# INVESTIGATING THE ROLES AND FUNCTIONS OF CLINIC SUPERVISORS IN THREE DISTRICTS IN THE EASTERN CAPE PROVINCE

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## Abstract

This research report presents the outcomes of an investigation into the roles and functions of clinics supervisors in three districts in the Eastern Cape Province against the background of health sector reform in the Province.

It describes in some detail the research process of *Participative Action Research*, which the research team undertook, before presenting the main findings and recommendations.

Central among the findings is the fact that clinic supervision is hampered by unresolved governance issues which lead to continued fragmentation of services, unclear roles and lines of accountability, excessive meeting loads and unstable working conditions. The report also concludes that, while clinic supervisors have a great range of skills at their disposal, training and support, particularly in the areas of organizational and human resource management, are an ongoing and urgent requirement.

## Introduction and Background

Health care provision at clinic level is central to the implementation of primary health care in South Africa. While the introduction of a district health system and a PHC approach have been national priorities since 1994, different provinces have had to approach implementation in different ways, depending on their historical legacies.

The Eastern Cape Province inherited from the previous regime a highly fragmented health system, having to integrate the health services and administration of the former Transkei and Ciskei as well as the old RSA. Thus, health service provision (as well as provision of other services) is highly uneven and inequitable in the Eastern Cape, presenting major challenges to the provincial administration.

Clinics are the cornerstone to the new district-based health system. Since 1994 numerous clinics have been built in the Eastern Cape, many of them in remote rural areas, which previously did not have any access to health care facilities. Today, some 650 clinics provide the first level of care to a population of six million. They are expected to render a wide range of services according to the *National Norms and Standards for Clinic Care,* which among other things, stipulate the following:

q "The clinic has at least one member of staff who has completed a recognised PHC course.

q Doctors and other specialised professionals are accessible for consultation, support, and referral and provide periodic visits. ……

q Medicines and supplies

? Suitable medicine room and medicine cupboards that are locked with burglar bars.

? Available electricity, cold and warm water".

Yet, the actual situation in many clinics bears little resemblance with the stipulated standards, as the following excerpt illustrates:

> "It has not rained in Mount Frere in the former Transkei for many months and the rain water tank at the Mntwana clinic has run dry. A truck has brought water to the outlying village of Dangwana and filled up the clinic's tank, but the water comes straight from the river and is too muddy for drinking or for using during procedures such as childbirth. The clinic has also run out of its supply of vaccines, but Sister Nqwaba comes down the road carrying a cooler box filled with new stock on her head. She has caught a taxi and fetched the stock from the hospital in Mount Frere. Unlike the situation a few years ago, the clinic can now get the medicines it needs, but still has very little else in the way of facilities. There is no electricity, even though that was promised three years ago, and there are not even paraffin stoves. A state-of-the-art satellite phone was installed in February but it only worked for the few days following its installation. There is not other form of communication, not even a radio-phone".

While not all clinics operate under such extreme conditions, the above situation is not exceptional, which is particularly true in the former Transkei. Anecdotal evidence describes services being rendered in collapsing rondavels, with no privacy for patients, and an increasing struggle to fill posts in rural clinics.

Under these conditions of remoteness and isolation "clinics in the public sector depend upon personal interaction with supervisory personnel visiting from a higher authority on a regular basis to enable them to improve the quality of services, to solve problems and to introduce new policies, programmes and approaches into clinic primary health care", as the Provincial Policy on Clinic Supervision points out. Both, the Provincial Policy and the National Norms and Standards furthermore stipulate that "each clinic will be supervised by a single, multi-purpose nurse who will be the single liaison between that clinic and higher authority". Tasked to be the go-between between clinics and management at a time of far-reaching change and innovation, clinic supervisors have been given a crucial role in ensuring the successful implementation of primary health care.

Yet, anecdotal evidence and experience has shown that supervision is happening unevenly, with visits often taking place infrequently and not being used most effectively to support quality of service provision in the

clinic.

Such anecdotes and experiences motivated the School of Public Health (SoPH) at the University of the Western Cape (UWC), in collaboration with three health districts in the Eastern Cape Province (Albany, Mount Frere and Umzimkulu) to develop a research project aimed at gaining insight into the status quo of clinic supervision in the selected districts, understanding the factors that hinder effective clinic supervision and making recommendation for improvements. Using a participative action research approach, the team of nine clinic supervisors, one PHC co-ordinator and the research co-ordinator collected data reflecting on their own practice over a period of five months. These data were then jointly analysed and written up. The results of this process are presented here.

## Literature Review

The ultimate aim of the study is to contribute to the improvement of quality of care at clinic level by addressing the supervisory system for clinic-level care. The study thus addresses issues of quality and skills assessments of the supervisory system and supervisors.

Issues of quality and skills assessment are frequently discussed in the literature, as usefully summarised recently by C Woodward . Woodward "describes strategies for improving the performance of health workers", including educational strategies, conferences, guidelines, self-assessments and peer reviews, to name but a few. She emphasises the importance of strategies, which focus on *Quality Improvement rather than Quality Assurance*, thus placing the benefit of continuous progress squarely at the centre of attention. She also makes the case for "involving health workers as key stakeholders in thinking through and developing opportunities for quality improvement".

Woodward describes a range of strategies, which support skills improvement, arguing from a strongly behavioural perspective, with a focus of behaviour changes of individuals and groups. Systemic and contextual issues receive little attention.

Reading through Woodward's bibliography, it is interesting to note, however, that the vast majority of publications are concerned with quality assurance of doctors, physicians and other medical categories. Few titles focus on nurses or allied health personnel who, particularly in developing countries, are the backbone of the health care system.

