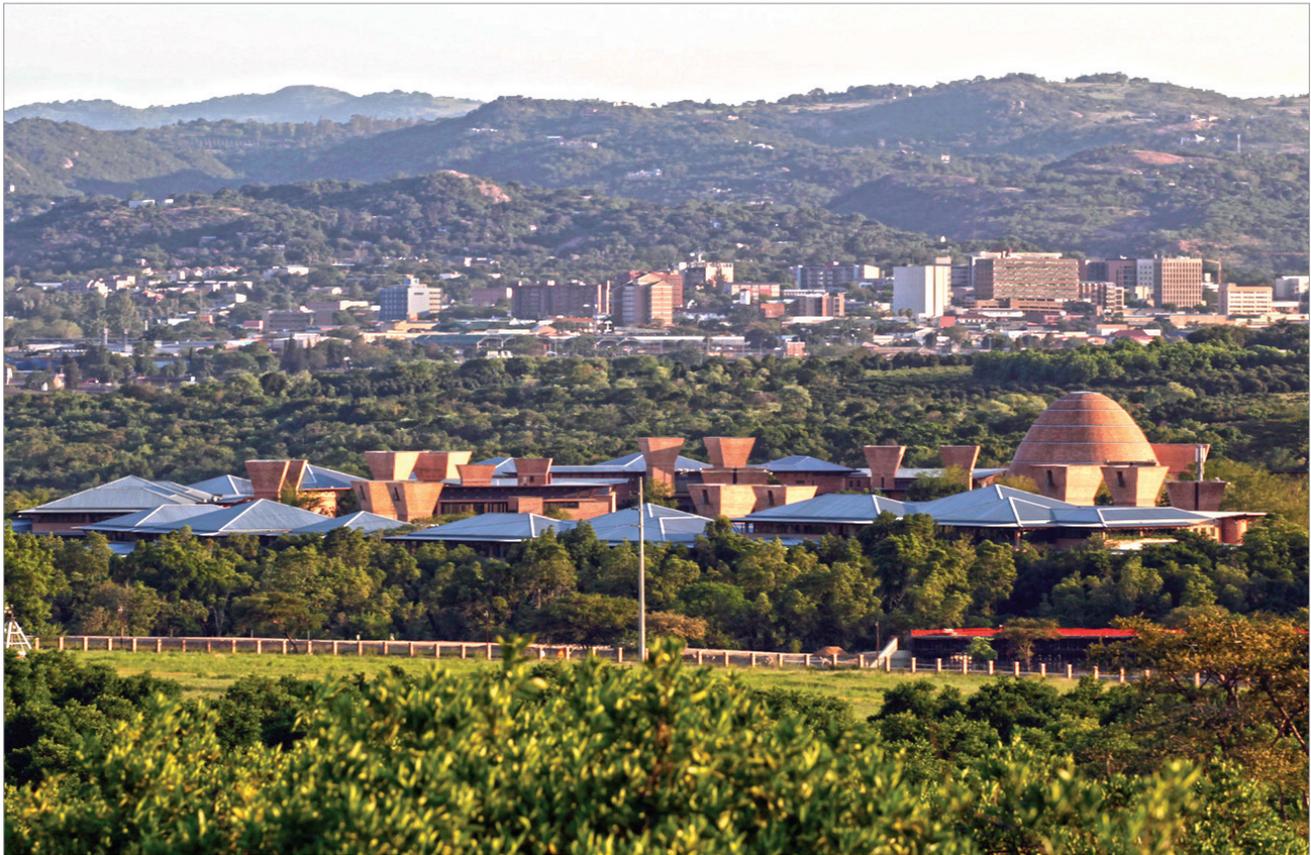




## TECHNICAL REPORT

# Evaluation of Primary Health Care Supervision Services in Mpumalanga Province



**OCTOBER 2014**

This evaluation of Primary Health Care Supervision Services in Mpumalanga Province, South Africa, was prepared by University Research Co., LLC (URC) for review by the Mpumalanga Department of Health and the United States Agency for International Development (USAID) and authored by Donna Jacobs, Freck Dikgale, Tina Maartens, and Sthembiso Mkhonto of URC. The evaluation was conducted under the USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project, which is made possible by the generous support of the American people through USAID. The evaluation was funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR).

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**On the cover:**

Mpumalanga Government Complex, Nelspruit, Mpumalanga, South Africa

TECHNICAL REPORT

# Evaluation of Primary Health Care Supervision Services in Mpumalanga Province

**October 2014**

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# Acronyms and Abbreviations

AOM	Acting Operational Manager
AIDS	Acquired Immune Deficiency Syndrome
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
CHC	Community Health Centre
CHW	Community Health Worker
DHIS	District Health Information System
DM	District Manager
DOH	Department of Health
EDL	Essential Drug List
EH	Ehlanzeni
FOM	Facility Operational Manager
GS	Gert Sibande
HIV	Human Immunodeficiency Virus
IMCI	Integrated Management of Childhood Illness
IPC	Infection Prevention and Control
M&E	Monitoring and Evaluation
NCS	National Core Standards
NK	Nkangala
PHC	Primary Health Care
PHCF	Primary Health Care Facility
PHCS	Primary Health Care Supervisor/s
PHCSM	Primary Health Care Supervision Manual
PMTCT	Prevention of Mother-to-Child HIV Transmission
PN	Professional Nurse
STG	Standard Treatment Guidelines
STI	Sexually Transmitted Infection
TB	Tuberculosis
URC	University Research Co., LLC



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# EXECUTIVE SUMMARY

In 2013, the Mpumalanga Department of Health proposed to evaluate the implementation of primary health care (PHC) supervision services in order to improve the quality of health care in Mpumalanga Province. In South Africa, PHC services are provided by professional nurses, who are often left on their own, with very little or no support at all. In order to alleviate this, PHC supervision was introduced to provide mentorship, regular skills assessment and development and improve the overall quality of care provided by health care staff.

In many regions, PHC supervision has been shown to improve performance of health workers. In fact, clinical supervision is regarded as one of the most important support systems for effective, high quality health care services. To fulfill this role, PHC supervisors need to be adequately trained and provided with the necessary resources, so that their activities extend beyond administrative activities.

This evaluation of PHC supervision services in Mpumalanga Province was done to investigate the role of PHC supervisors, the use of specific supervisory tools and the opinions of District Managers and Facility Operational Managers regarding PHC supervision. The evaluation was conducted in 96 fixed PHC facilities within all three districts in Mpumalanga—Ehlanzeni, Gert Sibande and Nkangala.

This design of the evaluation was both quantitative and qualitative. Specific questionnaires were used to elicit

information from 140 key informants: Facility operational managers (96); PHC Supervisors (41); and District Managers (3). In-depth focus groups were conducted in all three districts and evidence of documentation of PHC supervision was verified by visits to 96 facilities. Data was validated, verified and analysed using MS Excel and STATA software.

Some of the key findings include a large proportion of key staff in 'acting' positions, which can impact PHC supervision implementation and a good understanding of the role of PHC supervision and the supervisory process in most facilities. Over two-thirds of facilities received PHC facility administrative support, training and standard treatment guidelines from their PHC supervisors. However, many facilities indicated a lack of a documented data management system and data validation at facility level, as well as minimal support on review of the referral system. Feedback, follow-up and corrective measures seemed to be in place at all facilities evaluated.

Several detailed recommendations are made in the report, including the need to fill vacant posts and minimise the number of 'acting' positions and implement resilient data management systems at facility level.

As this is the first evaluation of PHC supervision services for the Department of Health, it would be important to conduct a larger, more detailed evaluation involving all PHC facilities—fixed and mobile—in order to generalise the findings.



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# 1. INTRODUCTION

Since 1994, the South African National Department of Health (NDOH) has utilized a district-based model of service delivery to implement Primary Health Care (PHC) services throughout the country. The emphasis of PHC is on improving universal access to high quality health services.<sup>1</sup> In 1997, the White Paper for the Transformation of the Health System in South Africa,<sup>2</sup> released by the NDOH, firmly positioned PHC as the strategic approach for developing a “unified health system capable of delivering quality health care to all South African citizens, efficiently and in a caring environment”.

Several other documents since then have re-affirmed the value of the PHC approach and highlighted the need to provide high quality PHC services. One of the most effective ways of improving the quality of health care in PHC facilities is by means of clinic supervision.<sup>3</sup> The PHC Supervision Manual<sup>4</sup> (PHCSM)—initially developed in 1996 and subsequently revised—aimed to provide supportive supervision to PHC providers and improve the quality of programs being offered at public health facilities. However, implementation of the PHCSM has not been uniform in all 9 provinces. Anecdotal evidence indicates varying degrees of implementation across the 52 districts, with serious inter- and intra-provincial differences. One of the most pertinent and worrying signs is the declining quality of care being provided at PHC facilities.

In 2013, the Mpumalanga Provincial DOH, in consultation with members of the M&E forum, including PEPFAR-funded partners and various stakeholders, identified the need to conduct research on the PHC services provided within the province. Led by the Mpumalanga Premier’s Office and funded by USAID through the Applying Science to Strengthen and Improve Systems (ASSIST) Project, a study was conducted to evaluate the implementation of PHC supervision in all 3 districts (Ehlanzeni, Gert Sibande, Nkangala), identify the challenges of PHC supervision and review the effectiveness and efficiency of primary health care service delivery.

This report serves to detail the findings of the evaluation, highlight successes, map out challenges and provide recommendations for improvement.

