. Application of the recommendations is much needed and would improve the quality of health services offered in primary health care facilities, with tangible benefits for communities who deserve better service.

5.4 CONCLUSION

The study was intended to develop an understanding of the challenges faced in implementing quality supervision of PHC facilities. The study was to be used as a benchmark for evidence-based decisions, policies and strategies to improve quality of care in PHC facilities.

Based on the findings discussed in this study, the researcher concludes that PHC facility supervision is a complex and costly exercise that requires the application of leadership and governance within the district health system (DHS). Lack of leadership and governance has manifested itself as the main deficiency within the primary health care system. The deficiency in leadership and governance manifested in what participants in the study viewed as a "systems failure". The implementation of quality supervision of PHC facilities would seem impossible without a prerequisite of a strengthened leadership and governance within the district health system, at all levels of management.

In conclusion, the study findings have contributed to understanding the challenges that hinder the implementation of quality supervision in O.R. Tambo district, rendering supervisory visits inefficient. Findings can be shared with other districts which face similar conditions. The lessons learned from the study are that each component of a supervisory system is important and as a system, all components have to function as required in order to produce an intended outcome.

The PHC facility supervisor and the operational manager of a PHC facility are the key managers to connect and mobilise the various components of the district health system in order to influence health outcomes. The absence of support from higher level management and leadership impacts negatively on the work of supervisors as revealed by this study, therefore, the implementation of the above-mentioned recommendation is necessary. The management and leadership support required is related to creation of a conducive environment for quality supervisory visits that yield better health service outcomes.

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7. APPENDICES

Annexure A: Interview guide for supervisors

Annexure B: Interview guide for operational managers

Annexure C: Guide for focus group discussions Annexure

D: Permission and clearance letters:

- Ethical clearance certificate from the University of Forte Hare Annexure
- Letter of permission to conduct the research from the Department of Health
- Letter of permission to conduct research from O.R. Tambo Health District

Annexure E: Participant consent form (specimen)

ANNEXURE A

INTERVIEW GUIDE: PRIMARY HEALTH CARE FACILITY SUPERVISORS CHALLENGES HINDERING THE IMPLEMENTATION OF QUALITY SUPERVISION IN PRIMARY HEALTH CARE FACILITIES IN OLIVER REGINALD TAMBO DISTRICT, EASTERN CAPE PROVINCE

DATE TIME PLACE

A1 DEMOGRAPHIC DATA

Mark with an X where applicable:

1. Gender: Male Female
2. Age in years: Less than 40, 41 – 55, More than 56
3. Supervisory experience in years: Less than 2 2 to 5 More than 5

A.1 PRACTICES OF FACILITY SUPERVISORS

A.1.1 How many PHC facilities do you supervise? _____

A.1.2 How many kilometres do you travel to get to the furthest facility? _____

A.1.3 How many facilities take you two hours or more on the road to reach? _____

A.1.4 What, apart from distances, causes you to spend time away from PHC facilities? Please explain. _____

_____

A.1.5 How does a lot of time spent on the road affect your supervisory visit?

_____

_____

A.1.6 Were you ever trained on PHC supervision according to the supervision manual?

Answer yes or no. _____

A.1.6.1 If yes, when was your last training? Mark with a cross where applicable:

2 years ago, 3 years ago, More than 3 years ago

A.6.1.2 Was the training of assistance to you? Yes or no. _____

A.6.1.3 if the answer is "yes", please explain. _____

_____

_____

A.1.6.4 If the answer is "no", please explain. _____

_____

A.1.7 Are you able to spend 70% of your time in supervisory work? Answer yes or no._____

A.1.7.1 If the answer is "no", please explain. _____

_____

Mark with an X where applicable:

		Always	Sometimes	Never
A.1.8	Do you use the supervisory assessment tools (red flag and/or regular review) in the PHC facility supervision manual when conducting supervisory visits?			
A.1.9	Do you develop an action plan after each visit based on the findings?			
A1.10	Are you able to follow up on the action plan progress between visits?			
A1.11	Are there other activities that prevent follow-up? on action plans between visits?			
A1.12	Do you review the previous action plan progress on each supervisory visit?			