But closer to home, a small number of mostly unpublished research studies have recently focused on the role of clinic supervisors in assuring quality of care in health clinics.

A study on *The Quality of Supervisor-Provider Interactions in Zimbabwe*[3] , published by the USAID's Quality Assurance Project provides insights into the strengths and weaknesses of district-level supervision. The study employed a range of qualitative methods, including structured observations, logs and checklists as well as interviews, which were then used by the research team to rate supervisors' skills on a scale from 1 to 10. The team found that while supervisors displayed strong technical competencies, they lacked skills of interacting with clinic staff and clients, and did not make adequate use of technical support such as checklists. They emphasised the need for continuous training, particularly in the areas of partnership building and communication with staff and clients. While interesting lessons can be learnt about the strengths and weaknesses of supervisors, the study lacks context and a view of supervision as part of the district health system.

An unpublished study conducted in Uganda in 1997 investigated how best to support health service supervision at clinic level through a range of site visits, workshops, and interviews with key personnel at district and MoH level. The recommendations emanating from the study centre around the need for careful planning of visits, the enhancement of the training function of supervisors, and a focus on making visits meaningful for clinic staff.

Another unpublished study, conducted by NJ Makhanya and NS Gwele in early 2001 evaluated the "Programme of Support and Training for Primary Health Care Co-ordinators" in Kwa-Zulu Natal . The pro-

gramme, commissioned by the Provincial Department of Health in Kwa-Zulu Natal aims at "supporting and mentoring Primary Health Care Co-ordinators (PHCCs) as well as assisting the Regional and District Offices in sustaining an on-going programme of support for the PHC Coordinators". The study examined the processes and outcomes of the training programme through a detailed document review as well as in-depth interviews with a number of PHCCs, facility managers, and facilitators. It found that "the supervisory process has greatly been improved by the training programme, both in terms of the process itself, as well as frequency and duration. It has become more methodological and focussed as well as being collaborative in nature".

All studies emphasise the need for and benefit of ongoing skills development, particularly in areas of management, communication, and human interaction, although only the last study places supervisors and the supervisory process in the context of rapidly changing and often very unstable systems of health care delivery.

All studies adopted qualitative approaches, using different mixes of interviews, focus group discussions, document reviews, checklists etc. to collect data which were then analysed using a range of qualitative (eg. logical and pattern analysis) and quantitative (rating) methods. All studies were conducted by researchers who interacted closely with a range of stakeholders.

## Methodology

The study presented here has adopted a somewhat different approach. While using qualitative methods of data collection and analysis, the research was conducted by 10 clinic supervisors, facilitated and supported by a researcher from the University of the Western Cape.

The study thus falls within the broad category of *participative action research* (PAR) or collaborative inquiry as introduced by Bray and others [5]. It works with Schon's concept of the reflective practitioner, described by Carr and Kemmis (1986: 162) as *"simply a form of self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their practice"*[6] . It is used here in a very practical way, as an approach, which allows clinic supervisors the space to investigate and reflect on their own professional practice in the context of the health care system.

*Participative Action Research and Collaborative Inquiry* are widely used in educational research, but increasingly also in other professional contexts such as agriculture and industry[7] . Both concepts build on traditions of action research, which aimed to "generate knowledge about a social system while simultaneously trying to change it" . A widely used definition of action research is the following one provided by Carr and Kemmis:

> "Action research is a form of self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of a) their own social or educational practices, b) their understanding of these practices, and c) the situations (and institutions) in which these practices are carried out" .

Bowling points out that

> "The emphasis of action research today has shifted from its early emphasis on rational social engineering to a method of community or organisational development by awareness raising, empowerment and collaborative investigation between trained researchers, professionals and lay people, with the help of designated mediators. The revival of interest in action research stems from some disillusionment with the use of positivist methods of evaluation. Action researchers do not treat participants as subjects but empower them to act on their own behalf as active participants in making change" .

*Participative Action Research* has taken these ideas one step further to contend that "the people who participate in the research process become full partners or co-researchers in running the research process itself" . The far-reaching implication is that "the researcher must be willing to relinquish the unilateral control that the traditional researcher has traditionally maintained over the research process"[12] .

*Collaborative Inquiry* has taken this concept one step further yet again by suggesting that those involved in the research process should form a "group of peers". "Members may bring a diverse set of skills and experiences to the group, but these are not viewed as the basis for early differentiation. ….. The initiator … has to quickly concede authority as soon as possible during the inquiry"[13] .

This study is methodologically located somewhere between PAR and Collaborative Inquiry. While it was initiated by an "outside researcher" who brought to the group skills particularly in research and facilitation, all participating clinic supervisors became full members of the group who brought to the team knowledge of and skills in a vast range of topics relating to supervision. How the research process unfolded is described below.

## THE RESEARCH PROCESS

The initial research proposal was developed by the School of Public Health, stating as the project aim that a study should be conducted to

- gain insight into the roles and competencies of clinic supervisors and to make recommendations for potential job restructuring, training and support;
- introduce clinic supervisors to the concept of *Participative Action Research* and *reflective practice* as an approach to professional and personal self-development and capacity-building.

A number of research questions were developed, keeping in mind that these would be adapted and changed in the course of the research process.

The initial proposal was then circulated to health districts in Regions A and E in the Eastern Cape, asking for parties interested in the project to come forward. The choice of districts to which the proposal was circulated was purposeful, in that the targeted districts already had a working relationship with the SoPH, which would facilitate collaboration. Furthermore, Regions A and E represent different historical characteristics, the former being largely situated in the old RSA, the latter in the old Transkei.