## 1.1 Background

The South African NDOH vision envisages ‘A long and healthy life for all South Africans’ through its mission is ‘To improve the health status through the prevention of illnesses and the promotion of healthy lifestyles and consistently to improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability’.

Primary Health Care is the main strategy for developing and promoting the health of our communities, using the District Health System as the vehicle for facilitating its implementation. The services to be rendered to each community must necessarily be based on their needs, acceptable to them and delivered in a manner that is accountable to them and with their full participation.

In order to attain the vision and mission of the NDOH, an effective and well-functioning health system is essential. South Africa has policies and guidelines that are on par with the best policies and guidelines in the world. Yet the implementation of policies and guidelines within a milieu of high disease burden and limited resources has been challenging for the country.

PHC supervision is a critical element of management and provision of health services. Supervision needs to be a priority within the health system if quality of services is to be improved and sustained. A supervisor needs to have expert knowledge, skills and experience within the primary health care field as well as managerial, mentorship and leadership skills.

The supervisor needs to establish an enabling environment for the provision of quality services by ensuring that the resources are in place to provide technically correct care:

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<sup>1</sup> World Health Organisation. 1978. Primary Health Care. Report of the International Conference on Primary Health Care. Alma-Ata, USSR. 6-12 September 1978. Available at: <http://whqlibdoc.who.int/publications/9241800011.pdf>.

<sup>2</sup> Government of the Republic of South Africa. 1997. White Paper for the Transformation of the Health System in South Africa. Available at: [http://www.gov.za/sites/www.gov.za/files/17910\\_gen667\\_0.pdf](http://www.gov.za/sites/www.gov.za/files/17910_gen667_0.pdf).

<sup>3</sup> Tarimo E. 1991. Towards a health district: Organizing and managing district health systems based on primary health care. Geneva: World Health Organisation. Available at: <http://apps.who.int/iris/handle/10665/40785>.

<sup>4</sup> Department of Health, Republic of South Africa. 2009. Primary Health Care Supervision Manual. Published by the National Department of Health Quality Assurance Directorate. Available at: [http://www.inpracticeafrica.com/~media/Guidelines/SA\\_NDOH\\_Primary\\_Supervision.pdf](http://www.inpracticeafrica.com/~media/Guidelines/SA_NDOH_Primary_Supervision.pdf).

- Adequate numbers of staff with appropriate knowledge and skills
- Drugs, clinical supplies and equipment
- Procedures, guidelines, norms and standards, including ethical guidelines
- A maintained infrastructure
- Services available at adequately convenient hours with enough staff
- Respect from all staff and consideration for privacy and confidentiality

The National Primary Health Care Supervision Manual serves to guide primary health care facility supervision.

## Elements of a supervisory visit

The PHC supervisor (PHCS) creates a vital link between service management and service delivery in PHC facilities. In order to sustain this linkage, the PHCS needs to focus on a number of key areas during an on-site clinic visit. These seven areas are described in Table 1 below.

## Supervision process

The supervision process consists of five steps:

- I. Regular review of PHC facility performance
- II. In-depth programme review
- III. Problem-solving discussions and improvement planning
- IV. Training
- V. Review of previous actions taken since the last supervision visit and new actions to follow

In order for a supervisor to supervise facilities effectively, the supervisor should have:

- Knowledge, skills and experience
- Sufficient time to supervise
- Transport to visit facilities
- Resources for communication and administration

The selection of suitable supervisors is critical to the success of supervision in a province. Supervisors should be selected, not only on the basis of technical expertise, but also on leadership and mentorship abilities.

## 1.2 Objectives of the evaluation

The evaluation of PHC supervision was conducted in Mpumalanga Province to gain insights into existing supervisory practices and assist in the development of improved supportive services. The specific objectives were:

- To describe the implementation of PHC supervisory services in Mpumalanga
- To identify gaps for improvement in the existing PHC supervisory practices
- To review the effectiveness and efficiency of PHC service delivery

**Table 1: Elements of supervisory visits**

No.	Elements	Description
i.	<b>In-depth Programme Review</b>	During the course of the year the Primary Health Care Facility Supervisor will conduct in-depth reviews of all important health programmes. The correct application of standard treatment guidelines (STGs) and use of the approved list of essential medicines/medicines is of great importance to ensure high quality care. The Primary Health Care Facility Supervisor will concentrate on the correct use of STGs by PHC facility health care personnel to ensure that PHC facility health care personnel will diagnose correctly, treat their patients with the correct medicines, give the correct non-medicine treatment where appropriate and refer patients in an appropriate and timely way for higher level care when necessary, thus reinforcing correct practice and ensuring adherence to established standards.
ii.	<b>Problem Solving</b>	Solving problems related to all aspects of the PHC facility is an integral part of the supervisory process. The PHC facility supervisor should engage with PHC facility health care personnel regarding any problems which are being experienced. Many problems can be dealt with on the spot at the PHC facility whilst others will have to be taken by the supervisor to the District or other responsible areas. A note will be made of problems requiring solutions at a higher level and actions taken will be reviewed at the subsequent PHC facility supervisor visit. The PHC facility supervisor must contact relevant authorities on behalf of the PHC facility to try and address the identified problems.
iii.	<b>Information System Review</b>	A functioning PHC information system is essential for the effective management of District Health Services. The PHC facility supervisor plays a very important role in ensuring the accuracy and validity of the information system, such as ensuring the proper use of the PHC facility registers, the correct completion of the monthly PHC report, the correct graphing of important data and the use of data for health service planning and monitoring accomplishments at the PHC facility level.
iv.	<b>Referral System Review</b>	Dealing with referral problems is an important element of the supervisory visit. Any problems with referrals, with regard to both patient movement as well as communication between PHC facilities and higher levels, will be investigated and facilitated.
v.	<b>PHC Facility Administration</b>	The primary health care facility supervisor, in collaboration with the PHC facility manager, should review certain administrative aspects related to the PHC facility. This would include health care personnel matters, financial matters, infrastructural aspects such as the condition of the building, water supplies, electricity, grounds, equipment, supplies as well as regulatory and legal issues (for example, OHS Act requirements, collection of vital statistics).
vi.	<b>Community Involvement Review</b>	The PHC facility supervisor will enquire about issues related to community involvement during each visit. Regularity and participation of PHC facility health care personnel in PHC facility committee meetings will be assured. Concerns of the PHC facility committee which should be brought to the attention of the District Management and any community problems that need urgent attention (such as malnutrition, disease outbreaks) will be noted. The PHC facility supervisor will also encourage PHC facility health care personnel to plan and conduct specific community outreach activities on a regular basis.
vii.	<b>Staff Support</b>	The needs of PHC facility staff should be identified and attended to by the supervisor. Such needs could include, for example, the need for additional staffing, or planning for study leaves. Staff should also be updated, trained and coached to perform better. There should be educational sessions at every visit to address specific needs of the staff.

Source: Primary Health Care Supervision Manual.

## 2. METHODOLOGY

### 2.1 Evaluation coverage

The evaluation of the PHC supervision study covered primary health care facilities in all the districts of Mpumalanga Province. Five of the seven elements of supervisory visits described in Table 1 were addressed in the evaluation. Table 2 shows the evaluation coverage in detail.

**Table 2: Evaluation coverage**

No.	Criteria	List
1	<b>District Name</b>	<ol style="list-style-type: none"> <li>1. Ehlanzeni (EH)</li> <li>2. Nkangala (NK)</li> <li>3. Gert Sibande (GS)</li> </ol>
2	<b>Type of health facility</b>	<ol style="list-style-type: none"> <li>1. Community Health Centres (CHCs)</li> <li>2. Clinics</li> </ol>
3	<b>Elements of the PHC supervision visits</b> <i>(addressing 5 of the 7 elements of a supervisory visit)</i>	<ol style="list-style-type: none"> <li>1. PHC facility administration</li> <li>2. Staff support</li> <li>3. In-depth programme review</li> <li>4. Information systems review</li> <li>5. Referral system review</li> </ol>

### 2.2 Evaluation design

The evaluation used a variety of methods to collect the relevant information. The structure of the evaluation included both quantitative and qualitative interviews with key informants at the facilities and district level. Table 3 details the evaluation design.

**Table 3: Evaluation design**

A: Facility level – 96 facilities sampled	B: Above facility level
1. <b>Individual interviews:</b> A total of 96 Facility Operational Managers (FOMs) were interviewed.	1. <b>Individual interviews:</b> Three District Managers were interviewed.
2. <b>Observations:</b> The availability of specific programme (TB, HIV/AIDS, STI, TB-HIV, IMCI, PMTCT, IPC, and EDL) guides and protocols (Pharmacy & Information Management) was verified	2. <b>Questionnaires:</b> Completed responses to the questionnaire were received from 41 PHC Supervisors.
3. <b>Documentation:</b> PHC monthly supervision tools (red flag & regular review list) were reviewed.	3. <b>Focus group interviews:</b> A total of three focus group discussions were held per district with a total of 41 PHC Supervisors.

## 2.3 Sample size

A total of 96 PHC facilities were covered (79 clinics and 17 CHCs), which is equivalent to 30% of the total PHC facilities in the province. The sample size was stratified proportional to the number of PHC facilities in each district, as shown in Table 4.

**Table 4: Sample size**

District	Clinics	CHCs	Total
Nkangala	23	6	29
Ehlanzeni	37	5	42
Gert Sibande	19	6	25
<b>Total</b>	<b>79</b>	<b>17</b>	<b>96</b>

## 2.4 Sampling procedure

A systematic probability sampling was used and stratified by district and type of facilities on the basis of proportionate distribution of facilities in the province. The sampling frame comprised all public health facilities listed in the Mpumalanga Provincial DHIS data sets; these were confirmed by both District Information and PHC District Managers prior to the study.