A1.13

Are you able to facilitate support of your facilities by other stakeholders in order to close the service gaps identified?

Total

A.14 In your experience with PHC facility supervision, what would you say is the root cause of poor implementation of quality supervision?

Answer:_____

_____

_____

A.14.1 How does this root cause affect the practice of quality supervision (i.e. assessment and facilitation) in a PHC facility?

_____

_____

_____

_____

A.14.2 Do you have a solution for the root cause mentioned above? Yes No

A.14.3 If the answer is yes, can you mention three possible solutions to the root cause?

i. _____

_____

_____

ii. _____

_____

iii. _____

_____

_____

A.2 PERCEPTIONS, OPINIONS AND ATTITUDES OF PHC SUPERVISORS

In the next question, please indicate your response with reference to the scale that follows hereunder. The choices of responses are: - 1 = strongly disagree (SD), 2 = disagree (DA),

3 = neither agree, nor disagree, 4= agree (A) and 5= strongly agree (SA).

Mark with an X in the appropriate box:

No.	Question	1	2	3	4	5
A.2.1	There is a relationship between the performance of the facility and the quality of supervision.					
A.2.2	The assessment checklist in the supervision manual when used correctly during a supervisory visit, brings up the most critical issues that threaten quality of health care service delivered in a facility.					
A.2.3	Most of the threats raised during an assessment can be addressed at facility level by the operational manager or person in charge of the facility.					
A.2.4	Threats emanating from the assessment that are above the competence of the PHC facility are easily solved at sub-district level.					
A.2.5	Supervisors have opportunity to present their supervisory findings and action plans to the subdistrict manager and team.					
A.2.6	The sub-district management work as a team to put appropriate interventions in place to address findings from the supervisory visits within the sub-districts in order to improve the quality of health service delivery and health outcomes.					

A.2.7 Supervisory visits are appreciated by the operational manager/person in charge and the staff.

A.2.8 Operational managers follow up on action plans developed during a supervisory visit.

A.2.9 It is easy for a supervisor to conduct on-the-job training for the PHC facility staff and the operational manager.

A.2.10 It is easy to communicate with the PHC facilities between visits.

A.2.11 PHC supervisory work is stressful.

A.2.12 Inability to manage stress may affect the quality of supervision.

A.2.13 Supervisors do not like to read and apply the supervision manual when conducting supervision.

A.2.14 Applying knowledge from the PHC facility supervision manual improves skills in supervision.

A.2.15 Sub-district managers and district managers respond to PHC facility supervisors' reports by mobilising support.

A.2.16 Health programme managers are always willing to listen to the supervisor's report.

A.2.17 Supervisors spend 70% of their work times doing supervisory work in the facilities.

Total

Thank you for your participation in this research study.

Annexure B

INTERVIEW GUIDE: OPERATIONAL MANAGERS

CHALLENGES HINDERING THE IMPLEMENTATION OF QUALITY SUPERVISION IN PRIMARY HEALTH CARE FACILITIES IN OLIVER REGINALD TAMBO DISTRICT, EASTERN CAPE PROVINCE.

DATE

TIME

PLACE

A. DEMOGRAPHIC PROFILE

Mark with an X where appropriate:

1.	Sex	Male	Female	
2.	Age in years	Less than 40	41 – 50	More than 50
3.	Experience as operational/clinic manager in years	Less than 1- 2	3 – 5	More than 5 years

B.1. EXPERIENCE OF OPERATIONAL MANAGERS REGARDING SUPERVISORY VISITS

Your facility has been visited monthly by the clinic supervisor over the last 12 months. Please answer the following questions regarding your experiences of PHC facility supervision:

Mark with an X where appropriate:

No	Question	Always	Sometimes	Never
B1.1	Do you use the supervisory assessment tools (red flag and/or regular review) during PHC facility supervision visits?			
B1.2	Do you develop an action plan after each visit based on the findings?			
B1.3	Are you able to follow up on the action plan progress between visits?			
B1.4	Are you able to communicate with your supervisor between visits when doing follow-up on action plans?			
B1.5	Do you review the previous action plan progress during each supervisory visit?			
B1.6	Do you get feedback on actions that were to be facilitated by the supervisor?			
B1.7	Are you able to feedback to your clinic staff the supervisory findings and plans?			
B1.8	Are you able to facilitate support of your facilities by other stakeholders in order to close the service gaps identified?			
B1.9	Do you use the operational manager's monthly checklist in the supervisory manual to address the gaps in operational management issues?			
B1.10	Do you review the performance of the facility on PHC indicators from the previous month's DHIS during the facility visit?			
	Total /10			

Quality supervision is composed of continuous assessment of gaps in health service delivery and facilitation for closure of the gaps identified during assessment in order to improve the quality of health care rendered and the improvement in health outcomes.