Three districts, Albany, Mount Frere and Umzimkulu responded to the call for expression of interest and put forward the names of altogether 10 clinic supervisors.

After funding had been secured from the *Health Systems Trust*, an initial workshop was held with all participants in East London on 9 February 2001. At this workshop the research team, consisting of the SoPH research co-ordinator and ten clinic supervisors, was constituted. Participants were introduced to the research method and the team reviewed the project objectives and research questions. The list of research questions agreed upon reads as follows:

- What is the present status of clinic supervisors in selected districts with regard to job descriptions, training received, workload and job satisfaction?
- To what extent does a match or mis-match exist between job description and job execution?
- How has the role of clinic supervisors evolved so far?
- How does the experience of clinic supervisors relate to formulated national norms and standards for clinic services?
- How does the work of participating clinic supervisors impact on the quality of care in clinics under their supervision?
- What, in stakeholders' perceptions, should be the scope of clinic supervision?
- What, according to documentation and stakeholder perceptions, are the skills required of clinic supervisors?
- What is the skills profile of existing clinic supervisors?

- Where should clinic supervisors best be located?
- What restructuring, training, development, and support are required to improve performance and job satisfaction?

It was emphasised that these questions could be revised at any stage in the research process.

The team also agreed on a range of data collection instruments. They agreed that all supervisors would keep a diary of their daily activities for the duration of the project. Further methods agreed upon included:

- Document analysis of all relevant documents (policy documents, job descriptions);
- Peer interviews among members of the research team;
- Mapping and basic information questionnaire to be completed by the team;
- Interviews with key provincial staff and district managers;
- Workshops with clinic staff and community health committees.

At a second workshop in March team members began the data collection process by filling in a basic information questionnaire (Appendix A), mapping their districts to familiarise themselves and each other with the number of clinics supervised, distances covered, terrain, road conditions, etc., and by interviewing each other. They also reflected on the first few weeks of keeping a diary which all found very time-consuming and sometimes tedious, but also enlightening.

The second workshop was followed by a series of interviews and four workshops with clinic staff and community members in Alexandria, Grahamstown, Mount Ayliff, and Umzimkulu. A fifth workshop, to be held in Mount Frere, had to be cancelled, because the provincial MEC for Health had decided to visit the district during the time when the workshop was to be held, and an alternative date could not be found. The workshops were attended by between 15 (in Mount Ayliff) and 40 (in Grahamstown) clinic staff and community health committee members. All workshops followed the same pattern, although slight adjustments were made after the first workshop (workshop programmes in appendix C). During this workshop we found that most community health committee members were not aware of the existence, role and function of clinic supervisors. We therefore inserted a plenary session into all workshops, which informed particularly community health committee members of the role and function of clinic supervisors.

Team members from the respective districts were present at and had organised the workshops. However, to encourage free and unconstrained discussion, they did not take part in the small group discussions, when staff and community health committee members discussed their experiences and existing skills of clinic supervisors. The workshops were conducted in Xhosa and English, and translation was provided where required. The feedback sessions of all workshops were taped and written up and the tapes transcribed.

Furthermore, the research co-ordinator interviewed the district managers of the respected districts as well as the director in charge of PHC in the provincial health department.

In the following step, all data were jointly analysed in a two-day workshop[14] . After revisiting the research questions, the team established a list of themes and analytic categories, which were then used to interrogate the data. The team worked individually to look at their "own" data (interviews and diaries), as well as in groups to look at clusters of data. We then discussed the emerging themes, turning them into research results as discussed below.

The research co-ordinator then took responsibility for writing the draft research report on the basis of the detailed notes taken during data analysis. The draft was circulated to all team members for comment, before being revised and submitted to funders and stakeholders.

## Results

### The clinic supervisor's role - theory and practice

The Provincial Policy stipulates that clinics should be visited by a supervisor at least once a month for a period of four hours, based on a regular schedule. It furthermore sets out nine "Elements of the supervisory visit" which emphasise a range of administrative and programme reviews as well as responsibility for staff training, coaching and problem-solving.

Against these stipulations we reviewed the day-to-day activities of supervisors on the team, often with quite startling results.

We found that team members spent an average of 22% (ranging from 3% to 46%) of their time in meetings and workshops; between 4% and 55% (20% on average) of their time are spent doing administrative work, while most supervisors only spend about 20% of their time visiting clinics. Everybody agreed that these proportions are unproductive and should be corrected as a matter of urgency.

These figures, which are very rough estimates based on diary entries, found repeated echoes in the comments of clinic staff, who again and again raised as a fundamental problem the fact that supervisors are continuously being called to meetings and workshops, having to cancel scheduled clinic visits. This is considered to be very disruptive for the clinic-supervisor relationship. The team's perception of the reason for this heavy and often un-coordinated meeting load is the slow and stop-start process of integration, decentralisation, demarcation and devolution which brings with it long decision-making processes. These processes are also considered to be the single most important barrier to greater productivity in delivering supervisory services. To mention just two examples:

At the workshop in Mount Ayliff (which presently belongs to Umzimkulu District) a number of participants voiced their frustration over the unresolved status of the area, which had been told it would join Mount Frere after demarcation, but the process had been left hanging. Mount Ayliff residents found that they lacked communication as to their status, and, more importantly, that they found it difficult to gain access to resources or to resolve legal matters. For the clinic supervisor this meant that she was unsure where to attend meetings, who to ask for resources and who to report to.