## 2.5 Data collection tools

A total of four questionnaires, using both open- and closed-ended questions were used for different key informants. Generally, the structure of the questionnaire included questions around knowledge, opinions, behaviour and attributes in relation to PHC supervision services.

The questionnaires can be found in Annex A. Prior to data collection, the questionnaires were pretested and then amended according to the pre-test results. All questionnaires were administered and transcribed by a trained data collection team to maintain consistency and ensure the quality of data.

## 2.6 Ethical considerations

The need to undertake the specific programme evaluation formed part of the strategic objective for Mpumalanga Department of Health. The study was incorporated as part of the evaluation agenda targeted by the province for implementation in 2013.

The questionnaire responses were anonymous to ensure confidentiality for all participants. Informed consent was obtained from every respondent and focus group participant. Any identifying details, such as names and initials recorded on the questionnaire, were also removed during data analysis to protect anonymity.

## 2.7 Data analysis

The data was entered into an Excel spreadsheet and analysed by district as well as by type of health facilities when further analysis was necessary. The comparative frequencies and statistical significance levels were computed using STATA version 14 with outputs tabulated and graphed accordingly. All the qualitative responses were also coded based on common and distinctive factors identified.

## 2.8 Constraints and limitations

- The findings depended mainly on the facilities sampled, and other factors associated with non-sampled sites may be unknown.
- There may be a similar situation with PHC Supervisors, since the study couldn't confirm if all the expected supervisors attended the focus group discussions.
- Limited time and resources limited the scope of the evaluation.
- Poor responses to some key questions may also have introduced some biases into the study findings.
- Limited knowledge of some key informants due to limited duration in their current position/role is another source of possible bias.
- It should be recognised that when the study was conducted, there was ongoing PHC supervision training in the province which may have affected the responses.

## 3. RESULTS

### 3.1 Participant characteristics

The PHC Supervisors, Programme Managers and Facility Managers supported by in-service training are the drivers of the supervisory system. Participants were asked about educational background, work experience and specific trainings received to support their work. Table 5 summarises the characteristics of the respondents.

#### *Facility level:*

- A total of 96 participants were interviewed. More than two-thirds of the participants (72.0% GS; 66.7% EH and 55.2% NK) held FOM positions, and the remaining one-third—higher in NK at 44.8%—were “acting” Facility Managers.
- The majority of the participants (75.8% on average) reported to have more than 10 years working experience as Professional Nurses.
- In terms of training received, the profiles of participants were quite similar, with fewer FOMs trained in NK District as compared to other districts. On average, more than two-thirds (73.8% EH, 64.0% GS and 58.6% NK) of facility managers received training on drug management. On average, almost half of the FOMs were trained on quality assurance (54.8% EH, 52.0% GS and 55.2% NK) and on management administration (69.0% EH, 40.0% GS and 37.9% NK), and about 40% (48.0% GS, 45.2% EH and 41.4% NK) on information or data management.
- Almost all of the FOMs interviewed were performing both clinical and management duties.

#### *Above facility level:*

- A total of 41 PHC Supervisors participated in in-depth focus group discussions and completed the questionnaires.
- In contrast to FOMs, the majority of the PHC Supervisors (57.1% GS, 56.3% EH and 55.6% NK) were “acting” in their positions.
- On average, the PHC Supervisors have been supervising the current allocated facilities for almost 4 years.
- About half (57.1% GS and 50% EH and NK) of the PHC Supervisors felt sufficiently trained in conducting PHC supervision and using the supervisory tools.
- In addition, all three District Managers were interviewed. Of the three, two were newly appointed to the role (EH & GS), while the NK District Manager had been in his position for 6.8 years.

### 3.2 The supervisory process

#### 3.2.1 Understanding the core task of PHC supervision

The PHC Supervisors and District Managers were also asked about their basic roles and responsibilities within the PHC supervisory system.

- In general, the PHC Supervisors mentioned that they provide guidance and supervision to the PHC staff, monitor and evaluate service delivery as well as liaise with the district programme coordinators.
- The District Managers indicated that they provide leadership, support, coaching and planning for the overall management of the PHC programme within their district. This includes ensuring that PHC Supervisors are skilled and updated in order to function effectively.
- In order to ensure that supported facilities achieve service targets, the PHC Supervisors indicated that they discuss and share new/updated information during the supervisory visits and quarterly review meetings with PHC staff. It is during these sessions that facility performance indicators are reviewed and improvement plans are developed to address any challenges likely to alter programme targets.

#### 3.2.2 Number of facilities, frequency and duration of visits

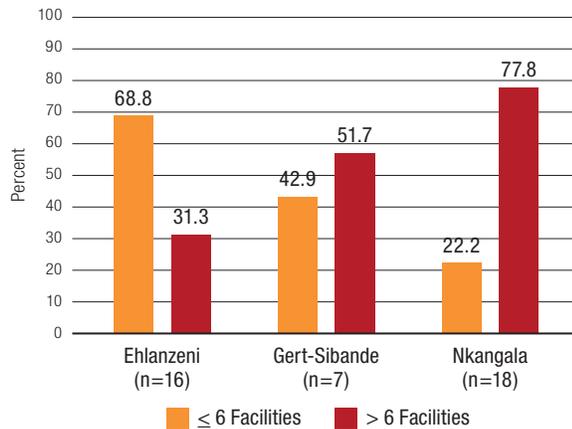
As indicated in the Mpumalanga DOH policy guidelines for PHC facility supervision, PHC facility supervision should be done at least once a month for a minimum of 4 hours per visit. It is noted that each PHC Supervisor shall be responsible for the supervision of a minimum of 4 and not more than 6 PHC facilities.

#### *Number of facilities per PHC Supervisor:*

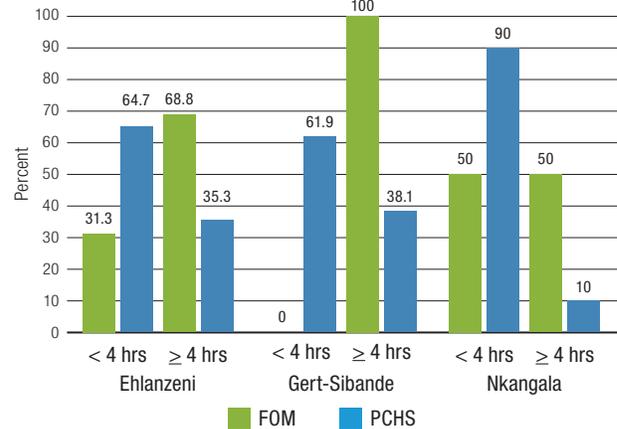
The PHCS were asked about the number of facilities allocated for supervision. It was found that:

- The number of facilities supervised monthly ranged from 2 to 72, with an average of 5 clinics per Supervisor in Ehlanzeni and 8 clinics per Supervisor in Gert Sibande and Nkangala. In EH District, more than two-thirds (68.8%) of PHC Supervisors were responsible for supervising 6 PHC facilities, while in NK District, the majority of PHC Supervisors (77.8%) were supervising more than 6 PHC facilities (see Figure 1).

**Figure 1: Facility workload of PHC Supervisors**



**Figure 2: Duration of supervisory visits**



*Duration and frequency of visits:*

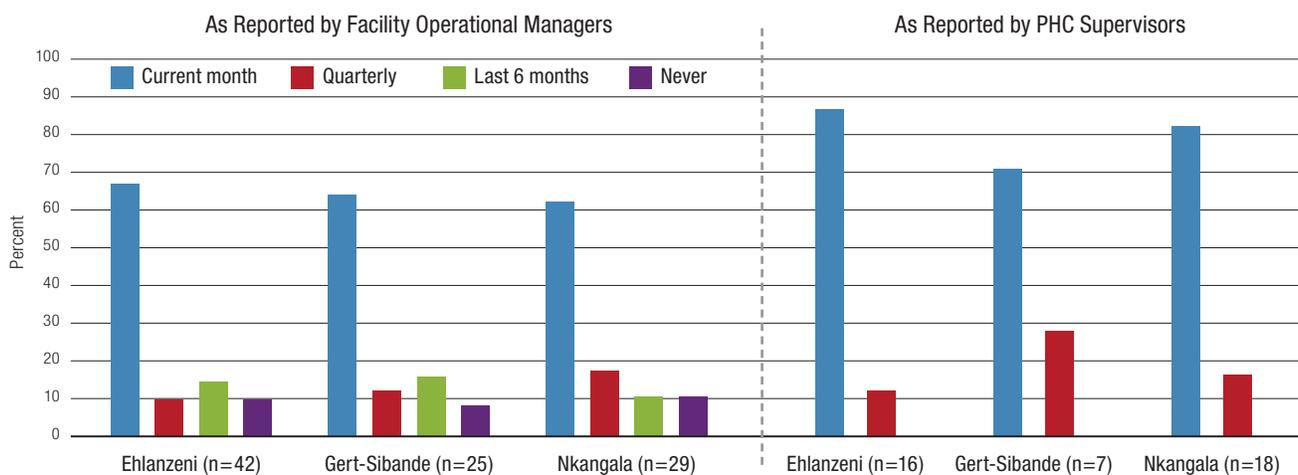
Both PHC Supervisors and FOMs were asked about how often they performed or received PHC supervision visits as well as the time spent per supervision visit. The supervisory tools for the last 6 months were also reviewed to determine the frequency of support visits. In addition, the indicator on supervision rate from the 2013 DHIS dataset was also examined for each district. It was found that:

- The self-reported time spent on supervisory visits seems to differ significantly ( $p > 0.05$ ) between FOMs and PHC Supervisors. The majority of FOMs (100% GS, 68.8% EH and 50.0% NK) reported that supervisors were spending more than 4 hours per facility conducting PHC supervision. However when PHC Supervisors were asked about the length of time spent per facility, the majority of them (61.9% GS, 64.7% EH and 90.0% NK) indicated that they spent less than 4 hours per supervision visit (see Figure 2).
- Approximately one third of FOMs (66.7% EH, 64% GS and 62.1% NK) reported that they received supervision visits regularly and that the last time of supervision was during

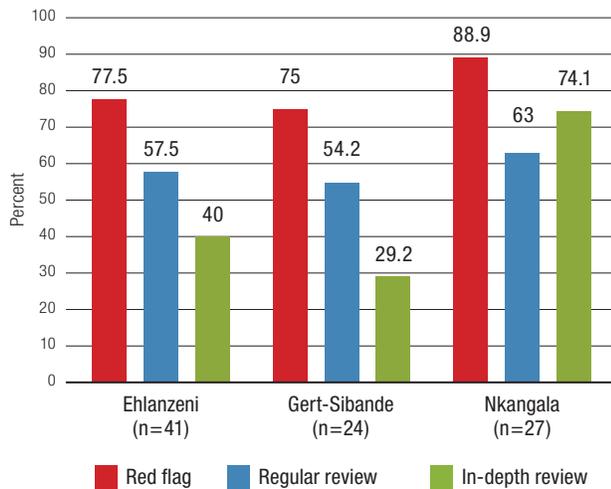
the current month as the evaluation study. Furthermore, about 9% of FOMs (10.3% NK, 9.5% EH and 8% GS) also reported that they never received any PHC supervision visits at their facilities (see Figure 3).

- In contrast, more than one third of PHC Supervisors (87.5% EH, 83.3% NK and 71.4% GS) reported that they did PHC supervision visits regularly (on monthly basis), and the remainder (28.6% GS, 16.7% NK and 12.5% EH) on a quarterly basis (Figure 3). Based on the results of the focus group discussion, PHC Supervisors indicated that they missed visits due to commitments (e.g., meetings and trainings) as well as the unavailability of resources (mainly transport).
- In order to verify the reports by FOMs and PHC Supervisors, the assessment team also reviewed the facility PHC records for the last 6 months. These showed that more than half of the facilities in NK (69.2%) and GS (57.2%) received supervision on a monthly basis. In EH, under half (40.5%) of the facilities assessed had evidence of monthly supervision visits.

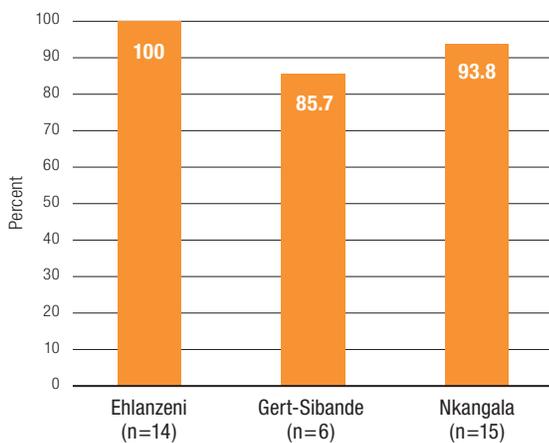
**Figure 3: Frequency of supervisory visits (as reported by PHC Supervisors and FOMs)**



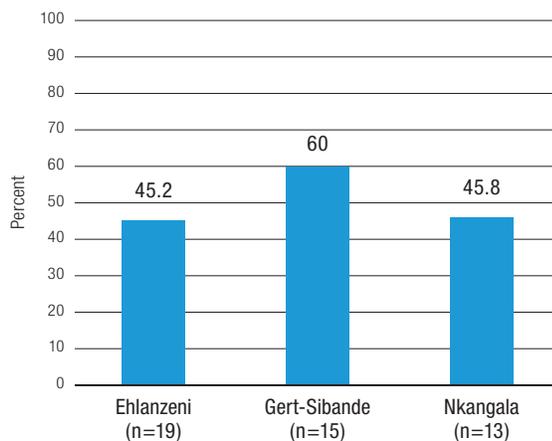
**Figure 4: Use of tools by supervisors during PHC supervisory visits**



**Figure 5: Percentage of PHC Supervisors who reported improvements through use of supervisory tools**



**Figure 6: Percentage of FOMs reporting that the PHC Supervisor compares the registers with monthly data reports during supervision visits**



### 3.3 Tools used during PHC supervisory visits

Use of a supervisory tool such as a checklist (red flag and regular review) helps to ensure that all key areas are covered during PHC supervision.

The majority of PHC Supervisors use the red flag and regular review supervisory tools: 77.5% EH, 75% GS and 88.9% NK of PHC Supervisors reported using the “red-flag” tool, and 57.5% EH, 54.2% GS and 63% NK PHC Supervisors reported use of the “regular review” checklist during a PHC supervisory visit (Figure 4). The highest reported usage of both “red flag” and “regular review” tools was in Nkangala District.

Almost all PHC Supervisors (> 95%) in all districts said they used the PHC supervisory manual as a guide to facilitate supervision activities. The majority of PHC Supervisors (100% EH, 85.7% GS and 93.8% NK) reported that the current supervisory tools had improved their ability to provide supervision and track improvements (see Figure 5).

### 3.4 Elements of PHC supervision evaluated

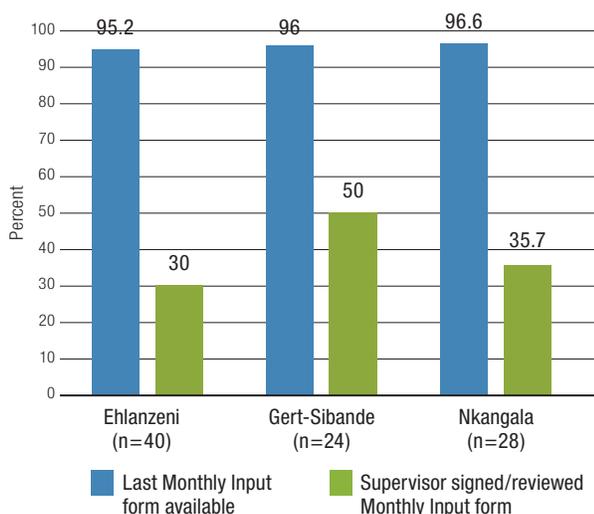
#### 3.4.1 Information system review

The PHC facility Supervisor plays a very important role in ensuring the accuracy and validity of the information system, such as ensuring the proper use of the PHC facility registers, the correct completion of the monthly PHC report, the correct analysis and graphing of important data and the use of data for health service planning and monitoring accomplishments at the PHC facility level. The supervisor also has responsibility to spearhead and facilitate monthly data reviews at their allocated facilities.

The key findings following the information systems review were:

- Fewer FOMs in EH (42.2%) and NK (45.8%) districts than in GS (60%) reported that the PHC Supervisor compares programmatic registers with facility monthly data input reports during supervisory visits (see Figure 6).
- Checking the availability of the last month’s input form, it was found that in almost all facilities evaluated (96.6% NK, 96% GS and 95.2% EH), the last month’s input form was available. However, it was also found that only in a minority of facilities in EH (30%), NK (35.7%) and GS (50%) does the PHC Supervisor sign-off on or review the facility monthly input form, as reported by FOMs (see Figure 7).
- The majority of FOMs in NK (60.7%) reported having evidence that their data was validated using a set of

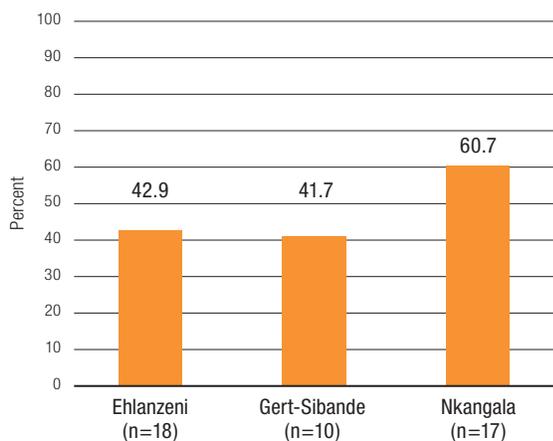
**Figure 7: Proportion of PHC facilities with last monthly data input form available and signed/reviewed by the PHC Supervisor**



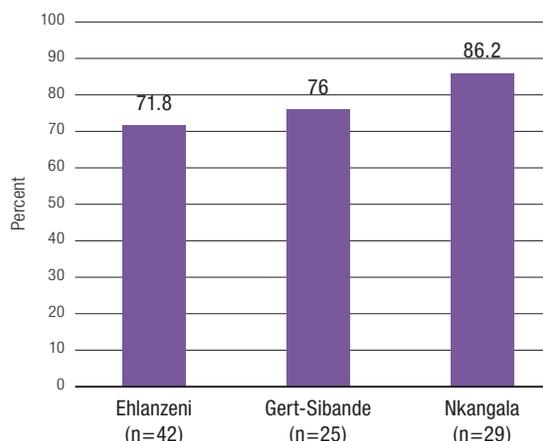
validation rules, as indicated in the PHC supervisory manual or guided by DHIS policy for PHC facilities (see Figure 8). This was not the case in the other two districts, where less than half of the FOMs (EH 42.9% and GS 41.7%) had evidence of data validation.