B1.11 In your experience of supervision and observations, what would you say are the main causes of poor performance of a facility, despite the 100% supervision rate (regular monthly supervisory visits?) Name three.

i. _____

_____

ii. _____

_____

iii. _____

B1.11.1 How do these causes affect the quality of supervision?

_____

_____

_____

_____

B1.11.2 Do you know of any solutions to the three main causes mentioned above?

Answer Yes or No _____

B1.11.2.1 if the answer is "yes" please mention three possible solutions below:

i. _____

_____

ii. _____

_____

iii. _____

_____

Thank you for your participation in this research study.

ANNEXURE C

GUIDE: FOCUS GROUP DISCUSSION

I am Mrs. Nontlantla Zamxaka, conducting research on "Factors that hinder the implementation of quality supervision in the O.R. Tambo district, Eastern Cape. I'm the organiser of the group discussion and I will be chairing the discussions. The information form and consent form will be issued to each of you to read and sign. The responses from this discussion will remain anonymous and will not be shared with anyone. Our discussions will be captured by the scribe and recorded by the digital recorder to ensure accurate interpretation of data.

The purpose of quality supervision is to identify in a measurable way the gaps between the current level of quality and the expected level of quality and to address any such gaps. The assessment and facilitation takes place along the input – process - outcome chain (IPO). Despite a 100% facility supervision rate at many primary health care facilities, the level of quality is not improving, as shown by national core standards assessment reports, audit reports, satisfaction surveys and health outcomes reports.

Our discussions will focus on exploring factors that are hindering the implementation of quality supervision in PHC facilities in our context within the O.R. Tambo district. Answers from the following questions will be discussed by the group to generate data. Participants will be given codes to align responses.

C1. What are the difficulties experienced in identifying the service delivery gaps during PHC facility supervision. What causes these difficulties and why?

C2. What are the difficulties experienced in closing the gaps identified along the IPO chain? What causes these difficulties and why?

C3. Where along the IPO chain are the gaps mostly found?

C4. How do the gaps affect the quality of supervision?

C5. How can one address the difficulties experienced in implementing quality supervision?

C6. Why are the gaps in quality supervision currently not being addressed?

Thank you for participation in the focus group discussion.

ANNEXURE D:

PERMISSION AND CLEARANCE LETTERS:

University of Fort Hare
Together in Excellence

ETHICAL CLEARANCE CERTIFICATE

Certificate Reference Number:	MUP061SZAM01
Project title:	**Challenges hindering quality supervision of primary health care facilities in Eastern Cape Province at Oliver Reginald Tambo District.**
Nature of Project:	Masters
Principal Researcher:	Nontlantla Caroline Zamxaka
Supervisor:	Dr W Mupindu
Co-supervisor:	

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.

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

07 March 2016

Eastern Cape Department of Health

Enquiries:	Madoda Xokwe	Tel No:	040 608 0830
Date:	14 March 2016	Fax No:	043642 1409
e-mail address:	zonwabele.merile@echealth.gov.za		

Dear Mrs. NC Zamxaka

Re: Challenges hindering implementation of quality supervision in primary health care facilities in Eastern Cape Province at Oliver Reginald Tambo District (EC_2016RP55_228)

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

SECRETARIAT: EASTERN CAPE HEALTH RESEARCH COMMITTEE

Ikamva eliqaqambileyo!