In Albany district the issue dominating all conversations about service provision is the continued fragmentation of services. At this stage five authorities continue to render services in the district, namely the Department of Health and four local councils, namely the Western District Council, Grahamstown TLC, Port Alfred TLC and Alexandria TLC. All these authorities have their own clinic supervisors who are responsible for vastly different numbers of clinics. While there have been continued efforts to achieve functional integration, these have been hampered by issues of accountability and resources. This has a dual effect on clinic supervisors in the area. Firstly, they work under very different conditions of service, leading to tension and animosity. Secondly, an even and rational distribution of workload is impossible: in one town one clinic is run by the TLC who has its own supervisor, while others are run by the WDC with one supervisor responsible for 15 clinics and mobiles. Yet, the local TLC supervisor has no jurisdiction to make decisions or intervene with WDC clinics, although functional support is often rendered. The often repeated perception of all stakeholders is that of officials blocking the way to integration in the upper echelons of power for political reasons, with little regard for the urgency of improving service delivery, including supervision. And there is agreement at local level that the full integration of services alone would lead to dramatic improvements in productivity and quality of care.

Another factor hindering regularity of clinic visits, particularly in the rural areas, is transport. Paging through the diaries of supervisors working in rural areas one finds numerous statements such as "waiting for transport", "transport not available". One team member in fact concluded her diary with the following statement:

"We have not been able to go out to most of our clinics, especially since the beginning of the year, because of transport problems".

At that stage there was one roadworthy and working vehicle in the district. All others were either unlicensed or broken down, the repair process being held up by long bureaucratic processes.

We found that within our group workload in terms of number of clinics under one supervisor's jurisdiction ranges from one to fifteen. Similarly, distances that have to be covered by supervisors vary dramatically. While some team members have all their clinics within a radius of 5-8 km and largely accessible on tarred roads, others have to travel up to 180 km on poorly maintained dirt roads to get to outlying clinics.

As a result, daily activities also vary substantially, as can be seen from the following responses to a question about daily activities:

> "I am the only one in my office, I don't have any other help, so on a daily basis I will go in, organise the activities for the day. Then I'll go out and do pre-clinic rounds, because the clinics here are in close proximity. When I am doing my clinic rounds I will check, collect the specimens, deliver medicines, receive medicines from the medical depot, pack them, and also arrange the bin cards. What takes most of my time is the drug management, sorting the cards and also receiving the medicines."

> "In the morning I attend to the correspondence on my table because I attend to leave allocation of nurses, problems and everything. Thereafter I check on the clinic ordering of drugs. I have to approve those orders. I look at the stores ordering, I approve that and after that I look to the scheduled clinic visit. I move out and if there are some meetings within the district I attend to that. Then there are some nurses who are coming for some clarity or problem-solving and I attend to that. Finally I move out to the scheduled clinic for the routine supervisory visit".

While both handle a considerable administrative load, taking responsibility for drugs, equipment, leave arrangements, etc., the supervisor in example one sees the four clinics in her jurisdiction virtually every day, often being able to lend a helping hand and watching service delivery very closely. The supervisor in example two often does not get to see one of the 13 clinics she shares with one colleague for many months, as many of them are two and three hours drive away and may become inaccessible after heavy rains.

A third quote highlights the centrality of access to transport in determining supervisory communication:

> "In the morning we meet with all the PHC programme providers in charge of mobiles and the health services. We give each other reports and discuss any problems. We discuss the problem, the transport: how we are going to use it so that each and everybody can use it and then we do allocation of transport. (…)."

Under such circumstances, supervision acquires very different meanings for different supervisors, a diversity which is reflected neither in policies nor in job descriptions. A diversity also, which is experienced as disorientating and disruptive by both clinic staff and supervisors.

Introducing a degree of uniformity into the supervisory system should therefore be a priority. Further to the resolution of governance issues as outlined above, guidelines should also be developed concerning clinic - supervisor ratios, taking into account environmental issues such as distances, road conditions, availability of transport, size and condition of clinics etc.

## Relationship with clinic staff

Clinic staff were asked about their positive and negative experiences with supervision and supervisors.

Given the diversity of contexts, it was quite surprising to find a fair degree of uniformity in their responses.

All stressed the fact that supervisors played a vital role in keeping clinic staff in touch with policy developments, treatment protocols, etc. Virtually all staff seemed to find visits productive and beneficial ***when they happen.*** However, most of them (and all clinic staff situated in rural areas) complained about irregularity and infrequency of visits. In every single workshop staff said that visits were being cancelled on a regular basis as

supervisors had to attend meetings and workshops. In some cases, staff recounted that visits were not being formally cancelled, but that supervisors simply did not turn up for scheduled visits. The unavailability of supervisors also has a negative impact on other aspects of clinic functioning. Most supervisors have responsibility for the ordering and delivery of drugs and equipment, leave arrangements, replacements and other staffing issues. If problems arise and action is required in the absence of supervisors, these remain unresolved, leading to severe bottlenecks in the provision of clinic services such as unavailability of drugs, broken equipment, closure of clinics because of unavailability of staff. Suggestions were made repeatedly that a) more supervisors should be appointed or all posts filled and b) a system of deputy supervisors should be put in place so that clinic staff could have a contact address at all times

Clinic staff furthermore suggested that supervisors could play a vital role in improving relationships between clinics and communities. On a number of occasions episodes were recounted of community members venting their anger about decreasing availability of services against clinic staff, who were themselves suffering from severe staff shortages. Clinic staff felt that supervisors should address communities to explain developments in the health sector.