- In order to explore the competence of the health care personnel with regards to the use of information, evidence of visual display of data in the form of graphs was assessed. It was found that in the majority of the facilities in NK (86.2%), GS (76%) and EH (71.8%), data was analysed and displayed in graphs (see Figure 9). However, disappointingly, in the majority of these facilities (> 70%) in all 3 districts, the graphs were out-of-date (in most instances by over 12 months). When FOMs were asked to provide reasons for this, they indicated that the facilities were awaiting updated information from the sub-district.

**Figure 8: Percentage of facilities with evidence of data validation**



**Figure 9: Percentage of facilities with data displayed in graphs**



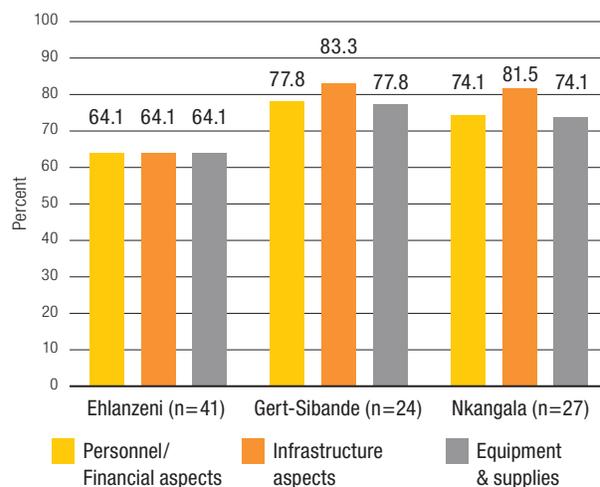
### 3.4.2 PHC facility administration

The PHC facility supervisor, in collaboration with the PHC facility manager, should review certain administrative aspects related to the PHC facility. This would include health care personnel matters, financial matters, infrastructural aspects, such as the condition of the building, water supplies, electricity, grounds, equipment, supplies, as well as regulatory and legal issues (for example, OHS Act requirements, collection of vital statistics).

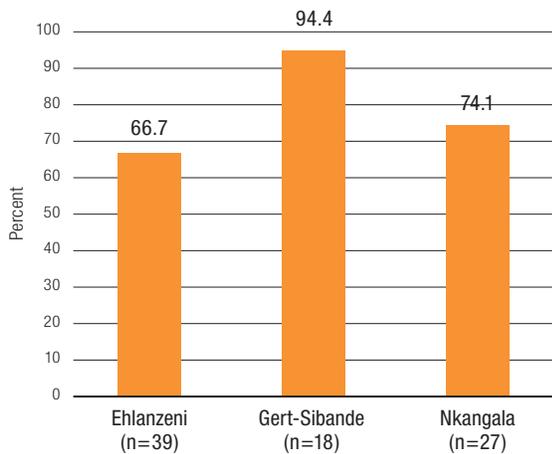
The key findings following the information systems review were:

- Approximately two thirds of the facilities (> 64%) evaluated in all the districts reported having evidence that PHC administrative aspects, such as personnel/financial matters and infrastructural aspects, including equipment and supplies, are being reviewed during the supervisory visits (see Figure 10).

**Figure 10: Percentage of facilities with review of PHC facility administration**



**Figure 11: Percentage of facilities where corrective action after PHC supervision was noted**



- Observing the previous supervisory tools or report, it was found that the corrective action plan (including follow-up) on administration aspects review was completed by PHC Supervisors (see Figure 11) in over two thirds of facilities (66.7% EH, 94.4% GS and 74.1% NK).

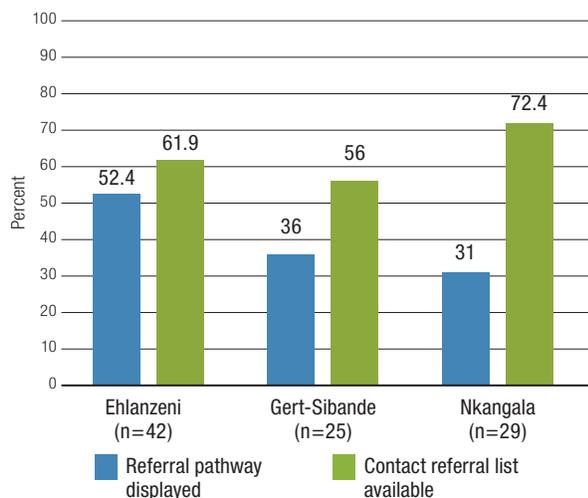
### 3.4.3 Referral system review

The PHC Facility Supervisor is responsible for smooth implementation of the referral system. Dealing with referral problems is an important element of the supervisory visit. Any problems with referrals, with regard to both patient movement as well as communication between PHC facilities and higher levels, should be investigated and facilitated.

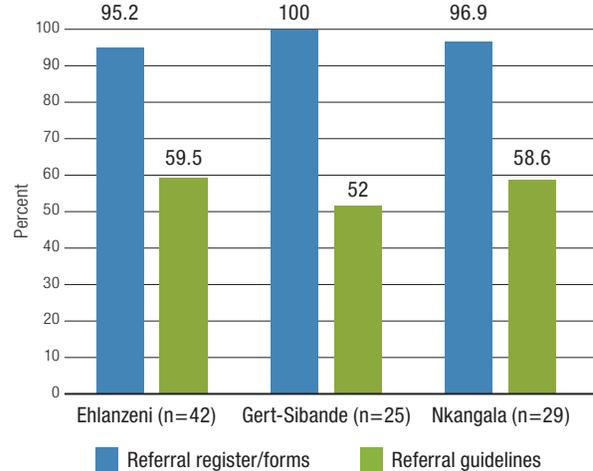
The key findings about referral system reviews were:

- In less than half of all facilities (52.4% EH, 36% GS and 31% NK), was the patient referral pathway visibly

**Figure 12: Percentage of facilities with appropriate referral information**



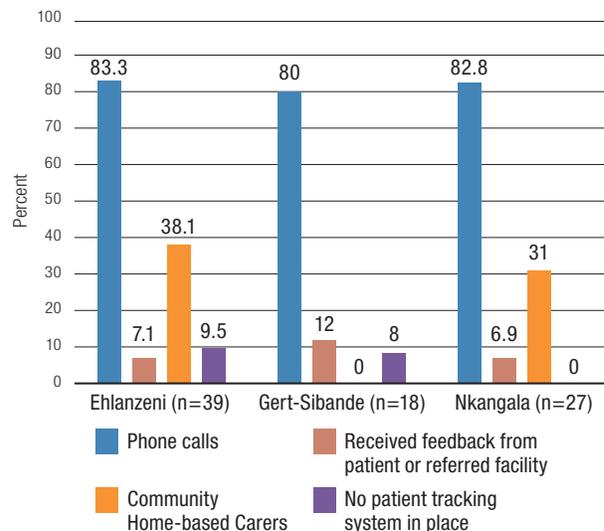
**Figure 13: Percentage of facilities using referral tools/documents in aiding patients referrals**



displayed. However, it was noted that the contact referral list to support the referral system was available in the majority of the facilities (61.9% EH, 56% GS and 72.4% NK) (see Figure 12).

- In almost all the facilities (95.2% EH, 100% GS and 96.9% NK), referral registers / forms were used as recording tools in aiding the referral system. More than half of the facilities (59.5% EH, 52% GS and 58.6% NK) indicated that they use the referral guidelines when referring a patient (see Figure 13).
- The use of phone calls seems to be the most predominant method of tracking patient movement during referrals (83.3% EH, 80% GS and 82.8% NK). Remarkable to note is the use of community

**Figure 14: Percentage of facilities using different approaches for tracking patient movement during referrals**



home-based care in Ehlanzeni (38.1%) and Nkangala (31%) districts to trace patients at community level (see Figure 14). Gert Sibande was the only district to indicate that they were not using community home-based carers to trace patients.

While the majority of PHC facilities indicated that there was a patient tracking system in place, there was a small number of facilities that indicated that they did not have a patient tracing system in place (EH 9.5% and GS 8%), which was of concern. Amongst those facilities that reported the use of phone calls, the highest number (96.7% EH, 100% GS and 86% NK) used their cell phones when communicating with higher levels (e.g. hospitals) on patient referrals. (see Figures 14 and 15). Furthermore, it was found the majority of PHC Supervisors (92.9% EH, 84% GS and 69% NK) do not review or have never reviewed the referral system during the supervisory visits (see Figure 16).

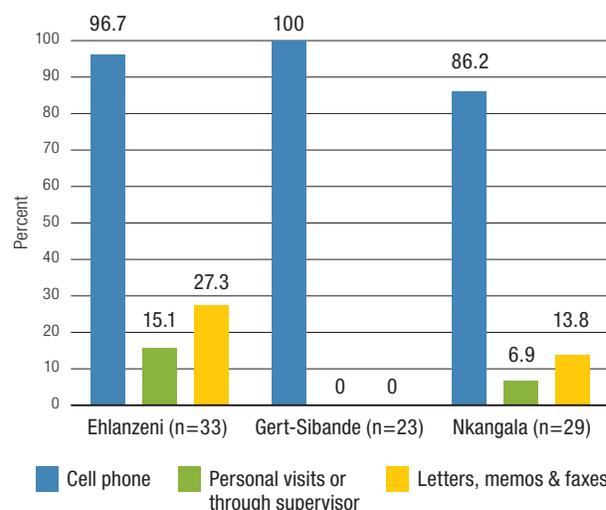
### 3.4.4 In-depth programme review

PHC Supervisors are expected to ensure compliance with standard treatment guidelines (STGs) by PHC health care personnel. That is, the PHC Supervisor should concentrate on the correct use of STGs by clinic staff, reinforcing correct practices (diagnosis, treatment, monitoring medicine stock-out, referral of patients, etc.) and ensuring adherence to established norms and standards.