Province of the
EASTERN CAPE
DEPARTMENT OF HEALTH

DISTRICT MANAGER'S OFFICE

Room 41 • 9th Floor • Botha Sigcau Building • Cnr Owen & Leeds Streets • Mthatha • Eastern Cape

Private Bag X5005 • Mthatha • 5099 • REPUBLIC OF SOUTH AFRICA

Tel: 047 502 9083. Fax +27 (0)47 532 3995 •Website: www.ecdoh.gov.za

Dear Mrs. Zamxaka

Re: Research study Permission request by yourself

Topic: Challenges hindering the implementation of quality supervision of Primary Health Facilities in Eastern Cape Province at O.R Tambo.

Permission is hereby granted for you to conduct the research study in O.R. Tambo district. You are also required to take into consideration the requirements by the Department of Health as detailed in the Provincial letter of approval to conduct this study.

Your compliance in this regard will be appreciated.

The District Manger
O.R. Tambo District

22/03/2016
Date

ANNEXURE E

PARTICIPANT CONSENT FORM

Participant information

CHALLENGES HINDERING THE IMPLEMENTATION OF QUALITY SUPERVISION IN PRIMARY HEALTH CARE FACILITIES IN OLIVER REGINALD TAMBO DISTRICT, EASTERN CAPE PROVINCE

You are invited to participate in a research study conducted by Mrs. Nontlantla Caroline Zamxaka from the Faculty of Science and Agriculture, School of Health Sciences at the University of Fort Hare, East London.

This is a research dissertation in partial fulfilment for a Master of Public Health degree (MPH). You were selected as a possible participant in this study because the research seeks to explore factors that hinder the implementation of quality supervision in primary health care facilities.

PURPOSE OF THE STUDY

The purpose of the study is to investigate the contributing factors concerning the challenges that hinder implementation of quality supervision of primary health care facilities.

PROCEDURES

If you agree to participate in this study, you will be asked to do the following:

- You will be provided with a participant information sheet, written in English, providing information about the research.
- You will be required to sign a written informed consent form for participation in the study.
- You will also be invited to a focus group to discuss the topic under research.
- There will be no payment for your participation.

- You will be provided with a list of questions to answer.
- All the information you share will be kept confidential and anonymous.
- There is no potential risk associated with your participation.
- There are potential benefits from the study as findings will assist both the Department of Health and you to plan evidence-based strategies to improve supervision of facilities.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of a coding system, whereby each participant will be allocated a number code, which will be known only to the researcher. Participants' information and results will be stored in electronic and paper format. All hard copies (paper format) of data will be secured in a locker with lock and key in the researcher's office, while electronic data will be stored on a password-protected computer and network drives. Access will be by the researcher only.

The results of the research will be submitted to the University of Fort Hare as part of a research dissertation. The findings from the research may also be submitted to the OR Tambo district health authorities or may be published in a scientific or academic journal. However, no information through which participants can be identified will be released to any person or agency.

PARTICIPATION AND WITHDRAWAL

Participation in this research is strictly voluntary, and you can decide whether to participate in this study or not. You are also free to stop participating in this research at any time you choose. Should you choose not to participate or to discontinue your participation in the research, there will be no consequences.

IDENTIFICATION OF INVESTIGATORS

Should you have any questions or concerns, please feel free to contact the investigator and supervisor; contacts below:

Principal Investigator: Mrs. Nontlantla Caroline Zamxaka, Eastern Cape Department of Health: District Health Services, Bisho. Contact numbers: 0833781488/ 040 608 1662/82, fax: 040 6098406. Email: nontlantlaz@gmail.com

Supervisor: Dr. Wiseman Mupindu, University of Fort Hare: Department of Health Sciences: Contact details: Wisemanmupindu@gmail.com : Tel: 0732707049

Signature of Participant .....Date: .....

Signature of Researcher.....Date.....

Witnessed: .....Date: .....

PARTICIPANT CONSENT

TITLE OF RESEARCH PROJECT:

CHALLENGES HINDERING THE IMPLEMENTATION OF QUALITY SUPERVISION IN PRIMARY HEALTH CARE FACILITIES IN OLIVER REGINALD TAMBO DISTRICT, EASTERN CAPE PROVINCE

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name .....

Participant's signature .....

Date.....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Name: Mrs. Nontlantla Caroline Zamxaka

Eastern Cape Department of Health

District Health Services

Bisho

Telephone: 040 608 1662/82

Cell: 083 378 148 8

Fax: 040 609 8406