Training of clinic staff is an aspect of supervision, which did not receive much attention in the workshops. While supervisors' diaries reveal a fair amount of on-the-job coaching, formal training seems to be less common. One area in which formal and ongoing training might be of great benefit is the management of integrated services. On numerous occasions clinic staff mentioned that they struggled with the newly introduced "one-stop service", which they find time consuming and difficult to manage.

Orientation of new staff as well as performance appraisals are other aspects of the supervisory process which, in the opinion of both clinic staff and supervisors, do not receive adequate attention. While the reasons for this were not explicitly spelt out, the perception is that supervisors are continuously involved in crisis management and efforts to keep basic services running, so that little or no time remains for developmental and other activities.

## Relationship with communities

One of the first and most striking lessons we learnt in the workshops with clinic staff and community health committee members was that few of the latter were aware of the existence and role of clinic supervisors. Having adapted our workshop format to include some information sharing on the role of supervisors, we found that community members were quick to grasp the potential role and importance of supervisors in strengthening links between communities and clinics. In most workshops the suggestion was made that clinic supervisors should address community health committees on a regular basis and should involve them in planning clinic services. In Region E in particular it was suggested that clinic supervisors could play a role in reviving the system of volunteers, which has fallen into disuse as volunteers have become demoralised.

Community Health Committee members in Region E did, however also have very critical things to say about the Provincial Policy which they had opportunity to discuss at their workshops. It was argued that while the policy sounded very good and was a best-case scenario, it was also unrealistic, given the circumstances in many clinics. Vivid pictures were painted of lack of water, electricity, and drugs, unavailability of services and poor accommodation. These issues, many community members felt, have to be resolved by provincial government, before supervision can become effective.

## Appointments and job descriptions

A comparative analysis of how team member were appointed and what their job descriptions looked like found that the situation presently is very uneven. We found that only four out of ten supervisors had been formally appointed while the others had been seconded, were acting, or were simply allocated to their position. To quote one supervisor: "I was never appointed. I was just told to go there and fill this position". It is

therefore also not surprising that team members came with a range of previous professional qualifications and experiences: one had been a chief professional nurse (CPN), three had been professional nurses, one had been a mental health co-ordinator, one an area supervisor, one a personnel matron, one came from school health services and one had already been a clinic supervisor in her previous post.

Similarly, an analysis of nine job descriptions showed them to have quite different formats. Only two out of nine reviewed documents shared the same format. This, although the Eastern Cape Department of Health has published a job description format which is applicable throughout the Province. Job descriptions differ dramatically in length and detail, and often cover quite different headings. While most stated objectives and job output, few had clearly stated requirements, job content, and lines of accountability. Only one job description clearly described required key competencies and career paths.

Following the review and taking into account the departmental format, the team developed a sample job description for clinic supervisors, which is attached as appendix C.

## Existing and required skills

In interviews and workshops the question was always asked what skills were required of supervisors and what skills present incumbents already possessed.

The list of required skills always included the following:

- Leadership skills to guide clinics;
- Communication skills
- Problem-solving skills
- Conflict management skills
- Performance management skills
- Financial management skills
- Skilled in all aspects of clinic work
- Ability to manage people
- Information technology skills.

Despite the diversity of previous experience, most team members felt that they were well skilled in most of these areas and able to conduct their work capably. This sentiment was echoed by clinic staff. All stressed, however, that they needed ongoing upgrading, particularly in the areas of financial management, information technology and different aspects of human resource management, including time- and conflict management.

## Training and support

Team members reported that while they had not received formal training as a result of their appointment, they have had access to a great number of training courses, including PHC management courses, labour relations courses, etc. They also have access to many workshops, which deal with specific issues of service implementation, lending a fair amount of technical support. One technical support initiative that was highlighted as exceptional is EQUITY's Clinic Supervisor Manual. While most supervisors only received training on the manual and started to use it in the course of the research project, all praised its usefulness and user -friendliness. Districts have made different provisions to work through its checklists and assess their appropriateness.

An area in which support and training are less frequent, however, is management training. Time-, self-, conflict-, and organisational management have received comparably little attention, a gap that has been identified by supervisors. The closing of this gap will become particularly urgent, when supervisors can begin to move

beyond crisis management in clinics and can support clinic staff in restructuring services, coping with uneven loads, and developing new skills. But even in times of crisis management, particularly skills in communication and conflict management are considered extremely valuable.

While it was stressed that existing training opportunities are appreciated and should be ongoing (a view which is echoed in the literature), it was also pointed out that training presently lacks co-ordination and timetabling. This means that new skills are not acquired in a structured and systematic way, leading to duplication and gaps as well as an ad hoc approach to training.

## Location of clinic supervisors in the district health system

### The Provincial Policy sets out that

"Clinic supervisors may be drawn from the staff of a hospital, from local government, from a municipal health service, from the district office staff, or other authorities. In each case the relationship of the supervisor to other institutions and the district will be defined in writing".

The team felt that while local arrangements might differ, supervisors should be moved as close to facilities as possible to enable close and ongoing supervision with a developmental focus.

The team had lengthy discussions about where best to place supervisors in the district organogram. While there was agreement on many aspects, participants did not want to agree on one organogram, but are recommending two possible solutions, which are appended to the report (appendices D and E).