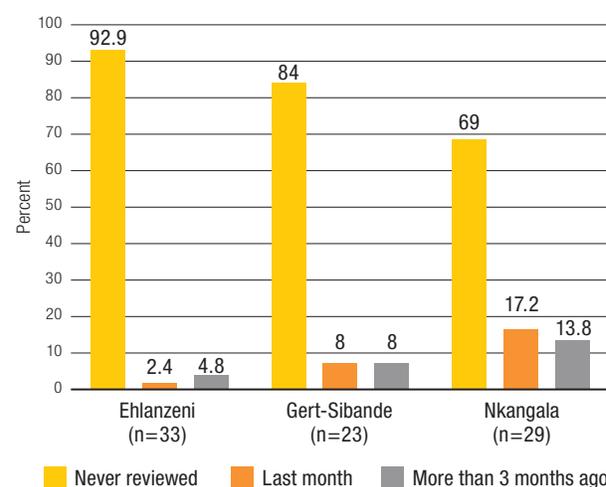
*The key findings regarding in-depth programme review were:*

- The standard treatment guidelines for specific health programmes such as TB, HIV/AIDS, STI, IMCI, PMTCT, IPC, EDL and SOPs (pharmacy and information) were available in almost all the facilities (> 90%) evaluated.
- More than two-thirds of FOMs (81% EH, 68% GS and 69% NK) reported receiving regular updates on STGs from their PHC Supervisors (see Figure 17).
- More than half of the FOMs interviewed (59.5% EH, 64% GS and 55.2% NK) reported that patient file/treatment cards were reviewed by the PHC Supervisor during their supervisory visits.
- Less than half of all FOMs interviewed (33.3% EH, 48% GS and 55.2% NK) reported that the medicine supply chain management was reviewed by the PHC Supervisor during the supervisory visit (see Figure 18).
- About half (56.0% GS; 54.8% EH and 51.7% NK) of FOMs reported to have received feedback on treatment or essential drugs from PHCS, following the supervisory visits (see Figure 19).

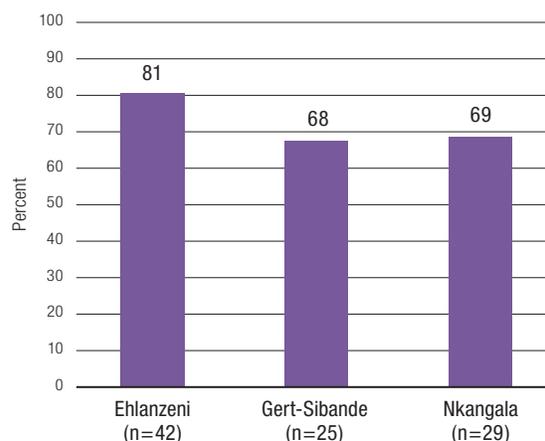
**Figure 15: Types of communication utilized between PHC facilities and Sub-district/District level**



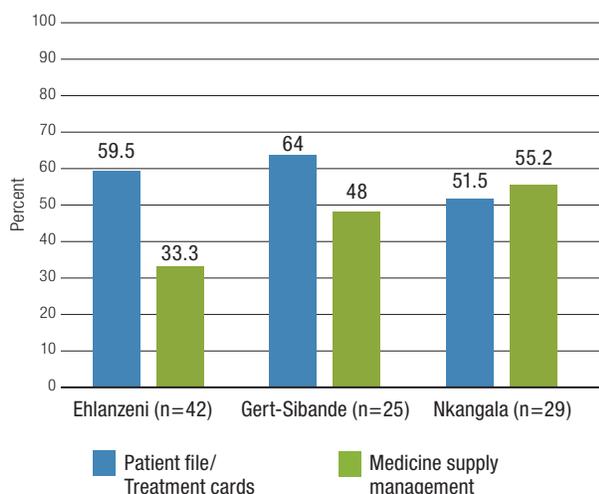
**Figure 16: Percentage of facilities indicating review of the referral system by PHC Supervisor**



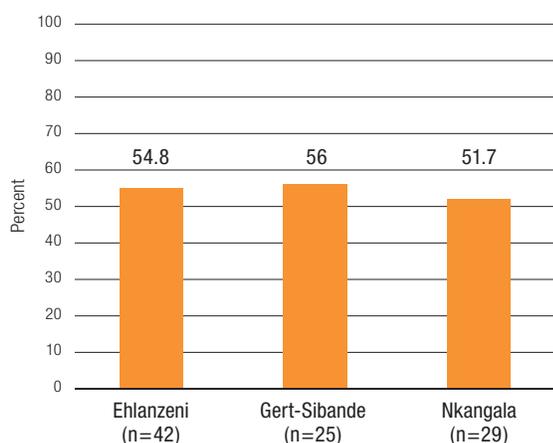
**Figure 17: Percentage of facilities receiving regular updates on STGs**



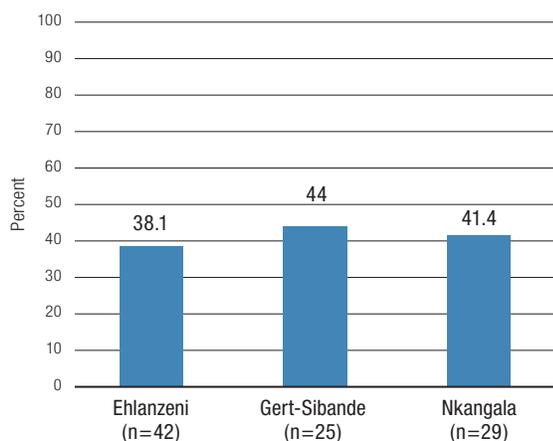
**Figure 18: Percentage of facilities with evidence of patient card and medicine supply reviews**



**Figure 19: Percentage of facilities reported to have received feedback on treatment or essential drugs**



**Figure 20: Percentage of facilities reporting that the PHC Supervisor had conducted an educational session for PHC staff in the last 12 months**



### 3.4.5 Staff support

#### Training

The PHC Supervisor carries a major responsibility to ensure that PHC facility health care personnel are updated, trained and appropriately coached. She/he must conduct educational sessions or co-opt experts in that field during each visit to address specific needs of the PHC facility health care personnel, covering elements of PHC facility service provision (updating and implementing programmatic changes), health care personnel management (new rules and regulations related to government service) and PHC facility administration. The main focus of this step is to conduct in-service training.

The following are the key findings of the evaluation regarding PHC personnel support:

- Less than half of the FOMs interviewed (44.0% GS, 41.4% NK and 38.1% EH) reported that the PHC Supervisor had conducted educational sessions for PHC personnel in the last 12 months (see Figure 20). However, it should be noted that majority of FOMs indicated that they were linked to a number of educational sessions or nominated PHC staff to attend educational sessions through support from their PHC Supervisor.
- Amongst those who received educational sessions in the last 12 months, the majority of them (68.9% EH, 63.6% GS and 83.3% NK) received training on patient management or treatment guidelines updates (see Figure 21).

#### Feedback

At the end of the supervisory visit, immediate feedback should be given to the FOM and a signed report left in the facility. The purpose of the feedback is to facilitate problem solving, planning, monitoring performance and aid the learning. Feedback may be either supportive or corrective. Feedback from districts and program managers should be shared with all PHC staff members.

The evaluation found that:

- More than two thirds of FOMs (66.7% EH, 68.0% GS and 86.2% NK) reported to have received feedback from the districts on the quality of data submitted (see Figure 22). About half of the FOMs (54.8% EH, 56.0% GS and 51.7% NK) received feedback from the PHC Supervisor on the treatment provided or on the use of essential drugs. In most cases, the nature of feedback was mainly to point out incorrect diagnosis, incorrect treatment/drugs and incorrect drug recordings.
- Almost all PHC Supervisors (87.5% EH, 100% GS and 77.8% NK) said they provide PHC supervisory feedback to the facility within two weeks from the visit. The feedback (either oral presentation or written notes/reports) is

given to the FOM and is discussed during PHC meetings or performance review meetings.

- All 3 District Managers interviewed also indicated having received regular feedback on the implementation of PHC supervisory tools at all facilities. However, they also indicated that there is still a need of follow-up with facilities to verify and ensure that supervision is done according to the standards.

#### Follow-up mechanisms and corrective measures

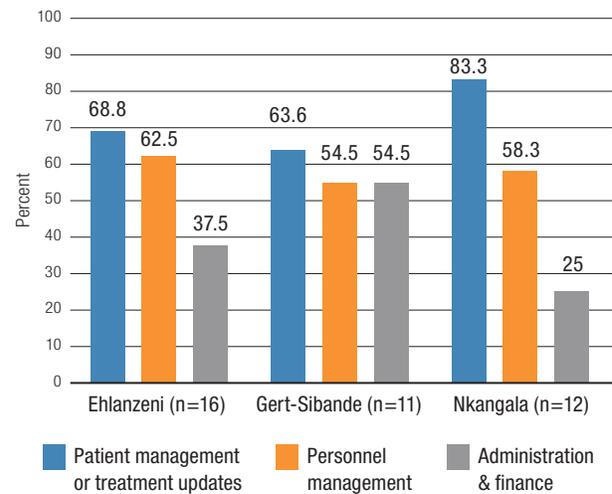
Corrective action plans or notes should be completed and signed by both the FOM and the PHC Supervisor. The District PHC Manager should also receive a regular monthly report from each PHC Supervisor and should use the information to manage and improve the quality of PHC services. The district submits summarized reports to the Provincial Office for monitoring and support.