## Conclusions:

- All stakeholders agreed that the most important contribution to making clinic supervision more effective would be to provide regular and ongoing contact between supervisors and clinics. While this has been recognised and stipulated in the Provincial Policy, the reality in those districts discussed in this study is quite different. Due to a variety of reason which range from uneven distribution of supervisors to understaffing, lack of infrastructural support and time spend in meetings and workshops, clinic supervisors do not get to clinics as often as they should.
- We found that the single most important challenge to clinic supervisors' performance and ability to fulfil their role is the fact that many governance issues remain unresolved. Continued fragmentation of services (in Region A), unfilled posts, unclear lines of accountability have an immediate and negative impact on working conditions and supervisors' ability to render effective service:
    - Very few clinic supervisors are presently formally appointed. Most live in states of permanent insecurity, having been seconded or simply allocated to their present positions.
    - Job descriptions are not uniform and mostly lack clear guidelines as to competencies and job requirements as well as career pathing.
    - In addition, a mismatch often exists between job description and actual functions performed. While the focus should lie on support and supervision of clinics and their staff, most supervisors find themselves occupied with a range of other activities: lending a helping hand rendering clinical care in understaffed clinics; taking full responsibility for provisioning of clinics, including deliveries, collection of faulty equipment, etc.; attending large numbers of unscheduled meetings and workshops throughout the province. This latter fact leads to consistent cancellation of scheduled clinic visits, a fact that was bemoaned by both clinic staff and supervisors,

as it makes planning impossible.

- Clinic supervisors lack infrastructural support. First and foremost among these is access to reliable transport without which clinic supervisors in rural areas cannot begin to fulfil their supervisory function. While not all districts suffer from an actual lack of vehicles, these are often not available, either because they are being used by other staff or because they are broken down or unlicensed. Processes to render vehicles roadworthy are cumbersome and bureaucratic, particularly for outlying districts. Thus, even the supply of dedicated vehicles to supervisors would only solve the situation if ways were found to keep these vehicles on the road through regular and unbureaucratic access to servicing facilities.
- There was agreement among all stakeholders that clinic supervisors have a great range of relevant skills at their disposal, which cannot always be adequately utilised. There was also agreement, however, that these skills need continuous updating and upgrading, particularly in the areas of budgeting, information technology and human resource and organisational management. We found that while training opportunities abound, these often lack coordination, leading to duplication, gaps in provision, and the need for last-minute absences from work. Equity's Supervisory Manual was highlighted as one very helpful instrument in focussing and supporting supervisors' work.

  Over and above ongoing training, supervisors are in need of other forms of ongoing support, such as supervision of their work and regular performance appraisal with a developmental focus. None of the ten supervisors on the research team had received any performance appraisal in the past few years.

## Recommendations

Based on these conclusions the research team resolved to make the following recommendations:

1. Governance and fragmentation issues, in particular the integration of different services rendering health care, should be resolved as speedily as possible, so that the position of clinic supervisors can be regularised and their services be used effectively.
2. The Department of Health should commission a study, which investigates supervisor - clinic ratios considering different environmental contexts (distances, road conditions, clinic size, etc.).
3. All clinic supervisor posts should be formally filled as speedily as possible and through proper procedures. Posts should be advertised and filled according to the requirements stipulated in the appended job description.
4. All authorities should in future implement the provincial format for job descriptions to assist uniformity and clarity of purpose. These job descriptions should also include clear career paths for clinic supervisors.
5. All newly appointed clinic supervisors should have access to a formal induction programme which introduces them in particular to aspects of management, leadership and communication as well as technical aspects of the job. Such an induction programme should be conducted or commissioned by the Provincial Department of Health.
6. Clinic supervisors should have access to continuous upgrading and updating of skills, particularly in the areas of budgeting, information technology, including geographic information systems, communication and human resource and organisational management.
7. The Department of Health should, as a matter of urgency, develop other forms of support for clinic supervisors, such as supervision, developmental performance appraisal as well as improved logistical support (secretarial support, removal of clinic provisioning from supervisory duties, etc.).

8. Communication between Province, districts, and clinic supervisors should be streamlined to avoid proliferation of meetings and workshops, which take supervisors away from their primary responsibilities for clinics for inordinate amounts of time.

## Appendix A

**Clinic Supervisor Research Project**

**Basic Information Questionnaire**

| 1. How many clinics do you supervise? | | | | |
|---|---|---|---|---|
| 2. How long does it take you to get each of these clinics? | In good weather? | In bad weather? | When last did you visit each clinic? | How often have you visited each clinic in the past 12 months? |
| Clinic 1<br>Clinic 2<br>Clinic 3<br>Clinic 4<br>Clinic 5<br>Clinic 6<br>Clinic 7<br>Clinic 8<br>Clinic 9<br>Clinic 10<br>Clinic 11<br>Clinic 12<br>Clinic 13 | | | | |

3. What do you do on a "normal" visit?

4. When were you appointed clinic supervisor?

5. What were you doing before?

6. What training/ support did you receive after being appointed?

7. Where are you situated? (hospital/district office/….)

8. Who do you report to?

## Appendix B

# CLINIC SUPERVISORS RESEARCH PROJECT

### Workshops with Service Providers and Community Members

**Umzimkulu District 14/15 May 2001**

### What we want to achieve with these workshops:

As part of a research project which looks at the problems, challenges and roles of clinic supervisors and clinic supervision we want to gather the opinions and ideas of those working with clinic supervisors with regard to the following questions:

- How has clinic supervision developed over the past seven years?
- What are your positive and negative experiences with clinic supervision and supervisors?
- What, in your view, should clinic supervisors be doing to assist with the rendering of better health care?
- What would you therefore like to see changed?

### Suggested agenda for the day:

10h00 - 10h30 Welcome tea,
Introductions
Background to research project
Why this workshop

10h30 - 11h00 What is the role of clinic supervision and supervisors?
Input from clinic supervisors, facilitator

11h00 - 12h00 Work in groups:

1. Discuss provincial policy
2. What are your best experiences with clinic supervision?
3. What are the biggest problems with clinic supervision at the moment?
4. Describe how you would like to see the clinic supervision system work.

12h00 - 13h00 Report-back from groups and plenary discussion

13h00 - 13h30 Lunch

13h30 - 14h15 Cont. work in groups:

1. What skills should clinic supervisors have?
2. What exists at the moment, what is lacking?

14h15 - 15h00 Report-back from groups and plenary discussion

15h00 Closure and thanks!

## Appendix C

**Sample Job Description for Clinic Supervisor**

Job Information Summary

Job title:

Job holder:

CORE:

Post level:

Minimum requirements:

Qualifications: Registration with SANC as:

- General nurse
- Midwife
- Community nurse
- Administration

Experience: 3years relevant experience

Knowledge, skills, and attitudes:

- Knowledge of relevant legislation
- Knowledge of PHC programmes
- Management skills
- Leadership skills
- Good interpersonal skills
- Ability to work in a fast changing environment
- Valid driver's licence

*Recommendations: Completion of Diploma in Clinical Assessment, Treatment, and Care*

Date of appointment:

Station:

Post report to:

Organogram:

## Job Purpose:

To ensure implementation of PHC programme at clinic level according to National and Provincial policy; and

in doing so contributing to the improvement of the health of the community

## Objectives:

- To empower health care providers to deliver quality care
- To coordinate services within the sub-district
- To allocate and correctly utilise staff
- To support and supervise staff
- To control equipment and material resources including drugs
- To identify areas of research
- To monitor delivery of services
- To promote community involvement

## Job Output

- Training of health care providers in clinical assessment and PHC programmes
- Complete supervisors checklist
- Arrange monthly visits
- Working together with programme managers to ensure implementation of PHC programmes
- Arrange leave roster - allocation list
- Identification of training needs
- Performance management of staff
- Quarterly/annual inventory checks and assist with maintenance and replacements
- Monitor monthly expenditure
- Monitoring of drug availability at clinics monthly
- Monitoring and analysis of monthly submission of PHC stats
- Encourage monthly community meetings
- Take part in research

## Competency Profile:

| Skills | Personal Attributes | Learning Fields | Learning Indicator |
|---|---|---|---|
| o Problem solving<br>o Decision making<br>o Operational planning<br>o Clinical skills<br>o Team leadership<br>o Communication<br>o Interpersonal<br>o Computer<br>o Project management<br>o Self management | o Self starter<br>o Driver<br>o Committed<br>o Healthy | o Management<br>o Clinical-all PHC<br>o Computer (use of DHIS) (Use of programmes)<br>o FMS and budget | o Attendance of workshops<br>o Attendance of conferences<br>o Self reading<br>o Presentation of data<br>o Record of relevant policy documents<br>o Ability to access data on DHIS and produce reports<br>*(Need to be set for each individual and may therefore differ from person to person.)* |

## Career Pathing:

- Promotion to the next higher post: [Application]
- Next higher post: [ ]
- Nature of work in next higher post: [ ]
- Progression to higher salary range: [ ]

Job Description Agreement:

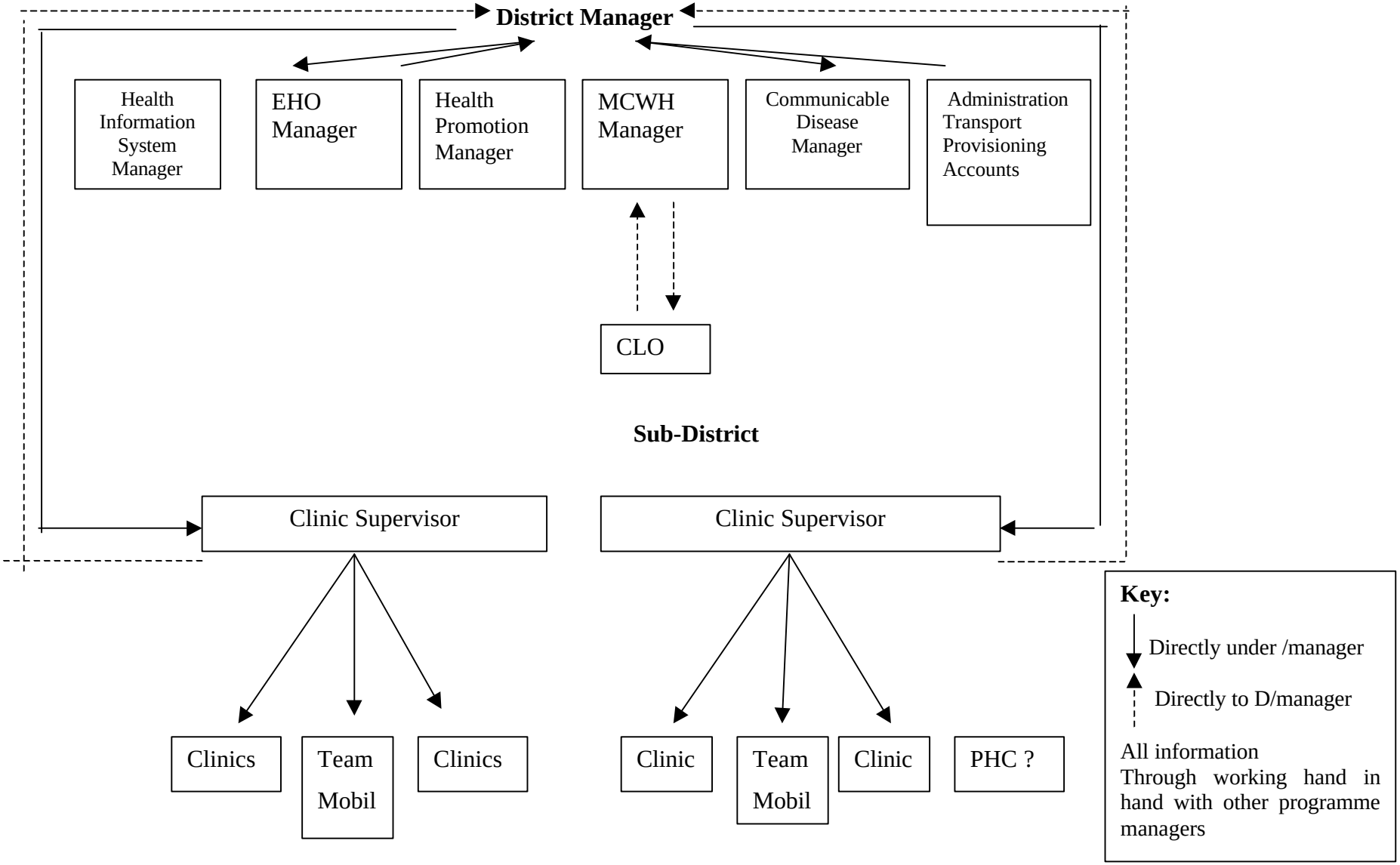
Signature of incumbent:

Signature of supervisor:

Date:

## Appendix D

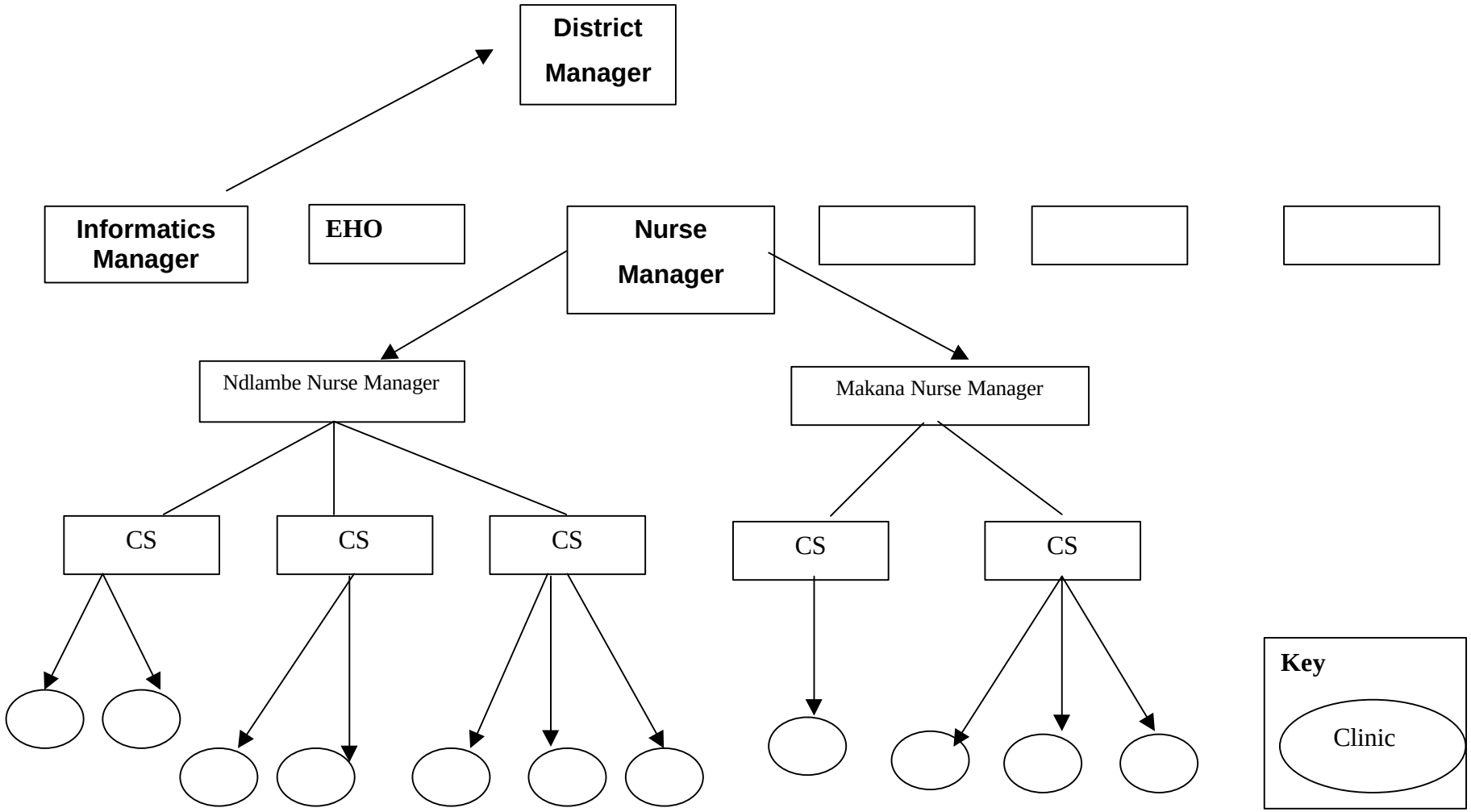
**ORANOGRAM I**
**UMZULU HEALTH DISTRICT**



**APPENDIX E**

**ORGANOGRAM II**

**ALBANY DISTRICT**



## Endnotes

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