While checking the documentation of the red flag and regular review checklist over the last 6 months, it was found that almost all of the facilities evaluated (95% EH, 79.2% GS and 100% NK) maintained documentation of supervisory actions, although this did not correlate completely with supervision visits. Furthermore, it was also found that in the majority of these facilities (81.1% EH, 72.2% GS and 70.4% NK), the required corrective action plans were completed and signed by both PHC Supervisors and FOMs (see Figure 23).

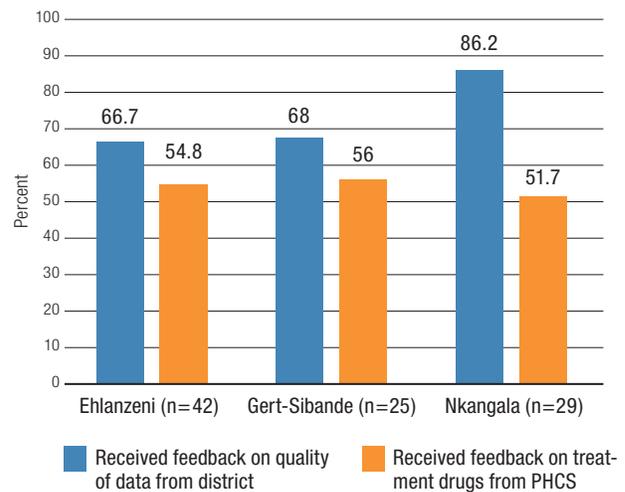
- When PHC Supervisors were asked about whether they develop corrective action plans following PHC supervisory visits, it was found that the majority of them (87% EH, 100% GS and 100% NK) mentioned that they develop/complete actions plans based on the key problems identified during the visits. In the last 3 months, key issues that came up for improvement in the feedback reports shared with the facilities included the following:
  - Checking the implementation of any new guidelines introduced.
  - A need to have monthly review meetings with facilities to discuss their performance and share information.
  - An urgent need to resolve issues related to infrastructure and maintenance of facilities, transport and shortage of staff.

To assess the effectiveness of PHC supervisory services at the administrative level, District Managers and PHC Supervisors were asked about the successes and challenges experienced, as well recommendations they would give to improve PHC supervisory services. Table 6 summarizes the key successes, challenges and recommendations mentioned by the District Managers and PHC Supervisors interviewed.

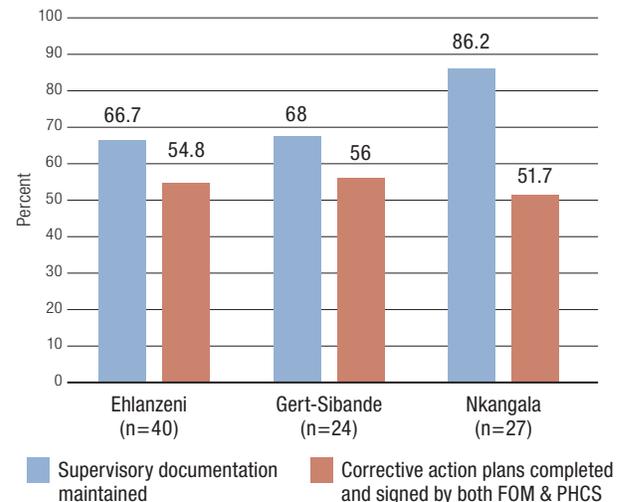
**Figure 21: Types of training conducted by PHC Supervisors in the last 12 months**



**Figure 22: Percentage of FOMs receiving feedback**



**Figure 22: Percentage of facilities with documentation and corrective actions plans in place**



**Table 6: Successes, challenges and suggestions for improving PHC supervision**

	As indicated by PHC Supervisors	As indicated by District Managers
<b>Success</b>	<ul style="list-style-type: none"> <li>The availability of documents (supervision tools &amp; manual) that guide them to perform their work at the facilities.</li> <li>The level of support received from the DOH is increasing although not yet of satisfactory.</li> </ul>	<ul style="list-style-type: none"> <li>The availability of resources to support PHC supervision.</li> <li>The PHC supervision structures that remain in place.</li> <li>The support received from the development partners to address some challenges.</li> </ul>
<b>Challenges</b>	<ul style="list-style-type: none"> <li>Too many meetings and workshops in different places are organized at the same dates.</li> <li>Too many facilities to visit, especially in remote areas.</li> <li>The lack of transport for supervision; where transport is available, it is old and unreliable.</li> <li>Unprofessional attitudes from FOMs towards PHC Supervisors due to the differences in salary scales.</li> <li>Acting too long as a PHC Supervisor without evidence of being appointed or somebody to the post.</li> <li>Targets set for certain indicators at the facilities are too high and may not be reached.</li> <li>Despite a number of submissions made to the district, infrastructure and equipment are still not maintained, and there is insufficient working space in some facilities.</li> </ul>	<ul style="list-style-type: none"> <li>There are shortages of human resources (both PHC Supervisors and FOMs) and unnecessary delays by the province to appoint PHC personnel.</li> <li>In some districts, there is no information and no PHC District Manager, which creates a challenge to manage supervision well.</li> <li>Inadequate systems in place to verify if action plans are followed up or implemented.</li> <li>No specific budget allocated or sufficient resources to perform PHC supervision tasks.</li> </ul>
<b>Suggestions to address the challenges</b>	<ul style="list-style-type: none"> <li>Adequate resources to support PHC supervision are required, i.e., ensuring sufficient budget for infrastructure, safe transport, filling of vacant posts and minimising acting positions.</li> <li>The department should also ensure adequate number of facilities allocated per PHC Supervisor as per standards with special focus to remote areas.</li> <li>FOMs should be trained to improve their attitudes and promote a teamwork spirit.</li> <li>Senior management need to be more supportive and enable PHC Supervisors to perform their supervisory functions.</li> </ul>	<ul style="list-style-type: none"> <li>Sufficient resources (budget and personnel) should be made available for PHC supervision services.</li> <li>The provincial office should take responsibility for filling all the vacant posts and do away with all acting positions.</li> <li>Incentive mechanism should also be put in place to motivate both PHC Supervisors and FOMs.</li> </ul>

## 4. DISCUSSION

This evaluation was undertaken in all 3 districts of Mpumalanga Province. In total, 141 health personnel took part: three District Managers from the 3 districts, 97 facility operational managers, and 41 PHC Supervisors. One of the most notable and worrying findings of the evaluation was the fact that a third of the FOMs and the majority of the PHC Supervisors interviewed were in ‘acting’ positions. Upon further questioning, it was realised that some of these individuals had been in ‘acting’ positions for up to 5 years. The advantages of engaging individuals in ‘acting’ positions include the fact that there is no overt vacancy in the post, there is someone to do the work immediately, and this is seen as a higher level of responsibility for the individual concerned. However, there are also several disadvantages with this arrangement, particularly over the longer term, as there is no permanency and ‘acting’ individuals are often uneasy, over worked, demotivated and frustrated.

### 4.1 The supervisory process

There was good understanding of the core tasks of supervision by all cadres of health workers interviewed, i.e., DMs, PHC Supervisors and FOMs. This was very encouraging, as it ensures alignment of work plans and expectations.

With regards to the number of facilities being supervised, this differed between the districts. In GS one supervisor claimed to be responsible for supervising 72 facilities, while another, in the same district, was supervising 2 facilities. In EH—the district with the majority of PHC Supervisors in ‘acting’ positions—supervisors were responsible for less than 6 facilities each, whereas in NK, all PHC Supervisors were responsible for >6 facilities each. This discrepancy would impact on the quality of supervision provided to each site.

In terms of the duration of supervisory visits, a statistically significant difference was noted between the duration reported by the FOMs and that reported by the PHC Supervisors. One explanation for this may be the differing understanding of what constitutes a supervisory visit, and how this may be different from any other visit (e.g., to drop off STGs / paperwork).

Review of PHC documentation revealed that not all facilities were receiving monthly supervision visits, highlighting a discrepancy between documentation of supervisory visits and reporting of supervision visits by PHCS. Of concern is the

fact that over 9% of facilities assessed were not receiving PHC supervision visits at all, due in part to a reported lack of resources for supervision.

### 4.2 Tools used for conducting PHC supervision

All PHC Supervisors and FOMs who participated in the evaluation indicated that the main tools used for supervision were the ‘red flag’ and ‘regular review’ tools, derived from the PHC Supervision Manual. All PHCs indicated that the revised PHC Supervision Manual had served to improve their skills and knowledge of PHC and their roles in the supervisory process.

### 4.3 PHC supervision elements evaluated

As per discussion with senior managers in the Mpumalanga DOH, five elements of the PHC Supervision process were part of the evaluation, as detailed below:

#### *Information system*

Evaluation of the information system involved a detailed examination of the data management system within the clinics evaluated. The URC team specifically enquired about validation of data, compared programmatic registers with monthly data input forms, and observed visual graphical illustration of data within the facilities.

In terms of the data management system, several facilities lacked a documented data management system, with most facilities indicating that the data-capturer or other delegated individual was responsible for data capturing within the facility. At all facilities, comparison of programmatic registers with monthly data input forms / reports was apparently done, however there was no sign off by PHCs evident within the documents submitted to higher levels. In terms of data validation, all facilities in EH & GS indicated that this had never been done. The only district where supervisors were conducting data validation was in NK, where there was ongoing training on data-related issues, at sub-district and facility level. Interestingly, the majority of facilities in NK revealed that they received feedback on the quality of data from higher levels, such as the sub-district and the district.

Despite the fact that over 70% of facilities evaluated had charts displaying data on the facility walls, the data contained in the charts was over 12 months old. As such, the data was outdated and of no use to measure progress within specific programs. Further enquiries regarding the outdated data led to facilities indicating that they were waiting for the district to provide them with updated data. This demonstrates poor capacity at facility level and an over-reliance on higher levels, such as the sub-district and district.

#### *PHC facility administration*

In terms of supervisors evaluating facilities on administration, and providing inputs / facilitating corrective action, it was revealed that over two thirds of facilities received this support.

#### *Referral system*

The evaluation found that the majority of PHC Supervisors do not review the referral system during their supervisory visits. However, at the majority of facilities, a contact referral list was readily available. In some facilities, there was even a map displaying the referral pathways. All facilities indicated that they were using appropriate referral guidelines, forms and registers.

The availability of a patient tracing system was also evaluated at all facilities. The majority of FOMs indicated that patient tracing was done by staff in the clinic using their own personal cell phones. In EH & NK, community based carers (CBCs) were also utilized to aid with tracing defaulting patients. In GS, important resources such as CBC were not utilized at all. However, of concern was the fact that some facilities reported that they had no patient tracing system in place at all. This could have serious repercussions for both the individual patient, the family and the health system as a whole, particularly in the case of communicable diseases, such as MDR or XDR TB.

#### *In-depth programme review*

During the evaluation of the quality of clinical care review, it was found that over 90% of facilities had standard treatment guidelines (STGs) for specific programs available. Of these facilities, over 60% received updates on STGs from their PHCs on a regular basis. Of concern is the number of PHC

facilities that did not have STGs during the evaluation and do not receive regular updates on the STGs.

In terms of the review of facility level patient charts and the supply chain for medication, over 50% of FOMs indicated that PHCs review patient charts and the supply chain for medication, and provided feedback.

#### *Staff support: Training*

One of the core tasks of PHCs is to provide / facilitate training for staff at the facilities they supervise. Over 50% of FOMs interviewed indicated that PHCs provide training onsite. There was also an indication that PHCs facilitated training courses for facility staff as necessary.

#### *Feedback, follow-up mechanism and corrective measures*

In terms of provision of feedback by PHC Supervisors, follow-up mechanisms and corrective measures in place, it was found that more than two thirds of FOMs reported receiving feedback from the districts on the quality of data submitted. About half of the FOMs received feedback on the treatment or use of essential drugs from the PHCs. In most cases, the nature of feedback was mainly on incorrect diagnosis, incorrect treatment/drugs and incorrect recording of medication. It was noted that almost all PHCS indicated provision of PHC supervisory feedback to the facility within two weeks of the visits. The feedback provided—in the form of either oral presentations or written notes/reports—was given to the FOMs and discussed during PHC meetings or performance review meetings. All three DMs also indicated having received regular feedback on the implementation of PHC supervisory tools at all facilities. However, during the evaluation there was very little documentation of this feedback, making it difficult to ascertain whether this was the case or not.

Evaluation of the red flag and regular review checklists over the last 6 months revealed that almost all the facilities maintained some of this documentation. Encouragingly, it was found that in the majority of facilities corrective action plans were completed and signed by both PHC Supervisors and FOMs.

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## 5. RECOMMENDATIONS

### Provincial, district and sub-district level

1. The Mpumalanga Provincial Department of Health should revise the staff establishment to provide an adequate number of posts for supervision. If there are adequate numbers, the provincial, district and sub-district budgets should ensure that the posts are funded and staff recruited and appointed. In the absence of sufficient number of supervisors, it is advised that each district/sub-district should establish a supervision team consisting of programme managers and available supervisors to conduct supportive supervision.
2. Sufficient and accessible transport should be provided for supervision visits.
3. Facility managers should be appointed and not “acting” to strengthen commitment and staff security.

### District and sub-district level

1. Communication between District Managers, sub-district managers and supervisors should be strengthened. District managers and sub-district managers should be aware of all the strengths and weaknesses within the supervision system and provide leadership and support to the system.
2. Supervisors should receive a training update on the role of supervisors and quality improvement in supervision. Specific issues that need attention include: the mentoring and coaching role of supervisors; the use of all the supervision tools; frequency of assessments; documentation of and feedback on supervision visits; information management and use; facility support on human resource management, clinic administration and referral system reviews; and provision of in-service training to facility staff on policy and guideline updates.
3. Capacity should be built amongst supervisors and facility managers on information management, data analysis, interpretation and the use of data for planning.
4. Staff morale and attitudes should be addressed with support from district and sub-district management.

### Facility level

1. Facility managers and supervisors should improve attitudes and teamwork.
2. Facility managers should prepare necessary documentation prior to supervisory visits.
3. Supervisors should improve compliance with the standards for supervision as in the National Supervision Policy and provide mentorship and coaching during supervision visits. Red-flag, regular review and in-depth review should be conducted with frequency as prescribed.
4. Documentation of all visits should be complete, available at facilities and signed by both the facility manager and the supervisor.
5. Supervisors should support facilities with the development of improvement plans and monitor the implementation of the plans and the progress in addressing challenges identified.
6. Supervisors and facility managers should improve on information management and use.
7. Supervisors should provide timely feedback to facilities on performance in all areas.
8. Improvement plans based on supervision findings should be integrated with improvement plans based on NCS assessment findings.

### Supervisors

With regard to administration, supervisors recommended:

1. That there should be equal distribution of staff in all facilities so that each facility can perform well and reach the targets set by the department.
2. The department should fill the vacancies as soon as possible so that there should be someone to account.
3. It was also recommended that facilities should function as they are classified. This is what came out: “Facilities which are classified as CHC but not operating as a community health centre should be encouraged to operate as a CHC”.
4. They recommended that there should be a good procedure or protocol for reporting.

## Leadership and management

With regard to leadership and management of the facility managers, supervisors recommended:

1. That facility managers should attend trainings on leadership and management to help them supervise or manage the facilities.
2. The department should introduce a system that ensure that everybody who underperforms should face a disciplinary action.

## Infrastructure

The group had different views on recommendations.

1. *“The department should stop renting houses and spending more money, instead the department should consult Indunas or traditional leaders to get free land and build clinics. Facilities should have their own budget for structures.”*
2. *“It is not easy to maintain the facilities, and the department should have their own people to maintain them rather than to wait for the Public Works department.”* [A member from National Department of Health also highlighted that all the provinces, districts and sub-districts have a budget allocated for infrastructure.]

## Transport

1. The respondents suggested that they would like to see the department providing ambulances for the clinics at all times to attend patient emergencies.

## Information systems

1. Information managers should provide enough training on information systems to both facility managers and data capturers to ensure that they know how to analyse, interpret and report the data.
2. All facilities in a sub-district should have information officers.

## PHC facility administration

1. Ehlanzeni recommended that facility staff should be allowed to attend training on record keeping and introduce an electronic system that keeps files or a duplication of patients' records at the facility.

## Referrals

1. The group recommended that there should be patient support from the hospitals and feedback when the patient has been referred. The feedback should be both ways—from higher levels, such as the district/province, as well as from facility and community level.
2. Supervisors also recommended that when drafting the referral policy, the department should also involve the sub-district so that everybody takes ownership.

## Staff support: Training

1. It was recommended that training should cover all the components of the PHC supervision manual and also make follow-up after the training.
2. The province, districts and sub-districts should communicate or organise training in different times to allow all facility managers and supervisors to attend the trainings.
3. It was also recommended that all professional nurses should attend training on midwifery.

## Programme review

1. Supervisors recommended that the department should appoint the required human resources in order to conduct regular patient care audits at the facilities.

## District managers

1. They suggested that there is a need for the department to conduct enough training for the supervisors and the facility managers in Mpumalanga Province.
2. Discipline needs to be maintained, especially where there is shortage of staff.
3. Incentives mechanism should also be put in place to motivate supervisors and facility managers. Funds should be allocated for PHC supervision services and relevant managers and PHC Supervisors appointed.

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## 6. CONCLUSION

This evaluation of the supervisory system conducted in all three districts in Mpumalanga Province revealed that supervision is occurring on a regular basis. The three main cadres of staff who participated in the evaluation—DMs, PHC Supervisors and FOMs—are all responsible for ensuring the overall effectiveness of the supervisory system. Several strengths and ‘best practices’ were noted in all three districts. However, there are also serious gaps with the organisation and platform of the supervisory system. For instance, there are more FOMs and PHC Supervisors in ‘acting’ positions than in permanent positions, which leads to demotivation, uncertainty and frustration amongst all cadres of staff. Another key issue to be addressed involves the fact that most FOMs have not received essential training on administration, quality assurance and information and financial management, and therefore they lacked the necessary management skills required to manage their facilities.

The detailed recommendations made above speak to the core of a well-functioning and effective supervisory system, to ensure that we attain the best possible health outcomes.

As this is the first evaluation of the implementation of PHC supervision services in Mpumalanga Province, the general consensus is that another, more detailed evaluation is required, to ensure generalisability of the findings and recommendations. Furthermore, it is suggested that mobile PHC units and Provincial PHC Managers be incorporated in the evaluation. It is also critical to ensure that ongoing initiatives, such as the PHC re-engineering process, the Ideal Clinic realisation and other relevant initiatives are taken into account when planning for such an evaluation.





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